DELIVERY SYSTEM TRANSFORMATION CONCEPT PAPER

Introduction

General Objective

Arizona has long been a leader in serving its 1.85 million Medicaid beneficiaries through creative and effective use of managed care delivery systems. Acute managed care organizations (MCOs), Regional Behavioral Health Authorities (RBHAs), and Arizona Long-Term Care System (ALTCS) plans (together, "the health plans") are the foundation of Arizona's management of its Medicaid program in a cost-effective and value-based manner. In 2015, Arizona was awarded a State Innovation Model (SIM) planning grant to facilitate system transformation. The agency responsible for the Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), is also responsible for managing the SIM. The goal of AHCCCS is to provide comprehensive, quality health care for those in need by: (i) bending the cost curve while improving members' health outcomes; (ii) pursuing continuous quality improvement; (iii) reducing fragmentation in health care delivery to develop an integrated system of healthcare, and (iv) maintaining core organizational capacity, infrastructure, and workforce. To effectuate this goal, AHCCCS understands that payment modernization is a critical component. Indeed, there are numerous payment reform efforts already underway in the State with commercial carriers and Medicaid health plans shifting away from traditional fee-for-service (FFS) models towards alternative payment model (APM) arrangements. AHCCCS has been a national leader among Medicaid agencies as one of the first in the nation to implement health plan contractual requirements with quantitative targets for value-based payment model adoption.[1] Indeed, for the calendar year ending 2015 – the most recent data available – across all product lines, 23% of AHCCCS's health care expenditures were made under value-based arrangements. While payment transformation has begun in Arizona, AHCCCS determined, through stakeholder outreach, that there were gaps in providers' abilities to succeed under new payment methodologies, and therefore a need for AHCCCS to intervene to support delivery system transformation.

A key theme for Arizona in pursuing its delivery system payment reform initiatives and APM requirements is reducing fragmentation that occurs between the main delivery and financing systems by encouraging the development of integrated systems that provide holistic care for individuals and thereby improve~~s~~ efficiencies and outcomes. Reduced fragmentation and APM requirements ~~that~~ will bend the cost curve and move providers toward models of payment that increasingly focus on quality rewards and penalties, and gainsharing and risk. In particular, Arizona seeks to invest in transformational projects to better position Medicaid providers and health plans to move more quickly toward APMs that utilize upside and downside gainsharing and comprehensive population-~~-~~based payment strategies. In making these changes to the delivery system, Arizona is focusing on some of the most complex and costly members, including individuals with both behavioral and physical health needs, members transitioning from incarceration into the community, and American Indian members.

[1] For example, MCOs in the acute care program ~~are~~ will be required to have a minimum of ~~20~~35% of their total payments to providers in value-based payment arrangements in ~~2016~~2017. ~~The 20% threshold will increase to 35% in 2017.~~

For this reason, Arizona seeks to fund time-limited projects aimed at building necessary relational infrastructure to improve multi-agency, multi-provider care delivery for the following populations:

- Individuals transitioning from incarceration who are AHCCCS-eligible.
- Children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder (ASD), and children engaged in the child welfare system.
- Adults with behavioral health needs.
- American Indians enrolled in the American Indian Health Program (AIHP) (both adults and children), including both those served through the Indian health delivery system (e.g., Indian Health Service (IHS)/Tribal 638 organizations) and those receiving some or all of their care from non-Indian health providers.

At the crux of the projects is improved care coordination and care management for these vulnerable AHCCCS members. Funding for transformational activities will target infrastructure investment and incentives for providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. AHCCCS has developed initial project components and milestones and is actively working with stakeholders to validate and refine these project strategies. Initially, AIHP projects were also developed within this framework. Based on recent guidance received from CMS, AHCCCS will continue to work with its stakeholders to develop strategies that strengthen systems of collaborative care among Indian health and non-Indian health providers and improve care coordination and care management capability for AIHP members. AHCCCS will seek to implement these strategies through the American Indian Medical Home waiver, State Plan Amendments and other means that support care management and patient-centered medical home service delivery.

Current State of Affairs

Arizona's Approach to Delivery System Transformation:

Arizona's publicly-funded health care system has historically been splintered, primarily due to the fragmented system of care in existence prior to the state's participation in Medicaid, beginning in 1982, as well as the way the program evolved once authorized by the legislature. In particular, the Medicaid program was implemented under 1115 demonstration authority and was envisioned as a partnership between the state and acute care health plans. After a disappointing two-year period using a contractor to run the program, Arizona directly administered the Medicaid program through a cabinet level department utilizing ~~managed care organizations~~MCOs. This turn around in acute care delivery allowed Arizona to launch a new component to the program, Arizona Long-Term Care System (ALTCS) in 1988. This new component utilized capitated comprehensive benefits through various program contracts serving both the disabled and the elderly. Finally, in 1995, AHCCCS completed a five-year phase-in of behavioral health services that were implemented through a separate contract with RBHAs and Tribal RBHAs.

For most Medicaid populations, services have been administered by these separate systems dependent on the needs of the populations: acute care plans for physical health and RBHAs for behavioral health. For individuals requiring long-term care, separate plans are responsible for all services: acute physical health, behavioral health and long-term services and supports. These systems have developed and functioned, for the most part separately, as the state added care components over time — unique providers, unique information and data systems, and unique

strategies to develop care protocols. The system for providing care to American Indians has evolved alongside these delivery systems, similarly with limited systematic integration.

Recently, however, Arizona has taken steps towards reducing these siloes by integrating payers for its Medicaid populations. In one example, AHCCCS has made one contractor responsible for all services for specialized populations, including children with chronic health conditions~~,~~ served by Children's Rehabilitative Services and individuals with serious mental illness (SMI). These modifications offered a new approach to integrated care, enhancing care- and case-management services at the payer level. For other populations, Arizona has required data sharing among its acute care plans and RBHAs to reduce blind spots in data that each plan faced and allow the MCOs to see data regarding utilization across the entire continuum of care. In addition, AHCCCS has Medicaid suspension agreements with the majority of counties such that individuals who become incarcerated (for less than one year) while enrolled in AHCCCS have their Medicaid eligibility suspended and then reinstated upon release rather than having to complete a new eligibility application upon release. AHCCCS is also planning to require (beginning in October 2016) the MCOs to have reach-in policies to prepare for an individual's release. These activities are critical foundational steps to ensure that individuals transitioning into the community from incarceration have immediate access to health care.

Finally, Arizona has been a national leader in aligning care for dual eligibles. AHCCCS requires its health plans to serve as Medicare dual eligible special needs plans and promotes enrollment of dual eligible members into the same health plan for both Medicare and Medicaid with over 45% of all dual eligible members aligned in the same health plan for their Medicare and Medicaid benefits. In addition, acute plans are now responsible for the general mental health/substance abuse services for their dual eligible members.

These improvements represent important change. However each of these integration efforts has exposed gaps in the overall delivery system and identified additional opportunities for facilitating integration throughout the care delivery and prevention continuum. While the State's Innovation Plan under SIM is focusing on efforts to address these gaps, in order for those changes to be sustainable in the Medicaid program, the State believes that investments must be made across the system, particularly~~including~~ at the provider level, to ensure that real delivery system change occurs. This will mean~~and~~ positioning providers to participate and succeed~~has a lasting impact~~ under new value-based~~ and~~ APMs that will hinge on provider collaboration across the delivery system and on information exchange and analysis. In addition to integrating payers, AHCCCS is challenged with developing provider networks that have the critical capabilities to provide whole person care that focuses on overall health and creating partnership across all aspects of health in order to improve patient outcomes.

In order to continue progress toward delivery system and payment reform and to further bring current initiatives to scale, AHCCCS seeks to develop a program that will incentivize both providers and MCOs to collaborate more effectively, leverage available data, and develop standard clinical and administrative protocols that more effectively engage patients and caregivers and ultimately provide~~ing~~ more effective care for the defined program populations. Funding available through the incentive payments will provide fiscal support for providers electing to be participating Delivery System Reform Incentive Payment Program (DSRIP) entities. The structure of the projects and the payment attribution and distribution will provide the catalyst for providers to jointly develop strategies and approaches to care that are beneficial to all of their patients and, in particular, AHCCCS enrollees. This is a critical investment strategy

as some of the providers serving these vulnerable populations may not otherwise be positioned to partner with AHCCCS health plans as they scale their APM initiatives, as well as participate in larger national initiatives, spearheaded under Medicare (such as Merit-based Incentive Payments or APMs) because of their patient mix, size or practice type. ~~In particular, behavioral health and pediatric providers.~~ This is particularly true in the case of behavioral health and pediatric providers.

The common theme of transformation for all projects, providers, and populations will be integration, coordination, and data exchange and analytics applied to care delivery within the participating provider entities. The existing provider entities will determine how best to leverage the strengths of their systems to connect and work with other systems and the health plans to achieve the core competencies described by AHCCCS. In addition, AHCCCS will be encouraging provider entities to form relationships with community-based social service resources to participate in the transformation projects, including but not limited to, self-help referral connections, community group resources, peer professionals, and housing and employment support services. However, specific tactics, providers, and services will be highly dependent on the targeted populations that the DSRIP provider entities seek to engage.

Behavioral Health and Physical Health Integration:

Historical Background

In 1990, AHCCCS began phasing in comprehensive behavioral health services, starting with seriously emotionally disturbed (SED) children under the age of 18 who required residential care. Over the next five years, other populations were added, including non-SED children in 1991, adults with serious mental illness in 1992, and adults needing general mental health and/or substance abuse services in 1995. The State supported a separate system of care for the treatment of behavioral health conditions instead of “carving-in” those services in the benefit plan administered by the acute health plans. This separation of behavioral health and physical health services was the desired approach of the behavioral health advocacy community at the time~~ and reflects the view still held by many advocates today that a system focused solely on behavioral health could better meet the needs of individuals with serious behavioral health conditions~~. The challenge for the State is balancing this long-held view with current health data and research showing health care disparities for persons with behavioral health conditions that could be addressed through system integration. Accordingly, and out of respect for the partnership with the behavioral health advocacy community, the State has taken incremental steps to move closer to an integrated behavioral and physical health delivery system but only after extensive stakeholder engagement. In 2014, AHCCCS shifted Medicaid-funded physical health services for individuals with SMI living in the State’s largest county and largest urban center to the RBHA administering services in that geographic area. In 2015, the remainder of the State moved to this integrated model for Arizonans with SMI.

In addition, state structural design utilized separate state agencies to oversee Medicaid health services exacerbating fragmentation. Historically, the Division of Behavioral Health Services within the Arizona Department of Health Services managed the behavioral health services and AHCCCS managed the physical health services. Effective July 1, 2016, the Division of Behavioral Health Services has been successfully merged with AHCCCS so that both physical and behavioral health services are now administered through AHCCCS.[2] The differing state administration means separate contracts for physical and behavioral health services for the

[2] The merger took place over several months and was completely finalized on July 1, 2016.

same members. This resulted in the development of entirely separate provider networks and delivery systems, where behavioral and physical health providers worked separately with limited collaboration.

With this historical background, it is not surprising that, in spite of these progressive changes toward integrated care, Arizonans with both behavioral health and physical health needs still struggle to receive the best care because of the lingering fragmentation throughout the delivery system. The lack of care coordination and integration between the two systems can hamper optimal care and result in an inadequate identification of and response to a person's total health needs. The adverse effect of uncoordinated care can have a particularly profound impact on the physical health of those with serious behavioral health conditions as further addressed below.

AHCCCS has care coordination requirements in its acute managed care contracts, including the following:

- The health plan must provide care coordination to members with special health care needs or chronic health conditions. In addition, the health plan is encouraged to develop specific strategies to promote care integration activities through contracting with behavioral health providers and consideration of members' behavioral health needs.
- The health plan is required to proactively provide care coordination for members with both behavioral health and physical health needs, including the requirement to meet regularly with the RBHAs.
- The health plan is required to develop a short- and long-term strategy to improve care coordination for individuals with behavioral health needs.

However, the ability for the managed care plans to effectively coordinate care and provide integrated care is limited by the providers' ability to participate in that process. The providers are directly delivering care and are in a better position to coordinate care in real time, but for them to do so effectively, many need infrastructure support to assist with data sharing, utilizing data analytics, having processes in place to support team-based care, and establishing the ability to make connections to social services. These areas represent fundamental changes in practice operational processes. In addition, it is difficult for providers to make these changes individually without transformation support and a common framework of clinical and administrative protocols designed and administered in coordination with the health plans. The DSRIP program provides the opportunity to support, facilitate and align this kind of delivery system evolution and thereby achieve a new level of integration and improved outcomes.

Impact of Fragmented Care for Children with Behavioral Health Needs, Children with and At-Risk for ASD, and Children Engaged with the Child Welfare System

Children with behavioral health needs, children with and at–risk for ASD, and children engaged with the child welfare system and their families have found that insufficient and inconsistent linkages between community-based health and behavioral care, social service resources, and hospital care can leave them frustrated.

In addition to responding to Arizona children and families, there are multiple compelling reasons to focus upon these pediatric populations, based on national research:

- Behavioral health care accounts for approximately 38% of Medicaid expenditures for children.

- Children in child welfare system and those on Supplemental Security Income/disability represent one-third of the Medicaid child population using behavioral health care but represent 56% of total pediatric behavioral health expenses.
- Almost 50% of children in Medicaid prescribed psychotropic medications receive no accompanying identifiable behavioral health services, such as medication management.[3]

As in the rest of the U.S., Medicaid-enrolled children with behavioral health needs often receive fragmented care from multiple public systems leading to poor health outcomes and costly utilization. A December 2013 report recommended that efforts be made nationally to improve care coordination for these children, including collaboration between child-serving systems, especially the child welfare, behavioral health, and primary care systems.[4]

Impact of Fragmented Care for Adults with Behavioral Health Needs

Adults with behavioral health needs too often find that the medical care, behavioral health care, and social services sectors rarely collaborate in a way that addresses their complex needs. A 2015 Government Accountability Office report showed that nationally over half of the Medicaid-only enrollees in the top 5% of expenditures had a mental health condition and one-fifth had a substance use disorder.[5] That report also observed that "Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens) the health care system is often too fragmented to effectively and efficiently serve them."

Individuals Transitioning from the Justice System:

Historical Background

On average, 9,000 Arizona Medicaid beneficiaries are incarcerated in a given month. In fiscal year 2015, of the approximately 120,000 individuals that transitioned from incarceration into the community, approximately 42,000 were enrolled (or re-enrolled if eligibility was suspended) in AHCCCS. AHCCCS analysis shows that there are a significant number of individuals who are eligible for Medicaid but not enrolled upon release.

Many individuals begin their incarceration with undiagnosed or underdiagnosed behavioral health conditions.[6] In addition, research on recidivism indicates that three out of four incarcerated individuals are re-incarcerated over the course of five years.[7] The inability to access behavioral health services, including treatment to address substance use disorder, is a contributing factor to recidivism. Further compounding the issue in Arizona is the significant shortage of behavioral health providers within the State's counties and federal correctional facilities.[8]

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[3] Rires SA et al. Examining Children's Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies, Inc. Hamilton, NJ December 2013.
[4] Ibid.
[5] General Accounting Office (GAO). A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures. GAO 15-460 May 2015.
[6] See www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf TAC—The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.
[7] Durose, Matthew R., Alexia D. Cooper, and Howard N. Snyder, *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010* (pdf, 31 pages), Bureau of Justice Statistics Special Report, April 2014, NCJ 244205.
[8] See Arizona State Health Assessment April 2014 at page 113, available at http://www.azdhs.gov/documents/operations/managing-excellence/az-state-health-assessment.pdf.

When these individuals transition out of incarceration, there is a need to ensure they have access to the needed services and social supports without a break in care. Individuals transitioning out of incarceration experience significant gaps in care. While incarcerated, these individuals generally receive health care services from the counties or the state's Department of Corrections (depending on whether they are incarcerated in a jail or prison). The providers within the jail and prison systems typically do not have access to an individual's health history (unless the individual is a repeat offender) and may not be aware of chronic conditions, treatment plans, or medications. Similarly when the individual transitions out of incarceration, community providers are not privy to the treatment the individual received while incarcerated. To further complicate the issue, often when leaving a prison or jail individuals (particularly those with chronic physical and/or behavioral health conditions) have no warm hand-off to transition their care and ensure continuity.

Impact of Fragmented Care for Individuals Transitioning From the Justice System
While AHCCCS has taken steps to keep members attached to their health plans through suspended enrollment during incarceration, and has established early intervention and outreach activities to enroll newly released individuals, additional strategies are needed to effectively engage previously incarcerated individuals with health care providers in their communities. National research has found that 80% of released individuals have chronic medical, psychiatric, or substance abuse problems, yet only 15% to 25% report visiting a physician outside of the emergency department (ED) in the first year post release.[9] It has also revealed that there is little care coordination between prison/jail and community health systems. For example, few individuals are released with a sufficient supply of chronic medications or primary care follow-up.[10] In addition, individuals leaving prison/jail may not fully understand the scope of Medicaid benefits available to them or how to appropriately access services. Given their additional need for support as they transition into the community, this population is likely to need a higher, more intense level of care coordination by providers as they are settled in the community.

American Indians:

Historical Background
The location of services for American Indians varies to a large extent. American Indians (including those who are enrolled in Medicaid), regardless of whether they live on or off tribal lands, can receive services at any Indian health facility, including IHS sites, Tribal 638 programs and facilities, and Urban Indian Health Programs. While the issue of provider choice is important, the lack of care coordination among providers and across the care continuum challenges service delivery for American Indians. Each of these settings provides care to individual members without visibility into the care the members may receive from other providers, making care coordination and whole-person care challenging.

Within the Medicaid program, American Indians may enroll in either the FFS AIHP or one of the AHCCCS-contracted managed health plans. For American Indian Medicaid eligible residents who live on tribal lands and do not elect a Medicaid enrollment choice, enrollment defaults to

[9] Mallik-Kane K, Visher CA. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington, DC: The Urban Institute; 2008 and Mallik-Kane K. Returning Home Illinois Policy Brief: Health and Prisoner Reentry. Washington, DC: Urban Institute Justice Policy Center; 2005.
[10] Wakeman SE, McKinney ME, Rich JD. Filling the gap: the importance of Medicaid continuity for former inmates. *J Gen Intern Med*. 2009; 24(7):860---862 and Flanagan NA. Transitional health care for offenders being released from United States prisons. *Can J Nurs Res*. 2004; 36(2):38---58.

AIHP. In contrast, if the American Indian Medicaid eligible resident does not live on tribal lands, and does not make a Medicaid enrollment choice, the individual is auto-assigned to a managed care plan based on factors such as family participation in the plan. Choice is key; American Indian Medicaid enrolled individuals can change enrollment from AIHP to a managed care plan at any time and vice-versa. These enrollment options have created churn between managed care and AIHP. In general, however, one third of Arizona's American Indian population is enrolled in AIHP and as of May 2016, the program had approximately 120,000 members.

This fragmented system of care is evident both (i) among Indian health providers and (ii) between Indian health providers and non-Indian health providers. For example, it is a common occurrence that primary care providers caring for individuals in Indian health organizations are not aware of their patients' admission to or discharge from a hospital outside their communities. Consequently, appropriate discharge planning and follow–up care does not routinely occur, sometimes resulting in avoidable ED visits or hospital re-admissions. Likewise, the attending hospital or ED provider who is seeing the patient for the first time is faced with providing care without complete knowledge of the patient's medical history, including medications. This significant fragmentation of services is believed to contribute to observed health disparities and present challenges in improving outcomes for American Indians in Arizona.

American Indians with chronic or complex conditions, including those with SMI, are often most negatively impacted by system fragmentation. Continuity of care, including medication and other therapies, are critical for those with serious health conditions. However, the current delivery system does not provide the infrastructure to support appropriate care management.

A key contributor to care fragmentation stems from inadequate health information technology (HIT) connectivity and interoperability. Health information for American Indians resides in different electronic health record (EHR) systems, with limited exchange of information needed to coordinate care. As described in the HIT section of Arizona's Innovation Plan, IHS, Tribal 638 facilities, ITUs, and non-Indian health providers often utilize distinct HIT/EHR systems and databases that do not presently communicate with each other, prohibiting the exchange of information needed to provide appropriate services and coordinate care.

The limited resources across the IHS and Tribal 638 facilities present another barrier to reducing fragmentation in the system. Generally, these organizations do not have the resources to hire additional staff to perform care coordination or care management or resources to enable interoperability that would support improved coordination.

In spite of significant resource limitations, IHS has been working across its national system to increase coordination of care through its Improving Patient Care (IPC) Program, a patient-centered medical home model. The IPC Care Model is based on the Chronic Care Model developed by the MacColl Center for Health Care Innovation. The IPC model modified the original Chronic Care Model to reflect the unique features of health care in the Indian health system. The model also has been adapted to address the strong role of family and the need to fully integrate the community and the Tribes into the vision for health care. Robust therapeutic relationships are a key element in this IPC model.

In summary, the delivery system and provider networks for American Indian Health Program members are often fragmented and fail to address the needs and care of the "whole" person across the care continuum. AHCCCS with its stakeholders has identified goals and

accompanying tasks that will help bridge existing gaps in care for the State's American Indian population through enhanced care coordination, care management and HIT interoperability.

Delivery System Transformation

Future State of Affairs

Arizona believes the initiatives described below will help the State take a critical step towards achieving true delivery system reform by reducing fragmentation and developing an integrated system that provides holistic care for individuals that bends the cost curve. Detail on each of the initiatives is further described throughout this section.

Behavioral and Physical Health Integration for Adults:

Specific Objective for Adults

There is a need for a comprehensive approach to integrated care in any care setting in which an AHCCCS member may receive either physical or behavioral health services to better address mental and physical health and addiction disorders. There are four projects in this strategic focus area, all of which are mandatory for providers that seek to participate in DSRIP projects targeting this focus area. The projects are designed to foster collaboration between providers in these unique systems through joint development of information sharing tools, data analysis, clinical and administrative protocols, and preparing providers to more effectively manage population health as reimbursement systems move toward shared accountability and shared risk. The projects are further described below.

Providers Involved and Role of Acute Health Plans and RBHAs

Providers interested in participating in the adult behavioral and physical health integration projects must collaborate with other providers in order to enable the creation of collaborative clinical and financial relationships that can most effectively impact care delivery. Successful entities must engage a minimum array of providers needed to address core health and social needs of this target population. Providers forming a participating entity must consider historical patterns of care for targeted patients and must include provider partners to address:

- Acute inpatient care needs.
- Behavioral health care needs, including substance abuse disorders.
- Primary care.
- Social and community supports, as needed.
- Access to care.

AHCCCS is not dictating a governance structure for the participating entities beyond a requirement that the participating entities have executed an agreement that defines how providers will work together to accomplish the projects. These agreements must describe, at a minimum:

- Which providers will act as 'leads' for purposes of reporting performance on DSRIP milestones and measures, convening meetings, and disbursing incentive payments.
- How the entities will engage in data sharing and data analytics, including clinical and financial measures.
- How entities will collaborate to develop shared clinical and administrative protocols.
- How acute health plans and RBHAs and Arizona Health-e Connection (AzHeC) will participate in the partnership and projects.
- Geographic reach of entity.

Prospective participating entities will submit applications to the State that address how the entities will develop and implement projects. The applications will be scored, selected, and approved prior to any project activities starting or funding being released.

In addition to being involved in the participating entities, AHCCCS expects its acute health plans and RBHAs to not only participate as members of the participating DSRIP entities, but also to:

- Provide the DSRIP entities with analytic support to inform their strategy development and implementation.
- Participate in joint planning and implementation of care coordination protocols and activities, particularly in light of existing care management and care coordination functions that the health plans operate, and thereby define the respective roles of the acute health plans, RBHAs, and participating providers.
- Participate in the DSRIP learning collaboratives.
- Play a substantive role in relevant projects.

Description of Adult Behavioral and Physical Health Integration Projects

Project 1: Integration of primary care and community behavioral health services (primary care site). The objective of this project is to integrate behavioral health services (some of which are paid for by RBHAs) into the primary care site. This project would include both SMI and non-SMI individuals. There are many core components for successful participation in this project that include, among many others: (i) utilizing a commonly accepted behavioral health integration practice self-assessment instrument; (ii) conducting a root cause analysis to determine why certain practice patients are frequent ED and/or inpatient service utilizers and identifying the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based; and (iii) enhancing EHR capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice and reduce administrative duplication.

Project 2: Integration of primary care and community behavioral health services (community behavioral health site). The objective for project 2 is 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 individuals who primarily receive their services at community behavioral health sites. The core components of project 2 are similar to project 1 except this project is within a community behavioral health care site and project 1 is within a primary care site.

Project 3: Integration of primary care and behavioral health services (co-located site). The objective of project 3 is 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. The core components of this project are the same as projects 1 and 2 except that this project takes place in a co-located care site where higher levels of integration are possible.

Project 4: Care coordination for adults with behavioral health conditions being discharged from an inpatient stay (hospital). The objective of project 4 is to more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient stay. Hospitals participating in this project will be required to focus on care coordination with

outpatient providers upon a patient's admission, and upon discharge, medication management and communication with the RBHA. There are many core components for successful participation in this project that include, among many others: (i) developing protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, seven days per week; (ii) providing 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; and (iii) following-up with the patient within 48 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.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the adult behavioral and physical health integration projects will be expected to meet each of the core components for each project, as well as provide required process and outcome reports on their progress. It is expected that payments made to DSRIP entities in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that DSRIP entities meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, DSRIP entities will only receive payments if they demonstrate improvement or high performance on clinical measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and care coordination strategies, and review whether additional changes to further encourage the effective integration and care coordination strategies are necessary.

At the conclusion of the demonstration, AHCCCS expects the necessary infrastructure changes will have been supported, and the model will be sustainable through APMs. Currently, AHCCCS has requirements for its health plans to have a certain percentage of its payments in value-based arrangements with that percentage increasing every year. AHCCCS may decide to add requirements to its contracts around value-based arrangements or refine existing contractual requirements to reflect the infrastructure changes implemented under DSRIP for specific projects to ensure the integration efforts are sustainable. For example, participating DSRIP entities could contract with health plans as an entity and negotiate APMs that include investments in integrated care for adults with physical and behavioral health needs.

Measurement of Transformation

DSRIP entities will be expected to meet certain performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

Behavioral and Physical Health Integration for Children:

Specific Objective

There is a need for a comprehensive approach to integrated care (physical and behavioral health) in any care setting in which an AHCCCS member under the age of 21 may receive either physical or behavioral health services (for example, from a primary care provider or a community behavioral health provider) to better address mental and physical health and addiction disorders. There are ~~four~~ six projects for this strategic focus area, all of which are mandatory for DSRIP participating entities, and are focused on children with behavioral health needs, children with or at-risk for ASD, and children engaged with the child welfare system.

Providers involved and Role of Acute Health Plans and RBHAs

AHCCCS anticipates that the provider characteristics and role of the health plans will be the same as described in the adult section.

Description of Behavioral and Physical Health Integration Projects for Children

Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site). This project is for primary care practices to integrate behavioral health services for children (some of which are paid for by the RBHAs) within the primary care site. This project focuses on the actions necessary to fully integrate care, including managing high-risk patients using an integrated treatment plan where both physical health and behavioral health providers give input, developing referral, consultation, and warm hand-off protocols and integrating patient records. There are many core components for successful participation in this project that are similar to the core components for the adult project 1.

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health site). This project is for community behavioral health sites to better integrate primary care services for the purposes of better care management of the preventive and chronic illnesses for children. This project focuses on the actions necessary to fully integrate care in a manner similar to project 1 and the core components are similar to the core components for the adult project 2.

Project 3: Improving treatment for the care of children with and at-risk for ASD. The objectives of this project is to improve the identification and care of Medicaid-enrolled children at-risk for Autism Spectrum Disorders or diagnosed with Autism Spectrum Disorder, and create sufficient and consistent linkages between primary care, behavioral health, and social service resources. This project would begin in DSRIP Year (DY) 2 and all participating providers would need to first successfully complete project 1 in this strategic focus area, as this project builds upon the foundation for care provided in an integrated setting addressed in project 1. This project focuses specifically on care coordination with autism treatment teams, early intervention programs, and schools to improve the care outcomes of children with Autism Spectrum Disorder. There are many core components for successful participation in this project that include, among many others: (i) utilizing a commonly accepted toolkit for caring for children with ASD as a guide for clinical management; (ii) developing procedures for referring children with positive screening to ASD treatment teams or programs; and (iii) routinely documenting family history of autism.

Project 4: Improving treatment for the care of children engaged in the child welfare system (primary care site). The objective of this project is to improve the care of Medicaid-enrolled children who are involved in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2, and all participating DSRIP entities would need to complete project 1 in this strategic focus area, as it builds upon the care provided in an integrated setting. This project specifically focuses on developing clinical protocols to help identify and address medical or behavioral health issues a child engaged in the child welfare system may have and to conduct care using Trauma-Informed Care principles. There are many core components for successful participation in this project that include, among many others: (i) ensuring that all practice pediatricians, family physicians, advanced-practice clinicians, and case managers who treat children engaged in the child welfare system complete a training program in Trauma-informed

Care and in Child and Family Team Practice that offers continuing education credits, unless having done so in the past three years; (ii) developing and implementing policies that allow for patients, in particular teens, to participate in shared decision making using the skills and techniques developed through Trauma-Informed Care training; and (iii) completing a comprehensive after-visit summary that is shared with the foster parents/guardians and the child welfare case worker, which can assist in guiding the foster parents/guardians and case worker in following-up on referrals and recommendations.

Project 5: Improving treatment for the care of children engaged in the child welfare system (community behavioral health site). The objective of this project is to improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity of care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2 and all participating DSRIP entities would need to successfully complete project 2 in this strategic focus area prior to starting this project, as it builds upon the foundation for care provided in an integrated treatment setting addressed in project 2. This project focuses on the actions to coordinate care specifically for children engaged in the child welfare system in a similar manner to project 4. There are many core components for successful participation in this project that include, among many others, (i) conducting a comprehensive behavioral health assessment within the timeframe established by AHCCCS for patients referred by the RBHA, a primary care provider, or when a case worker, patient or a patient's parent/guardian requests an appointment, and (ii) actively outreaching to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management.

Project 6: Care coordination for children with behavioral health conditions being discharged from an inpatient behavioral health stay (hospital). The objective of this project is to more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient stay. Hospitals participating in this project will be required to focus on care coordination with outpatient providers upon a patient's admission, and upon discharge, medication management and communication with the RBHA. There are many core components for successful participation in this project that include, among many others: (i) developing protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, seven days per week; (ii) providing 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; and (iii) following-up with the patient within 48 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.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the child behavioral and physical health integration projects will be expected to meet each of the core components for each project, as well as provide required process and outcome reports on their progress. It is expected that payments made to DSRIP entities in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that DSRIP entities meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, DSRIP entities will only receive payments if they demonstrate improvement or high performance on clinical measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and

care coordination strategies particular to the specific projects and target populations. Analysis of alternative payments strategies will be necessary to support and leverage the infrastructure changes through health plan contracts.

At the conclusion of the demonstration, AHCCCS expects that language will be added to the health plan contract requirements to embed and support the care coordination activities developed through the waiver. AHCCCS has requirements for its health plans to have a certain percentage of its payments in value based arrangements with that percentage increasing every year, and this language may be modified to reflect these new models. AHCCCS may decide to add requirements to its contracts around value-based arrangements to ensure the integration efforts are sustainable. For example, participating DSRIP entities could contract with health plans as an entity and negotiate alternative payment models that include investments in integrated care for children with behavioral health needs, children with or at-risk for ASD and children engaged with the child welfare system.

Measurement of Transformation

DSRIP entities will be expected to meet certain performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

Individuals Transitioning from the Justice System:

Specific Objective for Individuals Transitioning from the Justice System

There is a need to facilitate better provider, community, and justice system coordination to ensure individuals transitioning out of incarceration are (i) enrolled in AHCCCS (and a health plan) if eligible for AHCCCS, and (ii) have timely appropriate access to physical and behavioral health services. There is one project for this strategic focus area for adults, described below.

Providers Involved and Role of Acute Health Plans and RBHAs

For the Justice project, AHCCCS believes that RBHAs are best positioned to lead in this effort and as such, is proposing that RBHAs will organize providers interested in this project and provide support throughout the project. RBHAs will be expected to have agreements with providers to deliver, among other things, the following services:

- Behavioral health care services, including services for substance use.
- Primary care services.
- Social and community supports services, as needed.

The RBHAs will be expected to submit an application to AHCCCS that explains arrangements with providers and how the entities will effectively implement the project. Among other things, the RBHA will need to ensure its agreement with providers explains:

Description of the Justice Project

Develop an integrated health care setting within county probation offices or Department of Corrections (DOC) parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. The objective of this project is to develop an integrated health care setting within selected probation and parole offices to: (i) coordinate eligibility and enrollment activities to maximize access to services; (ii) assist with health care system navigation; (iii) perform health care screenings; (iv)

provide physical and behavioral health care services; (v) provide care coordination services to assist the individual in scheduling initial and follow-up appointments with necessary providers within or outside of the integrated setting; and (vi) assist individuals with arranging and coordinating continuing care once the individual is no longer required to participate in probation/parole activities. There are many core components for successful participation in this project that include, among many others: (a) establishing an integrated health care setting(s) co-located within select county probation offices and/or DOC parole offices, the number to be determined by the RBHA and AHCCCS; (b) developing an education strategy in cooperation with the probation and parole offices to encourage individuals pre-release to utilize the integrated health care setting post-release; and (c) enhancing relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, peer professionals, housing and employment support services by identifying the resources in the community, and creating protocols of when to engage or refer patients to these community-based resources.

A project targeting youth transitioning from the juvenile justice system wa~~i~~s under consideration, but is no longer proposed based on AHCCCS' assessment that there is existing funding supporting ongoing delivery system capacity development in this area~~for future development~~.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the Justice project will be expected to meet each of the core components for the project, as well as provide required process and outcome reports on their progress. It is expected that payments made to participating providers and plans in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that providers and RBHAs meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, providers and RBHAs will only receive payments if they meet specific outcome measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and care coordination strategies and evaluate options for alternative payment strategies to RBHAs and providers or develop plan incentives to support the transformation achieved through the DSRIP.

AHCCCS expects the necessary infrastructure changes will have been supported, and the model will be sustainable through value-based payment strategies targeting both providers and plans for this focus area. Currently, AHCCCS has requirements for its health plans to have a certain percentage of its payments in value-based arrangements with that percentage increasing every year and additional options could be identified associated with this specific project. AHCCCS may decide to add requirements to its contracts around plan incentives tied to outcomes associated with justice-involved individuals and/or the inclusion of value-based arrangements or care coordination payments to providers to ensure the integration efforts are sustainable. For example, RBHAs could implement provider pay for performance payments for successful transitions of individuals from the probation clinic to community providers or reward outcomes associated with wellness activities or treatment adherence successes by plans.

Measurement of Transformation

DSRIP entities will be expected to meet certain process performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

American Indians

Specific Objective for American Indians Receiving Services from AIHP

There is a need to improve health outcomes for American Indians by creating more robust care coordination and care management for American Indian Health Program (AIHP) members, through collaborations that seek to improve infrastructure, communication, use of data, consistent outcome measures, and application of operational and clinical protocols. Four projects have been developed for this strategic area. Each project is summarized below. Based on recent CMS guidance, AHCCCS will be exploring with stakeholders ways to achieve these projects through the American Indian Medical Home and American Indian Medical Home + waiver, a State Plan Amendment or other means and will not be pursuing this initiative under the DSRIP. However, it is important to note that these projects and their core components have undergone extensive stakeholder review and the descriptions below reflect that feedback. Nonetheless, AHCCCS will be making adjustments to the descriptions below based on CMS feedback but will continue to push for improved care management system development through regional collaboratives and expanded medical homes capability.

Description of Projects

Project 1: Provider Role in Care Management Collaboratives (CMCs) Formation, Governance and Management. Three regional CMCs are proposed to advance care management collaboration among Indian health and non-Indian health provider organizations. Providers will participate in CMC activities to ensure that commonly understood and shared care management strategies are developed and implemented. This project focuses on the activities in which providers will engage and collaborate constructively in the formation of the CMCs, participate in training developed by the CMCs, and implement protocols created collaboratively by the CMCs and providers.

Project 2: Care Management. The goal of this project is to develop a care management system for American Indian populations enrolled in AIHP and receiving treatment through Indian health and non-Indian health provider organizations participating in the CMC. This project focuses on the development and implementation of specific care management protocols, including standard care plan development, member engagement in care management, availability of care management services, and appropriate and timely communication of records for care management activities.

Project 3: Care Management and Data Infrastructure. The goal of this project is to develop a data infrastructure that can support data analytics using both clinical data and claims data for CMC participating providers. This project focuses on accessing and utilizing data analytics, requirements for which data must be shared/reported, and use of state-based resources, including the Controlled Substances Prescription Monitoring Program and the Network, the state's health information exchange.

Project 4: Transformation of primary care sites serving AIHP members into Patient-Centered Medical Homes (PCMH). The goal of this project is to train primary care practices and community behavioral health practices on core PCMH skills and track their increased skill level over time. This project focuses on the core requirements to develop PCMH functionality, including adopting a quality improvement strategy, conducting care management activities, using evidence-based care, enhancing access, and integrating portions of behavioral health into

the primary care setting, among other attributes. The project is built around the eight Qualis change concepts for safety net medical homes.[11]

Delivery System Transformation Assessment

In order to assess transformation at the system level, AHCCCS will focus on aspects of clinical performance that should improve as a result of better integrated care for enrollees with behavioral health needs. -In addition, AHCCCS will track evolution towards increased use of risk-bearing value-based payment models.the two core elements of system transformation underlying AHCCCS' proposed DSRIP activities:

1. Behavioral health and physical health integration, and
Care management.

AHCCCS has identified the following candidate measures for assessing delivery system transformation, with the intention that two measures will ultimately be selected for each of the three strategic focus areas. -Because AHCCCS is currently in the process of calculating baseline rates for these measures and other measures to identify where opportunities for improvement exist, final proposed measures will be presented to CMS by November 2016 and may include measures other than those presented below.

DSRIP Strategic Focus	Candidate Measure #1	Candidate Measure #2	Candidate Measure #3
Justice transition: Individuals released from Incarceration	Adults access to preventive/ambulatory health services (HEDIS)	Follow-up after emergency department visit for alcohol and other drug dependence (HEDIS)	Adult body mass index assessment, (HEDIS)
Children: behavioral/physical health integration	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified)	Follow-up after emergency department visit for mental illness (HEDIS)	Mental health utilization (HEDIS)
Adults: behavioral/physical health integration	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (HEDIS)	Follow-up after emergency department visit for mental illness (HEDIS)	HbA1c poor control >9% for adults with diabetes and a behavioral health diagnosis (HEDIS measure component, modified)

Integration of behavioral health and physical health services will be assessed via electronic implementation of a standardized integration assessment tool. All primary care and outpatient behavioral health practices participating in the child and adult integration projects, as well as the integrated care sites participating in the justice projects, will be required to complete the online assessment at the outset of the DSRIP period, after Year 2 and again prior to the end of Year 5. Results will be aggregated and AHCCCS will seek to confirm that the participating practices have collectively advanced service integration over the course of the DSRIP period. AHCCCS

[11] www.safetynetmedicalhome.org/change-concepts

has reviewed the wide array of instruments that have been publicized by AHRQ[12] and SAMHSA[13] and selected the following for final consideration:

- Integrated Behavioral Health Project Tool;
- Integrated Practice Assessment Tool, and
- Maine Health Access Foundation Site Self-Assessment Tool.

AHCCCS will consult with a group of providers before making a final selection(s).

Care management will also be assessed via electronic implementation of an assessment tool. Results will be aggregated and AHCCCS will seek to confirm that the participating practices have collectively improved their care management capacity and performance over the course of the DSRIP period. While there are proprietary instruments to assess care management, there are fewer published care management assessment tools than for behavioral health integration. AHCCCS is currently considering the following options for creating an assessment tool from published care management resources:

- Adapt the care management section of NCQA's PCMH recognition program[14];
- Adapt the California Quality Collaboratives Complex Care Management Toolkit[15], and/or
- Utilize the care management practice survey developed for and utilized by Pennsylvania as part of its MAPCP demonstration.

For the purpose of assessing adoption of risk-based APMs, AHCCCS proposes to track contracted health plan performance relative to the following targets, all defined using the Health Care Payment Learning and Action Network (HCP-LAN) framework[16]:

Measure #1: Percentage of overall managed care spend in alternative payment models (2016 baseline = 23%)

DSRIP Year	**Percentage spend in HCP-LAN Categories 2, 3 and 4**
1	30%
2	40%
3	50%
4	60%
5	70%

Measure #2: Percentage of overall managed care spend in HCP-LAN Category 3 or 4 (assumes CYE 2018 MCO VBP contract requirements modified to HCP-LAN APM framework)

[12] See https://integrationacademy.ahrq.gov/resources/ibhc-measures-atlas.
[13] See www.integration.samhsa.gov/operations-administration/assessment-tools.
[14] See www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh.
[15] See www.calquality.org/storage/documents/CQC_ComplexCareManagement_Toolkit_Final.pdf.
[16] See https://hcp-lan.org/groups/apm-fpt/apm-framework/

DSRIP Year	Percentage spend in HCP-LAN Categories 3 and 4
2	5%
3	10%
4	20%
5	40%

Once again, AHCCCS will consult with an invited group of providers and evaluate alternative payment model contract requirements before making a final selection(s).

Funding

AHCCCS proposes to fund the DSRIP activities through waiver savings and finance those payments through a combination of intergovernmental transfers and state funds made available through federal matching of a limited number of designated state health programs (DSHP). Funding will scale down throughout the final years of the waiver period ending in demonstration year five of the current renewal request.

Funding for transformational activities will target infrastructure investment and incentivize providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. AHCCCS has developed initial project components and milestones and is actively working with stakeholders to validate and refine these project strategies. Development of incentive payment methodologies will follow finalization of projects and their associated metrics.

Projects focusing on Individuals Transitioning from Incarceration will require the actual development of care coordination infrastructure, data analytics, and provider collaboration where little or no capabilities exist. AHCCCS is in a unique position to act as an agent for change and a convener of critical providers to leverage existing systems, as well as establish care coordination capabilities and data exchange capabilities. Additionally, AHCCCS may need to invest in state infrastructure to support this and other proposed projects. Such investments would be limited and might include expenses associated with certain administrative expenses, management information systems, health information exchanges and IT systems, medical management, policy and procedure development and data analytics. DSRIP investments at the state level will be limited to 5% of total DSRIP expenditures annually and will phase out by demonstration year 4.

Projects focused on behavioral health for adults and children will leverage existing provider infrastructure and health plan data and networks to build capacity to complete projects within those categories. Payments would be based on development of joint care coordination and care management plans, data sharing, and data analytics capabilities. In all cases, as providers implement and actively utilize care coordination, payments would transition to support those activities ultimately leading to alternative payment strategies.

AHCCCS has identified the total potential funding under the waiver for these projects at the following levels:

Programs	DY 1	DY 2	DY 3	DY 4	DY 5	Totals

Programs	DY 1	DY 2	DY 3	DY 4	DY 5	Totals
Transitioning from Incarceration	$22 m.	$22 m.	$22 m.	$18 m.	$16 m.	$100 m.
Adult BH Integration	$1567.9944 m.	$1567.9944 m.	$1567.9944 m.	$116 m.	$92 m.	$6780.97334 m.
Pediatric BH Integration	$1567.9944 m.	$1567.9944 m.	$1567.9944 m.	$116 m.	$92 m.	$6780.97334 m.
Totals	$3356.989 m.	$3356.989 m.	$3356.989 m.	$250 m.	$200 m.	$1,45760.94 668 mb.

Most funds would be paid to providers directly, including health plans as appropriate, though a small, annual percentage may be made available to coordinating entities to support transformational activities and potentially social support services as appropriate within project networks. It is important to note that the total dollars available through this program are not large relative to the value of services provided; total funding for this program represents less than 3% of the AHCCCS Medicaid expenditures. This was a strategic decision to emphasize that this funding is transitional, enough to catalyze change but also at a level that can be absorbed within longer term payment reform.

Funding for these payments would rely on (i) intergovernmental transfers from eligible providers, and (ii) state dollars associated with Designated State Health Programs (DSHP) matched at Arizona's federal medical assistance percentage rate for all projects. Arizona expanded coverage in 20145 and recently restored children's health insurance program coverage up to 200% of the federal poverty level. It is critical that Arizona be able to effectively provide coverage, ensure access, and manage these additional populations. Absent investment through these transformation efforts, it is unlikely that providers would be able to self-fund such coordination and collaboration nor would those transformations likely be made to encompass providers that currently have little interaction.

The State has focused significant resources in on expanding and restoring coverage, and the use of DSHP investments would enable this critical component allowing providers to move toward taking more accountability for care delivery. Absent the utilization of DSHP, reliance for the non-federal share would fall entirely on government providers (of which there is only one), local jurisdictions, such as universities (which have only limited resources to devote to these efforts) or counties. Arizona has a very limited public provider infrastructure. Relying on locally generated funding often limits a state's ability to invest in projects that are most ready for transformation or most likely to make an impact immediately on system change and beneficiaries' lives. Utilizing DSHP allows the state to target investments to the most appropriate providers, networks and plans rather than simply those that can provide the non-federal share.

AHCCCS has identified several state-only health programs for which it seeks federal matching funding.

State Only Programs

Program	Amount	Source
Smoking Cessation	$16.98 m.	Tobacco Tax
Prevention Services	$19.6 m.	Tobacco tax

Program	Amount	Source
Trauma Services	$25.0 m.	Indian Gaming
DD/HCBS Funding	$16.1 m.	General Fund
Individuals with SMI	$50.0 m.	General and County Funds

In addition, the state would receive $15 m. in inter-governmental transfers from providers to support DSRIP payments annually.

The transformational payments would support infrastructure and development payments in demonstration year's one and two and outcomes and quality measures in years two through five. AHCCCS would work with stakeholders, health plans and the Centers for Medicare & Medicaid Services to develop alternative payment methodologies during demonstration year five to transition to sustainable financing strategies focused on the value added through these projects post-transformation. In particular, AHCCCS would leverage health plan contracting opportunities to increase the use of reimbursement strategies that include provider entities in both financial risk and reward and recognize increased quality and health outcomes (category 3 and 4 alternative payment models within the HCP-LAN APM framework). In addition, through extensive stakeholder engagement and using its procurements, the State will continue to facilitate opportunities for integration. ~~Over the next four years, the State's procurement timelines are: acute contracts (effective 10/1/2018), Maricopa RBHA (10/1/2019) and Greater Arizona RBHA (10/1/2020).~~ AHCCCS will be conducting a significant procurement in 2018 and will seek stakeholder support to pursue additional payor integration. State share for this post-waiver period would rely on general fund dollars achieved through efficiencies and achievements in population health outcomes.

AHCCCS intends that this Medicaid investment will accelerate the transformation of the delivery system, resulting in sustainability through outcomes and value-based payment strategies, as well as to develop state accountability milestones to measure progress of the transformational program. AHCCCS is currently working on identifying the appropriate statewide measures that both have a high correlation to the transformation efforts and are measureable. AHCCCS is proposing to be subject to a one percent reduction in DSHP funding if it does not meet these defined goals.

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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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		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
	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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		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
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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		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
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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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
		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.					

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
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

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
	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

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**
	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

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
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.	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
		Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.					

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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
	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

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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**
	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

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
	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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)
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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

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
		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

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**
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.

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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
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	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
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		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
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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.			

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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)

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		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.			

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		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

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Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
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		DY 1		DY 2	
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	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).

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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	
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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

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		DY 1		DY 2	
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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.

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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

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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.

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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**
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.

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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

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
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

Strategic Focus Area: Adults Transitioning from the Justice System – DRAFT

Project 1: Develop an integrated health care setting with select county probation offices or Department of Corrections (DOC) parole offices, or near select offices through the use of mobile units, to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. County probation offices and Department of Corrections parole offices could also potentially be relocated to primary care practice sites under this project.

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CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment
1	Establish contracts with acute plans and T/RBHAs to be reimbursed for integrated services, ideally within select county probation offices or Department of Corrections (DOC) parole offices.	Document executed contracts with acute plans and T/RBHAs	N/A
2	Upon the request of the RBHA, participate in the RBHA-convened process designed to identify opportunities consistent with the objectives of this project for integrated care, ideally in select county probation office or DOC settings, and develop a strategy for addressing identified opportunities.	Document collaborative participation with the RBHA and work in good faith to identify opportunities for developing an integrated health care setting, ideally within probation and/or DOC parole offices.	N/A
3	Establish an integrated health care setting(s) co-located within select county probation offices and/or DOC parole offices, the number to be determined by the RBHA and AHCCCS. If the RBHA and provider agree, a provider using a mobile unit in near proximity to the offices, or a permanent location in close proximity to the probation office and/or DOC parole offices will be acceptable; however, those practices will receive fewer dollars for meeting the Core Components in this project.	N/A	Document that a) the integrated practice is operational and fully staffed, and b) the integrated practice is operating consistent with parameters set forth by AHCCCS, including in its facility and clinical operations.

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CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment
4	Develop a marketing plan in cooperation with the probation and parole offices to encourage individuals pre-release to utilize the integrated health care setting post-release.	Document a marketing plan developed in cooperation with probation and parole offices.	N/A

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		DY 1	DY 2
CC #	**Core Component**	**Practice Reporting Requirement for DSRIP Payment**	**Practice Reporting Requirement for DSRIP Payment**
5	For individuals who have suspended Medicaid eligibility while incarcerated with a known release date within 30 days for those in jail and within 90 days for those in prison, develop protocols with probation and parole offices to coordinate health care assessments and care management meetings with probation/parole pre-release visits and schedule appointments in the integrated co-located health care setting upon release.	Document protocols with agreement from the probation and/or parole office(s) for coordinating health care assessments and care management meetings at the integrated site pre-release and scheduling appointments upon release.	N/A
6	The practice should conduct a screening and assessment for physical and behavioral health needs (including substance use disorder needs) using standard protocols of the practice's choosing, and one for criminogenic risks using a tool agreed upon between practices and RBHAs during the individual's first visit to probation/parole, all unless the beneficiary declines a request from the practice.	Demonstrate that the practice has a protocol for performing screenings and assessments for physical and behavioral health needs and criminogenic risks during the first visit.	N/A
7	Develop protocols to ensure that prior to the conclusion of a visit, (i) a follow-up appointment has been made at a mutually convenient time, (ii) that the individual has a plan to access transportation to the follow-up appointment, and if not, that the care manager or a peer support assists the beneficiary in developing a plan to access transportation and (iii) that the practice has obtained contact information to reach the individual.	Demonstrate that the practice has developed protocols consistent with all three elements of this Core Component.	N/A

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CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment
8	Practices must have reliable and consistent access, within the practice or via telemedicine-enabled consultation, to medication-assisted treatment (MAT), and must develop or adopt protocols to provide MAT of opioids based on DSRIP entity guidelines; and must develop protocols to provide MAT of opioids using evidence-based guildelines. Such guidelines can be found here: http://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG	Demonstrate that the practice has at least one physician who can prescribe buprenorphine. Demonstrate that the practice has developed protocols consistent with the evidence-based guidelines issued by SAMHSA.	N/A
9	For homeless enrollees who need a short-term connection to assist effective community re-entry and connection to health services (as defined by AHCCCS and RBHA), provide post-incarceration health appointments, navigation, transportation and referral to appropriate social services within ___ days of release.	Document a process for identifying enrollees who are homeless within ___ days from release and protocols for providing expedited assessment, health services and linkage to needed social service supports.	Report upon the numbers of enrollees who were homeless upon release and were seen by the practice within ___ days of release and provided expedited services.
10	Peer support staff are part of the co-located staff to assist formerly incarcerated individuals with, including but not limited to, eligibility and enrollment applications, health care education / system navigation, information on other support resources, health literacy and financial literacy training.	Demonstrate that peer support staff have been hired and have participated in training provided by the RBHA; Provide evidence of job descriptions.	N/A

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		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
11	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, peer professionals, housing and employment support services 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.	N/A
12	Assess patient satisfaction with integrated practice services and identify what the practice might do to attain higher utilization of practice services among those on probation and parole and traveling to the probation or parole office per the terms of their release. Develop and implement changes in response to patient satisfaction assessment findings.	N/A	Assess patient satisfaction and identify what the practice might do to attain higher utilization of practice services among those on probation or parole. Develop and implement changes in response to patient satisfaction assessment findings.

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CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment
13	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (both sending and receiving data).	Document that an agreement with AzHeC has been executed.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into care management activities conducted by the provider.
14	Participate in RBHA training and education.	Demonstrate that the practice participated in RBHA-provided training during the DY.	Demonstrate that the practice participated in each RBHA-provided training during the DY.

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site)

Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (RBHAs)) within the primary care site. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an 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) a commonly accepted behavioral health integration practice self-assessment instrument and b) a family-centered care self-assessment instrument. 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 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 both assessments; 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 and the family-centered care toolkit to develop a practice-specific course of action to improve integration and family-centered care efforts. 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 and family-centered care toolkits 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 two toolkits they have adopted; Frequency distribution of practice-employed integration and family-centered care toolkits; 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 members with high risk						
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 management training; Evidence of training agenda and training materials.	N/A	N/A	N/A	N/A
		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. Members with high risk can be identified by using the CASII, but may also 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 disciplinary action in schools; recent involvement with law enforcement; involvement with the child welfare system; with or at risk for ASD. [3]	Develop a registry of members with high risk 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 members with high risk 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.	N/A	N/A	N/A	N/A
6	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and their parents / guardians 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 members with high risk have care	Demonstrate that the integrated care plan is documented in an 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 electronic medical record.	N/A	N/A

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		Demonstrate that all patients and their parents / guardians identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and identified 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 and parent/guardian goals, desired outcomes and objectives, culture, and readiness to address any individual needs.	plans consistent with the required elements.				

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		Demonstrate that behavioral health providers provide input into the integrated care plan when the behavioral health provider is the originator of the plan, consistent with Core Component 7.					
7	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 parents and guardians of children with high ED and / or inpatient use to access the primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measureable 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.	N/A	N/A

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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.	N/A	N/A
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	N/A	N/A

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	Relationships with Behavioral Health Providers						
10	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; (f) expectations for what information will be shared between providers, with the intention that at a minimum problem lists (in ICD-10 and lay terms), comprehensive medication lists, care plan and follow-up schedules will be shared after each visit.	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care management agreement.	Percentage of practices with referral and care management agreements; A listing of mental health and substance use providers with which each practice has completed a referral and care management.	Identify the names of practices with which the primary care site has developed a referral and care management agreement in DY 2.	Percentage of practices with an increase in the number of referral and care management agreements.	N/A	N/A

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	Clinical Care within the Primary Care Office						
11	In addition to the routine use of screening tools that are approved by AHCCCS (PEDS, ASQ and M-CHAT) to identify developmental delays, routinely screen patients (at the age-appropriate time, using the age-appropriate tool) for cognitive, emotional, and behavioral problems, including for depression, and drug and alcohol use. To assess cognitive, emotional, and behavioral health problems for adolescents, practices should use the Y-PSC. For drug and alcohol screening of adolescents, practices should use the CRAFFT Screening Test. For depression, practices should use the Patient Health Questionnaire for Adolescents (PHQ-A).	Identify the practice's policies and procedures for administration of screening tools.	Percentage of practices that have adopted all of the required screening tools; Frequency distribution of developmental screening tools used by practices.	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
		Confirm that results of all specified screening tool assessments are documented 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.			N/A	N/A
12	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 3 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
13	Follow the American Academy of Pediatrics clinical guidelines for the treatment of children with ADHD, anxiety and mild depression, including the use of psychotropic medications and appropriate consultation with behavioral health providers to assist with diagnosing. [2]	Document that all primary care clinicians and any behavioral health providers in the practice have undergone training on the guidelines.	Percentage practices where all primary care providers, advance-practice clinicians and behavioral health providers in the practice were trained on the American Academy of Pediatrics clinical guidelines by a DSRIP-provided event, or documentation of CME course completion.	N/A	N/A	N/A	N/A

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	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.	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.

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site)

Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (RBHAs)) within the primary care site. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an 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
	Community-based Supports						
17	Enhance relationships with Arizona Early Intervention Program (AzEIP), schools, community-based social service resources, including self-help referral connections, community group resources, family support services (including Family Run Organizations) by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these 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.	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
		Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.				N/A	N/A
	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

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site)

Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (RBHAs)) within the primary care site. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

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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
	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

Notes:

[1] Care managers are individuals that "link children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care." They are responsible for assessing and identifying the needs of the child, developing, in part, integrated plans of care, implementing the plan of care and periodically reassessing the needs of the child and care plan to address new or emerging needs.

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

		DY 1		DY 2		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	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Taking Steps Toward Integration						
1	Utilize a) a commonly accepted behavioral health integration practice self-assessment instrument and b) a family-centered care 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 both assessments; 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 and the family-centered care toolkit to develop a practice-specific course of action to improve integration and family-centered care efforts.	Identify the names of the integration and family-centered care toolkits 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 two toolkits they have adopted; Frequency distribution of practice-employed integration and family-centered care toolkits; Summary description of practice action plan areas of focus and goals.	N/A	N/A	N/A	N/A
	Management of members with high risk						
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 management training; Evidence of training agenda and training materials.	N/A	N/A	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

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		Document that care managers have been trained in motivational interviewing for patient self-management support.					
4	Track members with high risk to assist efforts to address their needs and coordinate their care. Members with high risk can be identified by using the CASII, but may also 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 disciplinary action in schools; recent involvement with law enforcement; involvement with the child welfare system; with or at risk for ASD. [3]	Develop a registry of members with high risk 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 members with high risk 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	b. The Arizona Early Intervention Program (AzEIP) using the online referral system: https://extranet.azdes.gov/azeip/AzeipREF/Forms/Categories.aspx, if the child is between birth and 36 months.	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.	N/A	N/A	N/A	N/A

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6	Implement the use of an integrated care plans to be coordinated by a clinical care manager.	Demonstrate that all patients and their parents / guardians 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. Demonstrate that all patients and their parents / guardians identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and identified 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 and parent/guardian goals, desired outcomes, and objectives, culture, and readiness to address any individual needs. Demonstrate 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 7.	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 members with high risk have care plans consistent with the required elements.	Demonstrate that the integrated care plan is documented in an electronic medical record in such a way that behavioral health providers and primary care providers both have access.	Percentage of practices that have integrated care plans documented in an electronic medical record.	N/A	N/A

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

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7	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 parents and guardians of children with high ED and / or inpatient use to access their primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measureable 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.	N/A	N/A
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.	N/A	N/A
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	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

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	Relationships with Primary Care Providers						
10	Develop referral agreements with primary care 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 primary care providers to provide input into an integrated care plan, when the integrated care plan is initiated by the behavioral health provider, (e) protocols for ensuring same-day availability for a physical health visit on the day of a behavioral health visit; and (f) expectations for what information will be shared between providers, with the intention that at a minimum problem lists (in ICD-10 and lay terms), comprehensive medication lists, care plan and follow-up schedules will be shared after each visit.	Identify the names of the primary care practices with which the community behavioral health care site has developed a referral and care management agreement.	Percentage of practices with referral and care management agreements; A listing of primary care providers with which each practice has completed a referral and care management.	Identify the names of practices with which the behavioral health care site has developed a referral and care management agreement in DY 2.	Percentage of practices with an increase in the number of referral and care management agreements.	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

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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**
	Clinical Care within the Primary Care Office						
11	In addition to the routine use of screening tools that are approved by AHCCCS (PEDS, ASQ and M-CHAT) to identify developmental delays, routinely screen patients (at the age-appropriate time, using the age-appropriate tool) for cognitive, emotional, and behavioral problems, including for depression, and drug and alcohol use. To assess cognitive, emotional, and behavioral health problems for adolescents, practices should use the Y-PSC. For drug and alcohol screening of adolescents, practices should use the CRAFFT Screening Test. For depression, practices should use the Patient Health Questionnaire for Adolescents (PHQ-A). [2]	Identify the practice's policies and procedures for administration of screening tools.	Percentage of practices that have adopted all of the required screening tools; Frequency distribution of developmental screening tools used by practices.	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.	N/A	N/A
		Confirm that results of all specified screening tool assessments are documented 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.			N/A	N/A
12	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 3 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
13	Follow the American Academy of Child and Adolescent Psychiatry (AACAP) clinical guidelines for the treatment of children with ADHD, anxiety and mild depression, including the use of psychotropic medications and appropriate consultation with behavioral health providers to assist with diagnosing. [2]	Document that all behavioral health providers and primary care clinicians in the practice have undergone training on the guidelines.	Percentage practices where all primary care providers, advance-practice clinicians, and behavioral providers were trained on the American Academy of Pediatrics clinical guidelines by a DSRIP-provided event, or documentation of CME course completion.	N/A	N/A	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

		DY 1		DY 2		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**	**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.	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 Arizona Early Intervention Program (AzEIP), schools, community-based social service resources, including self-help referral connections, community group resources, family support services by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these 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

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT
Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)
Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan.

		DY 1		DY 2		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	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	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
17	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

Notes:
[1] Care managers are individuals that "link children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care." They are responsible for assessing and identifying the needs of the child, developing, in part, integrated plans of care, implementing the plan of care and periodically reassessing the needs of the child and care plan to address new or emerging needs.

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 3: Improving Treatment for the Care of Children with and At-risk for Autism Spectrum Disorders (ASD) (primary care site)

Objective: To improve the identification and care of Medicaid-enrolled children at-risk for ASD or diagnosed with ASD and create sufficient and consistent linkages between primary care, behavioral health and social service resources for improved care.

		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
	Prerequisite Requirements for Project 2				
	Working toward an integrated primary care practice is a critical first component of improving the care of children with and at risk for Autism Spectrum Disorder. Practices must successfully complete Project 1 Core Components 2-4, 5, 7-8 in DY 1. Project 2 will begin in DY 2.	N/A	Listing of practices that successfully completed Project 1 Core Components 2-4 and are starting on Project 2 in DY2.	N/A	Listing of practices that successfully completed Project 1 Core Components 2-4 and are starting on Project 2 in DY3.
	Clinical Care within the Primary Care Office				
1	Utilize a commonly accepted toolkit for caring for children with ASD as a guide for clinical management. One such tool is "Caring for Children with Autism Spectrum Disorder: A Resource Toolkit for Clinicians" from the American Academy of Pediatrics.	Identify the name of the ASD toolkit the practice has adopted **and** document a practice-specific action plan informed by the toolkit, with measurable goals and timelines.	Percentage of practices that have identified the ASD toolkit they have adopted; Frequency distribution of practice-employed ASD toolkits; Summary description of practice action plan areas of focus and goals.	N/A	N/A
2	Develop procedures for referring children with positive screening to ASD Multidisciplinary Teams or programs, consistent with Core Component 5. If a child is referred to a behavioral health provider (or team) trained to evaluate autism, develop procedures for simultaneously referring the child to: a. An audiologist to determine whether hearing loss is an etiology of the developmental delay;	Document that policies and procedures have been established for referring patients to an audiologist, and depending on age of patient, AzEIP or the local school district, and DDD.	Percentage of practices with policies and procedures that meet this requirement.	N/A	N/A

		DY 2		DY 3	
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	b. The Arizona Early Intervention Program (AzEIP) using the online referral system: https://extranet.azdes.gov/azeip/AzeipREF/Forms/Categories.aspx, if the child is between birth and 36 months				
	c. The local school district through Arizona's FIND program (www.azed.gov/special-education/az-find/), if the child is over three years of age.				
	d. The Division of Developmental Disabilities (DDD) for eligibility determination.				
3	Routinely document family history of autism.	Document that the family history of the patient is being asked, and documented in the electronic medical record.	Percentage of practices that have documented that the family history of the patient is being asked, and documented in the electronic medical record.	N/A	N/A
4	Ensure that all pediatricians, family physicians, advanced-practice clinicians and case managers complete a training program in ASD that offers continuing education credits unless having done so within the past 3 years. This training should include support for a comprehensive assessment to ascertain the need for often co-existing conditions, such as speech and language delay or environmental hypersensitivity which can benefit from occupational therapy recommendations for parents and classrooms.	Identify names of pediatricians, family physicians, advance-practice clinicians and case managers who have completed an ASD training program for CEUs in the last three years, the percentage of such practice clinicians that they represent and the training program sponsor(s).	Percentage of practices in which all eligible staff received ASD training in the last three years; Listing of training programs.	Identify the names of pediatricians, advance-practice clinicians and case managers who completed training during DY2, but had not during DY1 or the three years prior to DY2.	Percentage of practices in which all eligible staff received training.

		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
	Relationships with ASD Treatment Providers / Team				
4	Develop referral agreements with ASD Multidisciplinary Teams, programs, or providers who are trained to evaluate children for autism and provide early intensive behavioral therapy to families and children.	Identify the names of the ASD Multidisciplinary Team(s) or program(s) with which the primary care site has developed a referral agreement.	Percentage of practices with referral agreements; A listing of ASD Multidisciplinary Teams/programs with whom agreements have been executed.	N/A	N/A
	Each referral agreement must include:				
	(a) 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 (for example, telephone, pager, email, etc.), and				
	(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.				

		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
	Community-based Supports				
6	Provide families and other caregivers of children with ASD information regarding parent support and other resources available to them. This should be done by offering specific information to families on local, state and national organizations that offer resources to families caring for children with ASD. Specific information can be delivered in the form of a hand-out listing the names of relevant organizations, the resources they provide, and telephone numbers and websites of the organizations.	Identify what resources are being shared with the parents and caregivers, and develop policies and procedures for ensuring that parents and caregivers receive the information regarding available resources.	Percentage of practices with policies and procedures for ensuring that parents and caregivers receive information regarding available resources.	N/A	N/A
7	Participate in DSRIP entity-offered training and education to understand the unique needs of children with ASD.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
	Prerequisite Requirements for Project 3				
	Working toward an integrated primary care practice is a critical first component of improving treatment for the care of children engaged in the child welfare system. Practices must successfully complete all Project 1 Core Components. Project 4 will begin in DY2.	N/A	Listing of practices that have completed the required Project 1 Core Components and are starting on Project 4.	N/A	N/A
	Be part of the Comprehensive Medical & Dental Program's (CMDP) Preferred Provider Network, and care for the minimum number of foster children required for participation in this project, as defined by AHCCCS.	N/A	Percentage of practices participating in Project 4 that are part of the CMDP Preferred Provider Network.	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
	Clinical Care within the Primary Care Office				
1	Actively outreach to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management. If current and prior provider are not known, outreach should occur through contacting CMDP and the T/RBHA, or if the child is under 6 years old, the primary care provider should utilize the Arizona State Immunization Information System (ASIIS) to identify any past providers. If the child has ongoing psychotropic medications, expedite contact with the prescribing physician, if known, to gather correct information about dosing and intended goals, as well as about any side effects.	Document a process for identifying medical and behavioral health providers that have served or do serve the child, and for obtaining information from those providers.	Percentage of practices with documented processes for working with the child protection worker and gathering data from providers, with an expedited procedure for children on psychotropic medications.	N/A	N/A
2	Offer patients and families consent forms to ensure that consent is obtained (when willing and within applicable state and federal laws). [1] An example of a consent form can be found here: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Consent_Obtain_Form.pdf	Document policies and procedures to obtain consent from patients / families when they are willing, and within applicable state and federal laws.	Percentage of practices with policies and procedures in place to obtain consent from patients / families when they are willing, and within applicable state and federal laws.	N/A	N/A
3	Ensure that all practice pediatricians, family physicians, advanced-practice clinicians and case managers who treat children engaged in the child welfare system complete a training program in Trauma-informed Care, and in Child and Family Team Practice that offers continuing education credits[2] unless having done so in the past 3 years.	Identify the names of pediatricians, family physicians, advance-practice clinicians and case managers who have completed a Trauma-Informed Care training program and / or a Child and Family Team Practice for CEUs in the last three years.	Percentage of practices in which all eligible staff received training; Listing of training programs.	Identify the names of pediatricians, advance-practice clinicians and case managers who completed training during DY2, but had not during DY1 or the three years prior to DY2.	Percentage of practices in which all eligible staff received training.

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
4	Develop and implement policies that allow for patients, in particular teens, to participate in shared decision making using the skills and techniques developed through Trauma-Informed Care training.	Document that policies have been developed and implemented to allow for adolescents to participate in shared care decision making.	Percentage of practices with implemented policies for teen shared decision making.	Demonstrate that the practice uses decision aids that are age-appropriate with adolescents.	Percentage of practices that use decision aids with adolescents.
5	Routinely screen patients for trauma utilizing a standardized and age-appropriate screening tool. Appropriate tools include: the UCLA Post Traumatic Stress Disorder Reaction Index (UCLA PTSD-RI) (ages 7+); the Abbreviated UCLA PTSD RI (ages 3 - 16); and the Trauma Symptom Checklist for Children (TSC-C) (ages 3-16).	Identify the practice's adopted trauam screening tool, and policies and procedures for administration of that tool.	Percentage of practices that have adopted the required screening of patients for trauma; Frequency distribution of trauma tools used by practices.	N/A	N/A
		Confirm that results of all specified screening tool assessments are documented 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.	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT
Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)
Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
6	After the initial office visit with the foster child, the practice must proactively schedule or outreach to the foster parent / guardian to schedule EPSDT appointments on a schedule as follows: visits are required 10 times in the first 2 years of life (ages 3-5 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and 24 months-of-age) and at least annually after age 2 per the Arizona Department of Child Safety policy. The initial and annual EPSDT/well care medical examinations must include: a. Complete health history & physical exam. b. Developmental and behavioral health screening. c. Growth and nutrition check. d. All medically necessary Immunizations. e. Vision and hearing tests. f. Assessment of vision and hearing related to eyeglasses and hearing aids. g. Dental care. h. Blood and urine tests. i. Follow-up and referral of any medically-necessary health and mental health care services. Even if the initial assessment does not indicate active concerns, practices must schedule office visits on an enhanced schedule for children engaged in the child welfare system (monthly for infants birth to 6 months; every 3 months for children between 6 and 24 months; bi-annually for children 24 months to 21 years of age) to help:	Document policies and procedures to a) schedule and perform complete medical examinations consistent with EPSDT requirements and b) schedule and perform additional EPSDT visits consistent with the enhanced periodicity schedule defined by DCS policy.	Percentage of practices with policies and procedures to schedule and perform timely and comprehensive EPSDT visits with children placed in out-of-home care consistent with DCS requirements.	Percentage of children had examinations consistent with EPSDT requirements consistent with the enhanced periodicity scheduled defined by DCS policy, and as applicable after the child is empaneled with the provider.	Percentage of practices that met this requirement at a level to be determined by AHCCCS.

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
7	In accordance with AAP's standards of health care for children and adolescents in foster care, at every visit, conduct a comprehensive child abuse and neglect screening, including an interview (being sensitive to the child's fears and anxieties), observing the child's affect, height, weight and head circumference (if younger than 3 years), skin examination, range of motion in joints and extremities, and genital survey (if indicated). For more information see: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx. Upon each visit, if any signs of child abuse or neglect are found, follow reporting practices established by AHCCCS.	Document a protocol for conducting a comprehensive child abuse and neglect screening at every visit.	Percentage of practices with required screening protocols in place.	Percentage of visits for children and adolescents in foster care including a child abuse and neglect screening.	Percentage of practices that met this requirement at a level to be determined by AHCCCS.
8	Complete a comprehensive after-visit summary that is shared with the foster parents/guardians and the child welfare case worker which can assist in guiding the foster parents/guardians and case worker 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	Document a protocol for developing and sharing comprehensive after visit summaries with foster parents/guardians that contain referrals, recommendations and protocols for assessing risk and monitoring the child's needs.	Percentage of practices with required comprehensive visit summary practice and protocols.	N/A	N/A
9	This comprehensive after visit summary should include protocols for foster parents/guardians to use to assess safety risk and monitor the child's medical or behavioral health issues at home. The first such parenting strategies should include education about the child's physical and emotional needs at the time of the initial visit, and repeatedly as required to assist the child and family in understanding their remaining care plan.			N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
10	Develop and implement a policy that comprehensive after visit summary should not divulge confidential information between the patient and provider, particularly for teens engaged in the child welfare system.[4], [5]	Demonstrate that a policy has been developed to ensure confidentiality between the patient and provider.	Percentage of practices with an appropriate confidentiality policy in place.	N/A	N/A
11	Coordinate care management with the T/RBHA. Treatment of medical conditions that may be affected by co-occurring behavioral health conditions should be done in consultation and coordination with the treating behavioral health provider, or the RHBA.	Document an effort to collaborate with each welfare system child's behavioral health provider(s), and/ or the RBHA in order to collaborate in care planning and treatment.	Percentage of practices routinely initiating communication with each child welfare child's behavioral health provider(s) and/or the RBHA in order to collaborate in care planning and treatment.	N/A	N/A
	Involvement with DSRIP Entity				
12	Participate in DSRIP entity-offered training and education to understand the unique needs of children engaged in the child welfare system.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.

Notes:

[1] Per ARS Article 7.1.,Medical Records: a health care provider is permitted to disclose medical records without the written authorization of the patient or the patient's health care decision maker to health care

[2] Examples of organizations offering CEU credit courses on Trauma-informed Care include the Arizona Trauma Institute (http://aztrauma.org/classes/) and the National Center for Trauma-Informed Care and

[3] Standards which are recommended by the American Academy of Pediatrics and Child Welfare League of America.

[4] See "Consent & Confidentiality in Adolescent Health Care: A Guide for the Arizona Health Practitioner. https://azmed.org/wp-content/uploads/2014/09/2011Adol_Consent_Conf_Booklet.pdf

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 5: Improving Treatment for the Care of Children Engaged in the Child Welfare System (behavioral health site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. [6]

		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
	Prerequisite Requirements for Project 4				
	Working toward an integrated behavioral health care practice is a critical first component of improving treatment for the care of children engaged in the child welfare system. Practices must successfully complete all Project 2 Core Components. Project 5 will begin in DY2.				

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 5: Improving Treatment for the Care of Children Engaged in the Child Welfare System (behavioral health site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. [6]

		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**
	Clinical Care within the BH Provider Office				
1	Conduct a comprehensive behavioral health assessment within the timeframe established by AHCCCS for patients referred by the RBHA, a PCP, or when a case worker, patient or a patient's parent/ guardian requests an appointment. The assessment must directly involve the child and include developmentally and culturally appropriate screening tools and assessments for the child's age and cognitive level. The assessment must also include the parent'(s)/family's strengths and needs to effectively address the child's needs –with the family of origin and/or foster parent(s), as applicable.[1]	Document policies and procedures to a) schedule and perform an assessment consistent the DBHS Practice Tool and AACAP guidelines following notification by the CMDP and within 30 days of out-of-home placement, and b) schedule and provide services monthly for at least the first six months of out-of-home placement.	Percentage of practices with policies and procedures to schedule and perform a) timely assessment visits with children placed in out-of-home care consistent with DCS requirements, and b) monthly visits for the six months of out-of-home placement.	Percentage of children who had a comprehensive behavioral health assessment within the timeframe established by AHCCCS.	Percentage of practices that met this requirement at a level to be determined by AHCCCS.
2	Actively outreach to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management. If current and prior provider are not known, outreach should occur through contacting CMDP and the RBHA, or if the child is under 6 years old, the primary care provider should utilize the Arizona State Immunization Information System (ASIIS) to identify any past providers. If the child has ongoing psychotropic medications, expedite contact with the prescribing physician, if known, to gather correct information about dosing and intended goals, as well as about any side effects.	Document a process for identifying medical and behavioral health providers that have served or do serve the child, and for obtaining information from those providers.	Percentage of practices with documented processes for working with the child protection worker and gathering data from providers, with an expedited procedure for children on psychotropic medications.	N/A	N/A

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 5: Improving Treatment for the Care of Children Engaged in the Child Welfare System (behavioral health site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. [6]

		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**
3	Ensure that all clinicians and case managers who treat children engaged in the child welfare system complete (when age appropriate) a training program in Trauma-informed Care, Child and Family team Practice (CFT), in Transition to Adulthood, and the Transition to Independence Process (TIP) model that offers continuing education credits unless having done so in the past 3 years. [3] [5]	Identify the names of clinicians and case managers who have completed the training programs for CEUs in the last three years.	Percentage of practices in which all eligible staff received training; Listing of training programs.	Identify the names of behavioral health clinicians who have completed training during DY2, but had not during DY1 or the three years prior to DY2.	Percentage of practices in which all eligible staff received training.
4	Adopt the AACAP's policy statement on "Prescribing Psychoactive Medications for Children and Adolescents"[4] and implement its prescribed practices.	Document that all behavioral health clinicians have undergone training on the AACAP's policy statement and that the policy statement has been incorporated into policy and practice.	Percentage of practices in which all behavioral health care clinicians were trained on the AACAP's policy statement by the DSRIP entity or the practice itself, or documentation of relevant CME course completion.	N/A	N/A
	Involvement with DSRIP-entity				
5	Participate in DSRIP entity-offered training and education to understand the unique needs of children engaged in the child welfare system.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in DSRIP-entity provided training; Evidence of training agenda and training materials.

Notes:

[1] For more information see the DBHS Practice Tool (www.azdhs.gov/bhs/guidance/unique_cps.pdf) and the AACAP Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System. (www.jaacap.com/article/S0890-8567(15)00148-3/pdf)

[2] Per ARS Article 7.1.,Medical Records: a health care provider is permitted to disclose medical records without the written authorization of the patient or the patient's health care decision maker to health care provider who are currently providing health care to the patient for the purposes of diagnosis or treatment of the patient. Written consent is needed to obtain the medical records of past providers.

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 5: Improving Treatment for the Care of Children Engaged in the Child Welfare System (behavioral health site)

Objective: To improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. [6]

		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

[3] Examples of CEU credit courses on trauma informed care include: the Arizona Trauma Institute (http://aztrauma.org/classes/) and the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) (www.samhsa.gov/nctic).

[4] www.aacap.org/AACAP/Policy_Statements/2001/Prescribing_Psychoactive_Medication_for_Children_and_Adolescents.aspx

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

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

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

Objective: To more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient behavioral 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
	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 parent or guardian 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 s/he 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 health literacy assessment with one of the endorsed screeners, and document policies and procedures for providing medication management support and education to parents and guardians who do not pass the literacy assessment.	Percentage of hospitals with documented procedures for conducting and following-up on health literacy assessments.
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

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

Objective: To more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient behavioral 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**
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.	Document that the HIE was consulted as part of the medication reconcilation process.	Percentage of hospitals with documented policies and procedures for consulting with the HIE as part of medication reconciliation.
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
	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: Children with Behavioral Health Needs - DRAFT
Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)
Objective: To more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient behavioral 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)
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: Children with Behavioral Health Needs - DRAFT

Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

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

Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

Objective: To more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient behavioral 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 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: Children with Behavioral Health Needs~~, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System~~ - DRAFT

The DSRIP entity and individual practices participating in this strategic focus area will be held	
NQF #	**Measures**
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
1448	Developmental Screening In the First Three Years of Life
0108	Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder
1799	Medication Management for People with Asthma
0002	Appropriate Testing for Children with Pharyngitis
0033	Chlamydia Screening
HEDIS	Adolescent Well Care Visits
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents
0038	Childhood Immunization Status
1407	Immunizations for Adolescents
HEDIS	Lead Screening for Children
1388	Annual Dental Visits
0710	Depression Remission at 12 months
1884	Depression Response at 6 months
1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
0717	Number of School Days Children Miss Due to Illness
2393	Pediatric All-Condition Readmission Measure
2337	Antipsychotic Use in Children Under 5 Years Old
HEDIS	Inpatient Visits/1000
HEDIS	ED Visits per 1000
1392	Well-child visits within the first 15 months
N/A	Depression Screening by 13 Years of Age - Brand new HEDIS measure
0005	CG-CAHPS Child