DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

JUL 25 2016

Mr. Thomas Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

Thank you for your submission on July 18, 2016, of additional materials related to the delivery system reform incentive payments (DSRIP) proposal that was a part of Arizona's section 1115 demonstration application entitled Arizona Health Care Cost Containment System (AHCCCS), Project Number 11-W-00275/09 and 21-W-00064/9.

The Centers for Medicare & Medicaid Services (CMS) completed a review of Arizona's additional materials in accordance with the April 27, 2012 final rule. On a case-by-case basis, CMS must determine whether the state has made a significant change to a demonstration application relative to the proposal it provided for public input prior to submitting it to CMS. Accordingly, we directed the state to complete an additional 30-day public comment period to allow public comment on the revised DSRIP materials prior to submitting it to CMS. The CMS will now begin its own 30-day federal comment period on the materials submitted July 18, 2016.

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's application. The documents will be posted on the Medicaid.gov website for a 30-day federal comment period, as required under 42 CFR 431.416(b). Arizona's DSRIP documents will be available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

If you have additional questions, please contact your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

Sincerely,

for

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

cc: Henrietta Sam-Louie, Associate Regional Administrator, CMS San Francisco Regional Office

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] 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 and developing an integrated system that provides holistic care for individuals and thereby improves efficiencies and outcomes that will bend the cost curve. 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.

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.

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

- 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 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 a fragmented system of care in existence prior to the state's participation in Medicaid, beginning in 1982. For most Medicaid populations, services have been administered by separate entities 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 functioned for the most part separately — 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, Arizona has taken significant steps towards reducing these siloes and integrating care for its Medicaid populations, making 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 improvements offered a new approach to integrated care, enhancing care- and case-management services. For other populations, Arizona has also required data sharing among its acute care plans and RBHAs to eliminate blind spots in data that each plan faced and allow the plans 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 have represented important change. However each of these integration efforts has exposed gaps in the overall delivery system and identified additional opportunities for facilitating integration. 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 to ensure that real delivery system change occurs and has a lasting impact under new value-based and APMs.

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 provide 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) providers. 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.

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

When Arizona launched the State's Medicaid program in 1982, the State maintained a separate system of care for the treatment of behavioral health conditions instead of "carving-in" those services in the managed care benefit plan. This separation of behavioral health and physical health services was the desired approach of the behavioral health advocacy community 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. While this perspective continues to evolve as there is more education regarding the interconnectedness between physical and behavioral health, the evolution is very slow moving. The challenge for the State is balancing this long-held view with today's health data 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, historically, Medicaid health services have been overseen by separate state agencies, with the Division of Behavioral Health Services within the Arizona Department of Health Services managing the behavioral health services and AHCCCS 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 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 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.

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

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.

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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.

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]

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.

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[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.

[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.

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 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. 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 providers have executed an agreement that defines how they 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 provider entities, but also to:

- Provide the provider 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

Providers 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 participating providers in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that providers 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 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 provider 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

Participating providers 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 projects for this strategic focus area, all of which are mandatory for DSRIP participating providers, 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 providers 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 providers 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.

Incentive Payments and Financial Sustainability.

Providers 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 participating providers in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that providers 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 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 provider 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

Participating providers 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 is under consideration for future development.

Incentive Payments and Financial Sustainability

Providers 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 plans 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 plans 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 plans 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

Participating providers 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 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]

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

Delivery System Transformation Assessment

In order to assess transformation at the system level, AHCCCS will focus on the two core elements of system transformation underlying AHCCCS' proposed DSRIP activities:

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

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 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.

Once again, AHCCCS will consult with an invited group of providers 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).

[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.

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
Transitioning from Incarceration	$22 m.	$22 m.	$22 m.	$18 m.	$16 m.	$100 m.
Adult BH Integration	$157.44 m.	$157.44 m.	$157.44 m.	$116 m.	$92 m.	$680.334 m.
Pediatric BH Integration	$157.44 m.	$157.44 m.	$157.44 m.	$116 m.	$92 m.	$680.334 m.
Totals	$336.89 m.	$336.89 m.	$336.89 m.	$250 m.	$200 m.	$1460.668 b

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 2015 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. 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	$18 m.	Tobacco Tax
Prevention Services	$19 m.	Tobacco tax
Trauma Services	$25 m.	Indian Gaming
DD/HCBS Funding	$16 m.	General Fund
Individuals with SMI	$50 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 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). 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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DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) STRATEGY FOR ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) — REVISED DRAFT

A. Opportunity Statement

Managed care organizations (MCOs), Regional Behavioral Health Authorities (RBHAs), and Arizona Long-Term Care Systems (ALTCS) plans are the foundation of Arizona's management of its Medicaid program. Through its creative and effective use of Medicaid managed care for 1.9 million beneficiaries, Arizona has made great strides in serving its Medicaid members in a cost-effective and value-based manner. As the state seeks to advance the use of alternative payment models with providers through its managed care contractors, it finds that many health systems are ill positioned to assume accountability for providing integrated care for their most vulnerable patients. Arizona seeks to ensure that, as more providers assume more downside risk for management of population health, these providers also possess care integration infrastructure necessary to successfully meet the needs of Medicaid beneficiaries. AHCCCS' managed care contractors, including MCOs and RBHAs, will be expected to play an active role in provider entities' DSRIP work.

Arizona's DSRIP program will help providers build capacity to succeed under payment reform and drive better health and financial outcomes. The DSRIP program design focuses on targeted populations of vulnerable Medicaid beneficiaries where care integration will likely have an immediate impact for enrollees and providers.

B. DSRIP Strategic Focus

Like many states, Arizona finds many large health systems, specialty health care, and social service providers with ill-defined and suboptimal operational relationships. 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:

- American Indians, including both those served through the Indian health delivery system [for example, Indian Health Service (IHS)/Tribal 638 organizations] and those receiving some or all of their care elsewhere.
- Individuals transitioning from incarceration who are AHCCCS-eligible and enrolled.
- Children with or at risk for autism, children with behavioral health needs, and children served by the child welfare system.
- Adults with behavioral health needs.

At the crux of the projects is improved care coordination for these vulnerable AHCCCS members. For the purposes of the projects, care coordination will generally follow the Agency for Healthcare Research and Quality (AHRQ) definition, with each project operationalizing service delivery in a manner that is appropriate for the specific population and goals of the program. The AHRQ

definition "is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."[1]

American Indians

Forty percent of Arizona's American Indian population of 350,000 is covered by Medicaid. AHCCCS has identified a significant opportunity to improve care for this member population by improving the integration of services among the state's hospitals and health care provider organization, including those located on and off Tribal reservations.

Medicaid covers services delivered both inside and outside the IHS/638 system. American Indian Medicaid members have the choice of receiving care through the AHCCCS acute plans (MCOs) or through the American Indian Health Program, a fee-for-service payment program administered by AHCCCS. Tribal members' health disparities are exacerbated by a fragmented delivery system that is difficult to navigate and provides little in the way of care coordination. Providers often have limited-to-no access to data from other settings in which the members they are seeing also seek care, making effective coordinated care extremely challenging.

Adults Transitioning from the Justice System

Adults transitioning from the justice system are a second proposed population of focus. On average, there are 9,000 Arizona Medicaid beneficiaries incarcerated in a given month. Approximately 100,000 individuals transition from incarceration to AHCCCS every year. 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 in the first year post release.[2] 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.[3] 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.

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[1] www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html

[2] 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.

[3] 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.

Children with Behavioral Health Needs, Children with or at Risk for Autism, and Children Engaged in the Foster Care System

Children with behavioral health needs, children with autism, and children engaged with the foster care 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 percent of Medicaid expenditures for children.
- Children in foster care and those on SSI/disability represent one-third of the Medicaid child population using behavioral health care, but represent 56 percent of total behavioral health expenses.
- Almost 50 percent of children in Medicaid prescribed psychotropic medications receive no accompanying identifiable behavioral health services, such as medication management.[4]

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.[5]

Adults with Behavioral Health Needs

Adults with behavioral health needs constitute the fourth target population. While RBHAs address both medical and behavioral health needs for the Seriously Mentally Ill member population, for other adults who receive care through both MCOs and RBHAs, they 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.[6] 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."

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[4] Rires SA et al. Examining Children's Behavioral Health Service Utilization and Expenditures**.** Center for Health Care Strategies, Inc. Hamilton, NJ December 2013.
[5] Ibid.
[6] General Accounting Office (GAO). A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures. GAO 15-460 May 2015.

C. System Transformation and DSRIP Entities

Current State and Transformation

Arizona's publicly funded health care system has historically been siloed, primarily due to a fragmented system of care prior to the state's participation in Medicaid, which began in 1982. For most Medicaid populations, services have been administered by different entities: acute care plans for physical health, RBHAs for behavioral health, and long-term care plans for long-term care. The system for providing care to American Indians has evolved alongside these delivery systems with little systematic integration. Recently, Arizona has taken significant steps towards integrating care for its Medicaid populations, making one contractor responsible for all services for specialized populations, including children served by Children's Rehabilitative Services and individuals with Serious Mental Illness (SMI). These improvements offered a new approach to integrated care, enhancing care- and case-management services. For other populations, Arizona has also required data sharing among its acute plans and RBHAs to eliminate blind spots in data that each plan faced and allow the plans to see data regarding utilization across the entire continuum of 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. However, each of these integration efforts has exposed gaps in the delivery system and identified additional opportunities for facilitating integration. 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 in the system to ensure that real delivery system change occurs and has a lasting impact.

DSRIP Transformation

AHCCCS seeks to develop a program that will incentivize both providers and health plans to collaborate more effectively, leverage available data, and develop standard clinical and administrative protocols that more effectively provide care for the defined program populations. Funding available through the incentive payments will provide fiscal support for providers electing to participate as 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 stakeholders and, in particular, AHCCCS enrollees.

The common theme of transformation for all projects, providers, and populations will be integration, coordination, and data exchange and analysis applied to care delivery within the DSRIP entities. However, specific tactics, providers, and services will be highly dependent on the targeted populations that the DSRIP entities seek to engage.

DSRIP Entities

AHCCCS will not pre-determine participation in the DSRIP program. Interested providers must collaborate with other providers within the DSRIP entities with the goal of facilitating the creation of collaborative clinical and financial relationships that can most effectively impact care delivery for population(s) they select. Successful DSRIP entities must engage a minimum array of

providers needed to address core health and social needs of the target population(s) that they seek to address. Providers forming a DSRIP 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.
- Health plans (except for AIHP).
- Primary and specialty care.
- Social and community supports, as needed.
- Access to care.

As DSRIP entities will be unique to their population and projects, AHCCCS is not dictating governance structures for the participating DSRIP entities beyond a requirement that the participating providers have executed an agreement that defines how they will work together to accomplish selected projects. These agreements must describe, at a minimum:

- Which providers will act as 'leads' for purposes of developing applications, reporting milestones, 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 health plans and AzHeC will participate in the partnership and projects.
- Geographic reach of entity.

AHCCCS will support the development and operation of the Care Management Collaboratives (CMCs) that will support the American Indian DSRIP strategic focus, but the participating providers will inform the operational structure of the CMCs. In the case of the justice system strategic focus, RBHAs will organize the providers within the DSRIP and provide support throughout the project, as they are best positioned to initiate projects in this category. Successful DSRIP 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 DSRIP activities or funding being released.

D. Projects

As described above Arizona has drafted four unique strategic focus areas for its DSRIP. Selected DSRIP entities must address all projects in each selected focus area. The strategic focus areas, draft projects, and core components are attached. AHCCCS will further define the projects and will develop project milestones and metrics based on feedback from CMS and stakeholders.

E. Role of MCOs, RBHAs, and ALTCS Plans

MCOs, RBHAs, and ALTCS plans are the foundation for Arizona's management of its Medicaid program. AHCCCS intends to leverage its managed care infrastructure to make DSRIP a success. As a result, AHCCCS intends that these three partners – and in particular given the

focus of its DSRIP, AHCCCS' MCOs and RBHAs – play an active role in the DSRIP provider entities' work.

For that reason, Arizona intends to ask that its MCOs and RBHAs not only participate as members of the DSRIP provider entities, but also:

- Provide the DSRIP provider 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 MCOs and RBHAs operate, and thereby define the respective roles of MCOs, RBHAs, and DSRIP providers.
- Participate in the DSRIP learning collaboratives.
- Play a substantive role in relevant DSRIP projects and, in the case of the RBHAs, organize and support the DSRIP entities participating in the justice system strategic focus area.

F. Funding and Attribution

The State intends to access approximately $1.6 billion in total computable funding over five years to support DSRIP initiatives. The non-federal share of the funding will be provided through Designated State Health Program funding during the waiver period. Post-waiver transformation will be funded through alternative payment model strategies, as well as the establishment of the American Indian Medical Home initiative.

The attribution strategy will be finalized as projects are finalized. However, lives qualifying in each strategic focus areas will likely be attributed through health plan and RBHA enrollment as well as DSRIP provider networks.

G. Desired Outcomes

Consistent with AHCCCS contractual requirements, Arizona health plans have begun to contract with providers using alternative payment models.[7] Many of these arrangements, however, do not yet require significant downside risk on the part of participating providers. Arizona seeks to implement a DSRIP that will ensure that, as providers begin to assume significant downside risk for management of population health, the providers will have developed the needed care integration infrastructure to successfully meet the needs of these four target high cost, high need populations.

[7] For the current contract period, the eight acute plans that have 1.5 million members enrolled are responsible for having 20% of their medical spend in value-based arrangements. Based on AHCCCS policies, this can range from P4P all the way up to sub- capitated risk. AHCCCS has informed its MCOs that the alternative payment methodology percentage will be 35% for the contract period starting 10-1-16, and 50% for the contract period starting 10-1-17. Similar requirements exist for RBHAs and for Arizona Long Term Care System MCOs.

With this in mind, AHCCCS will identify the desired metrics to measure the results for its DSRIP, against which it will assess DSRIP and DSRIP provider entity performance. Initial process milestones will evolve into Arizona reporting on specific DSRIP outcomes on an annual basis overall and at the provider level. These metrics will be finalized once projects are finalized with CMS and the stakeholder community.

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	
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 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
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 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	
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 coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.	N/A	N/A
		Document that care coordinators 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 coordinators that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A
		Document that care coordinators 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

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	
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-high risk patients 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.
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.	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 identified as high-risk have been referred to a care coordinator 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.

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	
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 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	
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 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.

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	
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 Community Behavioral Health Providers				
8	Develop referral agreements with mental health and substance use providers in the community 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.

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	
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				
9	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.	N/A	N/A
10	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.	N/A	N/A
	Integrated clinical records				
11	Establish and implement integrated access to clinical information from BH providers in primary care records, as appropriate and permissible.	To be defined	To be defined	To be defined	To be defined
12	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.	To be defined	To be defined	To be defined	To be defined

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	
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				
13	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, and peer professionals by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Percentage of practices that have community-based resources lists with contact information, a schedule for updating the resource and protocols for engaging the resources and/or referring patients.	N/A	N/A
	E-Prescribing				
14	Consult Arizona's Controlled Substances Prescription Monitoring Program 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.

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	
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
15	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.
	Involvement with DSRIP Entity				
16	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.

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	
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 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
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 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	
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 coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.	N/A	N/A
		Demonstrate that the care coordinator(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 coordinators that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A
		Demonstrate that care coordinator(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

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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 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	
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 Primary Care Providers and Hospitals				
7	Develop referral agreements with primary care providers in their community 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.
8	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.

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	
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
9	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
	Clinical Care within the Behavioral Health Office				
10	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.	N/A	N/A
11	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 5.
	Integrated Clinical Records				
12	Establish and implement integrated access to clinical information from primary care providers in BH records, as appropriate and permissible.	To be defined	To be defined	To be defined	To be defined
	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.	To be defined	To be defined	To be defined	To be defined

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	
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
	E-Prescribing				
13	Consult Arizona's Controlled Substances Prescription Monitoring Program 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.
14	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.
	Involvement with DSRIP entity				
15	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.

Note:

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

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

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

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

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Management of High-Risk Patients				
3	Utilize care coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.	N/A	N/A
		Demonstrate that the care coordinator(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 coordinators that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A
		Demonstrate that care coordinator(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

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
4	Track-high risk patients 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.	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 identified as high risk have been referred to a clinical care coordinator 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.			

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
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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.
	Integrated Clinical Functions				
8	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.	N/A	N/A
9	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.

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
10	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 that the integrated care plan (Core Component 6) is documented in an integrated, and electronic medical record, in such a way that primary care providers and behavioral health providers both have access.	N/A
11	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.
12	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.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
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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
13	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
	E-Prescribing				
14	Consult Arizona's Controlled Substances Prescription Monitoring Program 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.
15	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
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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
	Involvement with DSRIP Entity				
16	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 Behavioral Health Stay (Hospital)

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

		DY1		DY2	
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
	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.	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) 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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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		DY1		DY2	
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	(b) reconciling medications received in the hospital to what may be taken (or available) at home;	Document that a medication reconciliation took place immediately prior to discharge.	Percentage of hospitals with documented policies and procedures for performing medication reconciliation.	N/A	N/A
4	(c) educating on how and when to take the medications.	Document that the patient received education on all medications.	Percentage of hospitals with documented policies and procedures for performing medication education.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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		DY1		DY2	
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**
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Discharge				
5	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.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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

		DY1		DY2	
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	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
7	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 Behavioral Health Stay (Hospital)

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

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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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

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

		DY1		DY2	
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**
9	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				
10	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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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

		DY1		DY2	
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				
11	Participate in DSRIP entity-offered training and education.	N/A	Percentage of hospitals that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	Percentage of hospitals that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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

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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

	DSRIP Entity Requirements
1	The DSRIP entity must execute an agreement with each participating provider that defines how each participating provider will engage with the DSRIP entity in order to accomplish each project. These agreements must describe, at a minimum:
	• How providers will document and report milestone achievement and report performance measures specific to each project. • Provider commitment to participate in DSRIP entity meetings and provider training events. • DSRIP entity obligation to disburse DSRIP incentive payments to participating providers for milestone achievement and achievement on project-specific performance measures. • How DSRIP entities will engage in data sharing and data analytics, to support provider activity. • How DSRIP entities and participating providers will collaborate to develop shared clinical and administrative protocols. • How acute plans, RBHAs and AzHeC will participate in DSRIP entity activities and with participating providers to advance provider performance on DSRIP projects.
2	Each DSRIP entity must create its own portfolio of technical assistance offerings to its providers, based on the needs of participating providers, to support provider efforts to address DSRIP project core components and based on any requirements for training established in the core components of each project. Such technical assistance might include, but is not limited to, didactic education, interactive one-on-one practice coaching and peer-based learning. The DSRIP entity should use multiple modalities, potentially including a learning collaborative to address provider needs. The technical assistance portfolio may change over the 5 years of the DSRIP program, but must be established within the first 120 days of the program.
3	Each DSRIP entity must identify which participating providers will be participating in each of the projects, all of which are required at the DSRIP-entity level, within the timeframe established by AHCCCS.
4	Each DSRIP entity must report on the performance of its providers within the timeframe established by AHCCCS, and using the metrics established by AHCCCS. Each entity must also assist AHCCCS in facilitating audits and record reviews, as requested by AHCCCS.

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 1: Provider Role in CMC Formation, Governance and Management
Objective: Participate in collaborative CMC activities to ensure commonly understood and shared care management strategies are developed and implemented, resulting in improved care for high-risk AIHP members in need of structured care management support.

		DY 1
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment
1	Participate in the Steering Committee and any work groups developed by the CMC.	Identify the executive(s) from its organization who will participate on the CMC Steering Committee and any CMC-organized work groups.
2	Develop an agreement with the CMC to participate and collaborate in CMC-organized activities.	*N/A: The CMC will document that an agreement has been signed between the participating provider and the regional CMC.*
3	The executive assigned to the Steering Committee will attend all meetings, or send a designated representative when the executive is unable to attend, and will participate in collaborative work (with the CMC) to develop protocols for comprehensively identifying and prioritizing AIHP members for whom care management resources would be beneficial. Such work should also include the development of a standardized approach to care plan development, which includes consumers, and defining the respective care management roles of the CMC and participating providers, and to define the respective care management roles of the CMC and participating providers.	*N/A: The CMC will document that all Steering Committee meetings have been attended by a provider executive, or by a designated representative.*
4	The participating provider will implement the care management protocols, as collaboratively developed through and documented by the CMC.	Document that the participating provider is working to implement a care management model designed in collaboration with the CMC.
5	The participating provider will report progress on Core Components of projects in this strategic focus area to the CMC.	*N/A: Evidence of this Core Component will be measured in other Projects. Performance relative to this Core Component will therefore not be assessed to inform distribution of any DSRIP dollars.*

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 1: Provider Role in CMC Formation, Governance and Management
Objective: Participate in collaborative CMC activities to ensure commonly understood and shared care management strategies are developed and implemented, resulting in improved care for high-risk AIHP members in need of structured care management support.

		DY 1
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment
6	The participating provider will participate in education and training offered by the CMC.	*N/A: The CMC will document that a clinician affiliated with the participating provider attended the CMC's education and training offerings over the course of the year.*

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 2: Care Management
Objective: To develop a care management system that will support the care delivered to American Indian populations enrolled in AIHP and receiving treatment through Indian health provider organizations and non-Indian health provider organizations participating in the CMC.

		DY 1	DY 2
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment	Provider Reporting Requirement for DSRIP Payment
1	For primary care practices and community mental health practices: Implement the protocols established through CMC-coordinated efforts (Project 1, Core Component #3), including engaging AIHP members who have been prioritized for care management, and developing individualized care plans.	Document that the provider has implemented the established protocols; Document that the provider has the capability to implement the protocols, consistent with Core Component 4.	Document that the provider conducts proactive outreach and engagement of AIHP members, and that care plans are developed.
2	For primary care practices and community mental health practices: Utilize the predictive modeling software employed by the CMC for improved population health.	*N/A*	Demonstrate that the practice has incorporated the software tools into its practice and utilizes them to proactively identify patients who are in need of care management support.
3	For primary care practices and community mental health practices: Utilize the care plans for all care management activity. Utilize the standardized care plan template to be developed collaboratively with the CMC in Project 1, Core Component #3 when available.	Document that care managers a) have been trained in how to develop a standardized care plan, and b) are utilizing care plans for all care managed AIHP members.	Document that care coordinators are sharing the standardized care plan with other providers, including through any electronic platform developed or adopted by the CMC.
4	For primary care practices and community mental health practices: Participate in collaborative work (with the CMC) to define how to attribute AIHP members in need of care management to a participating provider organization.	*N/A: The CMC will report the participation levels of participating providers.*	*N/A: The CMC will report the participation levels of participating providers.*

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 2: Care Management
Objective: To develop a care management system that will support the care delivered to American Indian populations enrolled in AIHP and receiving treatment through Indian health provider organizations and non-Indian health provider organizations participating in the CMC.

		DY 1	DY 2
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment	Provider Reporting Requirement for DSRIP Payment
5	For primary care practices and community mental health practices: Providers of a certain size, to be determined by AHCCCS, must have a care manager(s) employed by the practice. The number and full-time status of the care manager(s) should be directly correlated with the number of high-risk patients attributed to the provider. Providers that are smaller than the size set forth by AHCCCS must develop care management agreements with the regional care management support consistent with Core Component 6.	Identify the name of at least one care manager serving site and the hours for which the care manager is available. Provide documentation of a job description. Document that the care manager has been trained to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Document that care coordinators have been trained to engage and educate patients who are frequent ED utilizers to utilize the primary care practice or a behavioral health practice, instead of the ED, when appropriate.
6	For regional care management support organizations designated by AHCCCS: Care management services must be available during 24/7 to a) support AIHP member evaluation during ED visits; b) answer after-hour and weekend questions from providers regarding member care plans; and c) coordinate follow-up post-ED evaluation / after-hour clinical interventions with primary care or community mental health practice; d) support practices too small to support a care manager during regular business hours.	Develop agreements with small primary care and community mental health providers to provide care management services to the practice. Agreements should have protocols for accessing medical records. Document the staffing plan for 24/7 care management coverage. Develop agreements with any primary care and community mental health providers to provide care management services outside of non-traditional business hours. Agreements should have protocols for accessing medical records.	Work with all practices for which an agreement is place on two quality improvement projects to improve the care management process. Such projects should be focused upon a mutually agreed and defined set of projects.

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 2: Care Management
Objective: To develop a care management system that will support the care delivered to American Indian populations enrolled in AIHP and receiving treatment through Indian health provider organizations and non-Indian health provider organizations participating in the CMC.

		DY 1	DY 2
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment	Provider Reporting Requirement for DSRIP Payment
		Document the staffing plan for 24/7 care management coverage.	
7	For hospitals, primary care practices and community mental health practices: Develop protocols for transition planning and collaborative care management for AIHP members: (a) leaving the justice system. (This protocol should, in part, state that upon notification from the criminal justice system that an AIHP member is transitioning back to the community, actively outreach to the AIHP member to schedule a well-visit.) (b) being discharged from inpatient care. (This protocol should, in part, state that shortly after hospital notification of an outpatient primary care practice (or a community behavioral health provider, when appropriate) that an AIHP member will soon be discharged, actively outreach to the AIHP member to schedule a post-discharge visit within 3 days after hospital discharge and conduct 3) medication reconciliation within 7 days of hospital discharge. Prior to the post-discharge appointment, obtain the discharge summary.) (c) being discharged from crisis stabilization services. (This protocol should, in part, state that upon notification that an AIHP member is being or has been discharged, actively outreach to the AIHP member to schedule a post-discharge appointment. Prior to the post-discharge appointment obtain the discharge summary.)	Document that policies and procedures have been developed to provide transition planning and collaborative care management for AIHP members.	Document that an annual review of the policies and procedures has been conducted to identify opportunities for process improvement to better manage the identified transitions of care for AIHP members.

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 2: Care Management
Objective: To develop a care management system that will support the care delivered to American Indian populations enrolled in AIHP and receiving treatment through Indian health provider organizations and non-Indian health provider organizations participating in the CMC.

CC #	Core Component	DY 1 Provider Reporting Requirement for DSRIP Payment	DY 2 Provider Reporting Requirement for DSRIP Payment
	(d) entering the foster care system or transitioning from the foster care system (due to family reunification, adoption or aging-out). (This protocol should identify the actions the primary care and community mental health practices must take to ensure a) immediate care is provided to AIHP members that need care (e.g., children entering foster care); and that b) for AIHP members that might not need immediate care (e.g., adults aged-out of the foster care system), that medical and behavioral health records are transitioned to a new provider (if applicable) within a reasonable time frame.		
8	Provide all medical records to AzHeC or non-IHS / tribal provider when referring the AIHP member for any testing, treatment, or follow-up.	N/A	Document that the provider has protocols in place for sharing medical records with all providers participating in the AIHP member's care.
	Incorporate results of screening, diagnostic testing, or procedures from the non-IHS / tribal provider into the AIHP member's medical record and HIE upon receipt.	Document that the provider has a procedure for incorporating the results from secondary treatment providers into the AIHP's member's medical record and the HIE.	N/A
	Assess the information received from the non-IHS / tribal provider and take appropriate action, including when necessary, furnishing or requesting additional services.	Document the provider has a procedure for assessing the clinical information received from secondary providers and protocols for acting upon it.	N/A

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 3: Care Management and Data Infrastructure
Objective: To develop a data infrastructure capability in support of care management protocols, including data analytics for both clinical data and utilization data for CMC participating providers.

		DY 1	DY 2
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment	Provider Reporting Requirement for DSRIP Payment
1	Participate in CMC-offered coding training and education to improve the claims detail that flows to the CMC and AHCCCS.	Document participation in all CMC-offered coding training and education.	Document participation in all CMC-offered coding training and education.
2	Establish processes and dedicate staff to update data that reside in CMC analytic tools and that are used to identify recent utilization, gaps in care and/or care management detail.	Document processes and identify staff who are responsible for updating data used by the CMC to identify AIHP members in need of care management and for tracking their care.	N/A
3	For primary care practices and community mental health providers: Establish processes for a) utilizing CMC analytic data and dedicate staff to identify and b) actively engaging complex needs members in care management activities.	N/A	Document processes for utilizing the CMC analytical tools to a) identify members in need of care management services, and b) actively engaging complex needs members in care management activities.
4	For primary care practices and community mental health providers: Establish protocols for identifying complex members during office visits so that timely interventions and supports can be provided. Such protocols should include an assessment of medical and behavioral health needs, and of social determinants of health, including housing, employment and food security needs. Evidence-based screening tools should be used, when possible, and be consistent with Core Components 6 & 11 of Project 4. Results of assessment / screening tools must be documented in the medical record.	Document that policies and procedures are in place to identify individuals with complex medical and behavioral health needs, and that social determinants of health are identified; Demonstrate that the results are documented in the medical record, and as applicable in the CMC analytics tool.	% of patients seen in the last year with documented medical and behavioral health needs, and social determinants of health.
5	For participating hospitals: Provide ADT notification and ED discharge summaries to the AzHeC.	*N/A: The CMC will report whether the participating hospital has provided ADT and ED discharge summaries to AzHeC.*	*N/A: The CMC will report whether the participating hospital has provided ADT and ED discharge summaries to AzHeC.*

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT
Project 3: Care Management and Data Infrastructure
Objective: To develop a data infrastructure capability in support of care management protocols, including data analytics for both clinical data and utilization data for CMC participating providers.

		DY 1	DY 2
CC #	Core Component	Provider Reporting Requirement for DSRIP Payment	Provider Reporting Requirement for DSRIP Payment
6	For participating hospitals: Establish protocols for identifying complex members during ED visits so that timely interventions and supports can be provided. Assessment information should be included on ED discharge summaries that are shared with AzHeC.	Document that policies and procedures are in place to identify individuals with complex medical and behavioral health needs, and that social determinants of health are identified; Document that the results are recorded in the medical record.	% of patients seen in the last year with documented medical and behavioral health needs, and social determinants of health.
7	Register with Arizona's Controlled Substances Prescription Monitoring Program	Identify the percentage of prescribers in the organization who are registered for the CSPMP.	N/A
8	Consult Arizona's Controlled Substances Prescription Monitoring Program 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	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.
9	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.
10	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 (for primary care practices and community behavioral health practices only) incorporating its data into care management activities conducted by the provider.

Strategic Focus Area: Members Served by the American Indian Health Program - Optional - DRAFT
(Optional) Project 4: Transform primary care sites serving AIHP members into Patient-Centered Medical Homes.
Objective: Assist primary care practices on developing core PCMH skills, and possible certification, and track their increased skill level over three years.

		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
	Engaged Leadership			
1	Demonstrate practice leadership is committed to transforming the practice into a Patient-Centered Medical Home.	Written documentation that the practice leadership has designated staff resources and allocates time for care teams to learn, implement and manage the transformation process, including the name of the physician champion and hours designated weekly to oversee the transformation process; Written documentation of practice's transformation vision statement, and objectives.	N/A	N/A
	Quality Improvement Strategy			
2	Use an organized approach to identify, report and act on improvement opportunities, and set goals for improvement.	Written documentation of the organized QI approach (e.g., PDSAs, Model for Improvement, Lean, FMEA, Six Sigma, etc.) to be used within the practice; Written example of use of selected approach to address one quality issue.	Written documentation of use of QI approach to address at least 3 quality issues, including description of projects, measures developed, data collection and project results.	N/A

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(Optional) Project 4: Transform primary care sites serving AIHP members into Patient-Centered Medical Homes.
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		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
3	Build quality improvement capacity and empower staff to innovate and improve.	Name and qualifications of clinician responsible for overseeing the practice's quality initiatives; Written curriculum used to train existing staff in QI process.	Written documentation of the number of hours staff have committed to QI projects.	Written documentation of content of QI training incorporated into all new employee training.
4	Regularly produce and share reports on performance at both the organizational and provider/care team level, including how performance compares to goals.	Examples of reports the practice intends to implement on a regular basis; Written plan for sharing report results within the practice, including to whom and how frequently.	Samples of regularly produced reports on how providers and/or care teams are performing and meeting quality goals; Written evidence, such as meeting minutes or description of new initiative, that there is systematic follow-up on the reports that show opportunities for improvement.	N/A
	Empanelment and Population Health Management			
5	Maintain a process to measure and promote continuity between a patient and his/her care team so that patients and care teams recognize each other as a partner in care.	Written protocol for assigning patients to a care team.	Written procedures for assessing the care team's patient panel assignments for workload balance and evidence that panel assignments are updated on a regular basis.	Written evidence that practice regularly measures how frequently a patient is cared for by a member of his/her care team when seeking in-person or remote care and that the continuity rate is improving.

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		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
6	Track high-risk patients 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; children and youth in foster care; individuals with multiple chronic conditions. *Complementary to Project 2.*	Written evidence that the practice regularly receives payer-generated, gaps-in-care reports covering the top 5 chronic diagnoses within the practice's patient population and uses this information to identify gaps in care.	Develop a) a registry of high-risk patients and b) processes for routinely screening for high-risk status indicators, which includes assessing the patient's co-morbidities, any of the high-risk indicators included in this Core Component, and includes key social determinants of health, such as housing, employment status, food insecurity, and for children Adverse Childhood Experiences (ACEs).	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs, T/RBHAs into the high-risk registry; Written protocol detailing the outreach process to patients needing intervention, including which conditions are the focus of outreach, process for identifying patients with gaps in care and method and timeframe for patient outreach; Written evidence that it maintains its registry and regularly updates a list of high-risk, high need patients.
	Continuous & Team-based Healing Relationships			
7	Set clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes and accountability.	Written documentation of process used for identifying members of the care team; Job descriptions for each care team member; Work flow map of work required before, during and after patient visits that maximizes the skill set of the care team.	Written evidence that the care team(s) meet regularly to discuss patient needs.	Written evidence of program to cross-trained care team members to maximize the skill set of the care team and optimize efficiency and outcomes.

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		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
	Organized Evidence-based Care			
8	Assure well-coordinated, evidence-based care for highest-risk patients. *Complementary to Project 2.*	Written protocol detailing the content of patient assessment based on patient's specific symptoms, complaints or situation, including the patient's preferences and lifestyle goals, self-management abilities and socioeconomic circumstances contributing to high-risk designation; Written protocol for content of care plan and timeline for its development.	Written evidence that 80% of high-risk patients have written care plans.	Written evidence that 90% of high-risk patients have written care plans.

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CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment	DY 3 Practice Reporting Requirement for DSRIP Payment
	Integrated Care			
9	Ensure that care addresses the whole person, including mental and physical health needs, by routinely screening adult 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; and screening pediatric patients for: developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) AND must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. 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).	Copy of training curriculum regarding use of screening tool and names of clinicians that have completed training.	Results of screening are documented in the medical record.	N/A

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		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
10	Develop referral agreements with mental health and substance use providers in the community 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, and the protocols for referring a patient to a behavioral health provider when any of the screening assessments are positive. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.).	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care coordination agreement.	Enhance relationships with behavioral health providers by updating referral agreements to include protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers.	N/A
	Patient-Centered Interactions			
11	Encourage patients and families to collaborate in goal-setting and decision-making.	Name of shared decision-making tool selected by practice; Curriculum for training all staff that interact with patients and families in shared decision-making approaches. Written protocol for consistently documenting patient/family involvement in goal setting, decision making.	Documentation that patients have had an opportunity to participate in goal setting and decision making.	Documentation that patients have had an opportunity to participate in goal setting and decision making.

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CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
12	Maintain a formal approach to obtaining patient and family feedback and incorporating this feedback into the quality improvement system and in strategic and operational decisions of the practice.	Evidence that practice has a formal approach to obtaining patient and family feedback, such as an established patient advisory group that meets regularly or a patient survey that is implemented within established timeframes.	Practice provides written documentation in the form of meeting minutes or quality initiative description that patient and family feedback has been the basis for at least one quality improvement initiative during the preceding 12 months.	N/A
13	Encourage patients to develop self-management skills.	List of self-management classes or educators to which practice refers patients.	a) Training curriculum designed to train staff in patient empowerment and problem-solving methodologies; b) List of positions trained in patient empowerment techniques.	N/A
14	Guide the practice by principles of patient-centered and culturally competent care.	Practice vision and mission statement include the principles of patient-centered and culturally competent care.	Job descriptions include principles of patient-centered and culturally competent care. Employee evaluation metrics include measures of patient-centered and culturally competent care.	N/A

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		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
	Enhanced Access			
15	Maintain a system to increase patient access to their care team in order to improve continuity of care and reduce need for ED visits.	Written policy specifying the timeframes for returning patient telephone calls: a) For urgent medical/behavioral calls received during office hours, return calls are made the same day; b.) For urgent calls received after office hours, return calls are made within 1 hour; c) For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	The practice has implemented same-day scheduling for urgent care and routine care.	N/A
	Care Coordination			
16	Identify the practice's medical neighborhood to include specialists, a hospital(s), nursing homes and other organizations with which the practice or its patients interact on a regular basis.	List of specialists, hospitals, nursing homes, home health, home care and other organizations, including drug and alcohol abuse treatment programs, that are part of the practice's medical neighborhood, including key contact names, telephone numbers and email addresses.	Written protocol detailing standardized communication process, including patient information flow and communication timelines, for each member of the practice's medical neighborhood and evidence that the protocol has been adopted by the agreeing parties.	N/A

Strategic Focus Area: Members Served by the American Indian Health Program - Optional - DRAFT
(Optional) Project 4: Transform primary care sites serving AIHP members into Patient-Centered Medical Homes.
Objective: Assist primary care practices on developing core PCMH skills, and possible certification, and track their increased skill level over three years.

		DY 1	DY 2	DY 3
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
17	Follow up via telephone, visit or electronic means with patients within a designated time interval after an emergency room visit and completes a medication reconciliation within a designated time interval after hospital discharge. *Complementary to Project 2.*	a) Written evidence that the practice has established a system for regularly receiving timely information from hospital partners about emergency department visits; b) Written protocol requiring follow-up after ED visits to occur within 72 hours of visit.	Written protocol requiring follow-up after ED visits to occur within 72 hours of visit and follow-up and medication reconciliation within 72 hours after hospital discharge.	Written evidence of an audit of a random sample of medical records and communication logs to determine what percent of the time the written outreach protocol and medication reconciliation protocol are being followed.
18	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, and peer professionals by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Name of designated staff person responsible for providing patients with referral, scheduling and follow-up assistance to ensure patients have optimal access to community resources	N/A

The primary care practices, community behavioral health practices and hospitals 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 provider 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
0576	Follow-Up After Hospitalization for Mental Illness (FUH)
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
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
2372	Breast Cancer Screening
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
0002	Appropriate Testing for Children with Pharyngitis

The primary care practices, community behavioral health practices and hospitals 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 provider level.

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
1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
0717	Number of School Days Children Miss Due to Illness
2337	Antipsychotic Use in Children Under 5 Years Old

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

Project 1: Develop an integrated health care setting within select 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.

Objective: 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.

		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
1	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 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 within probation and/or DOC parole offices.	N/A
2	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.	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.
3	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

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

Project 1: Develop an integrated health care setting within select 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.

Objective: 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.

		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
4	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
5	The practice should conduct a screening and assessment for both physical and behavioral health needs (including substance use disorder needs) during the individual's first visit to probation/parole unless the beneficiary declines a request from the practice.	Demonstrate that the practice has a protocol for performing and assessment and screening during the first visit.	N/A
6	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
7	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, and information on other support resources.	Demonstrate that peer support staff have been hired and have participated in training provided by the RBHA; Provide evidence of job descriptions.	N/A

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

Project 1: Develop an integrated health care setting within select 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.

Objective: 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.

		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
8	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
9	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.
10	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.

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

Project 1: Develop an integrated health care setting within select 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.

Objective: 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.

		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
11	Participate in RBHA training and education.	Demonstrate that the practice participated in RHBA-provided training during the DY.	Demonstrate that the practice participated in each RHBA-provided training during the DY.

Strategic Focus Area: Justice System Coordination for Individuals Involved in the Juvenile System – DRAFT
Project 2: To be defined
Objective: To be defined

		DY 1	DY 2
CC #	Core Component	Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment

Strategic Focus Area: Adults Transitioning from the Justice System – 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
0710	Depression Remission at 12 months
1884	Depression Response at 6 months
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other
0105	Antidepressant Medication Management
CMS	Screening for Depression and Follow-up Plan
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0576	Follow-up after Hospitalization for Mental Illness (7-day)
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
2372	Breast Cancer Screening

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
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	
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 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
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
	Management of High-Risk Patients				
3	Utilize care managers [1] 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.	Percentage of practices that have identified a care manager for each practice site; List of names of care managers by practice site.	N/A	N/A

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
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	
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 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
4	Track high-risk patients 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 disciplinary action in schools; recent involvement with law enforcement; involvement with the child welfare system; with or at risk for ASD.	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.	N/A	N/A

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
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	
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	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 high-risk patients 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 primary care providers and behavioral health providers both have access.	Percentage of practices that have integrated care plans documented in an electronic medical record.

		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 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.			

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

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
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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
	Relationships with Behavioral Health Providers				
8	Develop referral agreements with mental health and substance use providers in the community 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.

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
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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
	Clinical Care within the Primary Care Office				
9	Routinely screen patients (at the age-appropriate time) for developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) AND must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. 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 adopted developmental screening tool, and policies and procedures for administration of that tool(s) and of the M-CHAT, CRAFFT and PHQ-A.	Percentage of practices that have adopted all of the required screening patients for developmental delay and disorders, depression, drug and alcohol use; Frequency distribution of developmental screening 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
10	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

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
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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
11	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.	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

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
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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
	Integrated Clinical Records				
12	Establish and implement integrated access to clinical information from behavioral health providers in primary care records, as appropriate and permissible.	To be defined	To be defined	To be defined	To be defined
13	Enhance electronic health record (EHR) capabilities between primary care providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined	To be defined	To be defined
	Community-based Supports				
14	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. 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

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
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	
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
	E-Prescribing				
15	Consult Arizona's Controlled Substances Prescription Monitoring Program 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.
16	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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	
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				
17	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.

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, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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	
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 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
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
	Management of High-Risk Patients				
3	Utilize care managers [1] 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 behavioral health care site.	Percentage of practices that have identified a care manager for each practice site; List of names of care managers by practice site.	N/A	N/A

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
Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health 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 the care manager(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient	Percentage of practice care managers that have received DSRIP entity care management training; Evidence of training agenda and training materials.	N/A	N/A
4	Track high-risk patients 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 disciplinary action in schools; recent involvement with law enforcement; involvement	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.	N/A	N/A
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.	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	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.

		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 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.	consistent with the required elements.		

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

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	
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 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.			
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.

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

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	
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 Primary Care Providers				
8	Develop referral agreements with primary care providers in the community 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	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.

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

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	
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				
9	Routinely screen patients (at the age-appropriate time) for developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) AND must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. 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 adopted developmental screening tool, and policies and procedures for administration of that tool(s) and of the M-CHAT, CRAFFT and PHQ-A.	Percentage of practices that have adopted all of the required screening patients for developmental delay and disorders, depression, drug and alcohol use; Frequency distribution of developmental screening 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
10	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

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

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	
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
11	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.	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
	Integrated Clinical Records				
12	Establish and implement integrated access to clinical information from primary care providers in behavioral health records, as appropriate and permissible.	To be defined	To be defined	To be defined	To be defined
13	Enhance electronic health record (EHR) capabilities between behavioral health and primary care providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined	To be defined	To be defined

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

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	
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				
14	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 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
	E-Prescribing				
15	Consult Arizona's Controlled Substances Prescription Monitoring Program 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.
16	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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	
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				
17	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.

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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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

		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 treatment 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

CC #	Core Component	DY 2		DY 3	
		Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	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.
	Relationships with ASD Treatment Providers / Team				
4	Develop referral agreements with ASD treatment teams, programs, or providers who are trained to evaluate children for autism and provide early intensive behavioral therapy to families and children. Each referral agreement must include:	Identify the names of the ASD treatment 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 treatment teams/programs with whom agreements have been executed.	N/A	N/A

CC #	Core Component	DY 2		DY 3	
		Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	(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.				
	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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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 the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child

		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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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 the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child

		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 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]	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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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 the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child

		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	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.	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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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 the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child

		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
	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: a. Monitor developmental milestones and any signs and symptoms of abuse and/or neglect, b. Monitor a youth's emotional adjustment to the child welfare system and visitation, c. Ensure the child has all necessary academic supports, clinical or community based referrals, medical equipment, and medications; and d. Support and educate foster parents/guardians.[3]				
6	At every visit, conduct a comprehensive child abuse and neglect screening, including through 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. 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 children who had a child abuse and neglect screening at every visit.	Percentage of practices that met this requirement at a level to be determined by AHCCCS.

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
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 the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child

		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	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.	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
8	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
9	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]	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
10	Coordinate care management with the 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

		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
	Involvement with DSRIP Entity				
11	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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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.

		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, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - 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.

		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

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
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.

		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 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]	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.

[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

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
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

	DSRIP Entity Requirements
1	The DSRIP entity must execute an agreement with each participating provider that defines how each participating provider will engage with the DSRIP entity in order to accomplish each project. These agreements must describe, at a minimum:
	• How providers will document and report milestone achievement and report performamce measures specific to each project. • Provider commitment to participate in DSRIP entity meetings and provider training events. • DSRIP entity obligation to disburse DSRIP incentive payments to participating providers for milestone achievement and achievement on project-specific performance measures. • How DSRIP entities will engage in data sharing and data analytics, to support provider activity. • How DSRIP entities and participating providers will collaborate to develop shared clinical and administrative protocols. • How acute plans, RBHAs and AzHeC will participate in DSRIP entity activities and with participating providers to advance provider performance on DSRIP projects.
2	Each DSRIP entity must create its own portfolio of technical assistance offerings to its providers, based on the needs of participating providers, to support provider eforts to address DSRIP project core components and based on any requirements for training established in the core components of each project. Such technical assistance might include, but is not limited to, didactic education, interactive one-on-one practice coaching and peer-based learning. The DSRIP entity should use multiple modalities, potentially including a learning collaborative to address provider needs. The technical assistance portfolio may change over the 5 years of the DSRIP program, but must be established within the first 120 days of the program.
3	Each DSRIP entity must identify which participating providers will be participating in each of the projects, all of which are required at the DSRIP-entity level, within the timeframe established by AHCCCS.
4	Each DSRIP entity must report on the performance of its providers within the timeframe established by AHCCCS, and using the metrics esablished by AHCCCS. Each entity must also assist AHCCCS in facilitating audits and record reviews, as requested by AHCCCS.

AHCCCS
Arizona Health Care Cost Containment System

DSRIP Community Forum

June 6 & 7, 2016

Today's Meeting

- Discuss AHCCCS's overarching care delivery and payment reform strategies.
- Describe the Delivery System Reform Incentive Program (DSRIP) opportunity and Arizona's proposal
- Community input and engagement.

Transformation Strategies

- Behavioral-Physical Health Integration
  - Care Management for members with complex needs
  - Health Information Exchange
  - Value Based Payments
- Justice System Transitions
- American Indian Care Management capacity

Persons with Complex Needs-BH

Condition	Asthma	Diabetes	HIV/AIDS	MH	SUD	Delivery	LTC	None
Asthma		24.5	3.9	65.1	29.1	6.5	7.3	17
Diabetes	18.5		2.6	52.4	23.9	3.1	12.7	29.7
HIV/AIDS	17.9	15.6		48.1	39.4	2.1	7.2	29
MH	17.6	18.7	2.8		26.7	4.0	11.9	42.9
SUD	20.8	22.6	6.0	70.8		4.5	10.2	15.6
Delivery	9.3	5.9	0.7	21.3	9.0		0.5	66
LTC	12.5	28.6	2.8	74.7	24.4	0.6		14.1

Justice System Transitions

- Have 9,000 unique Medicaid members incarcerated at some point monthly
- 50% of population entering Pima county jail are AHCCCS enrolled – another 30% enrolled in past 2 years
- Many individuals released from incarceration have mental health and/or chronic physical conditions, and substance use disorder

American Indian Health Program

- 120,000 Americans Enrolled in FFS – one-third of Arizona American Indian population
- $1 billion per year - $650 m to IHS/tribal 638 providers
- Limited care management infrastructure – compared to MCO capacity – staffing and payment
- Vast geography – majority of members in 3 counties – Coconino – Apache – Navajo – 33,638 square miles – 2 MA and 1 Maryland
- Healthcare disparities – American Indians 4 times more likely to die from diabetes than non-American Indians AZ

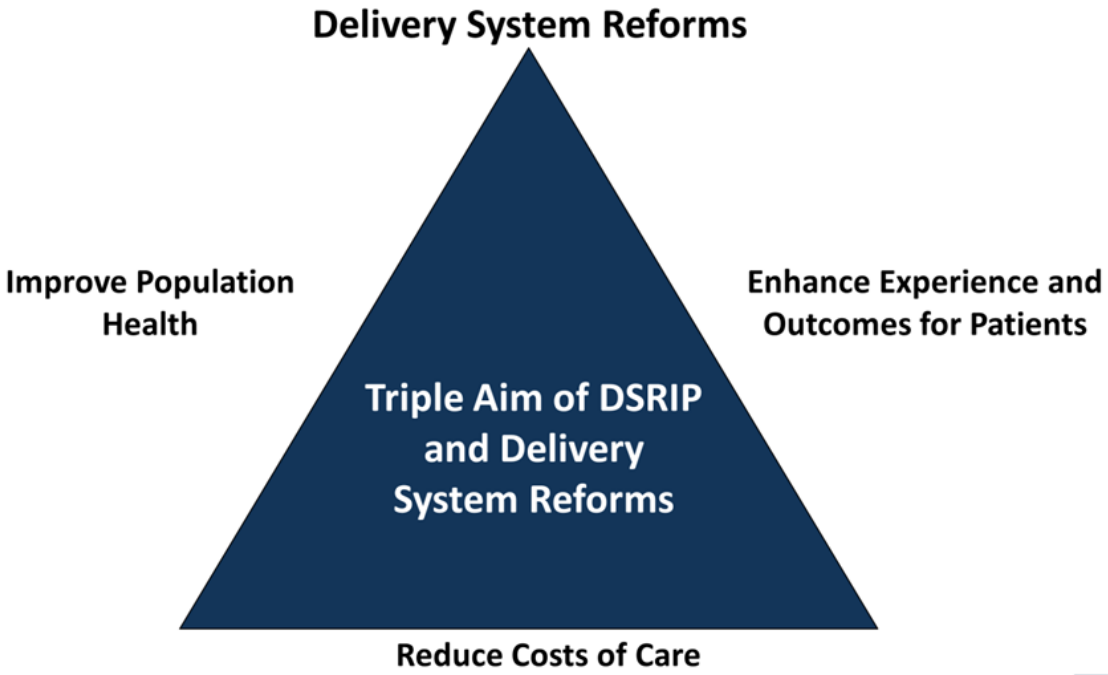
What is DSRIP?

- Federal funds administered by the Centers for Medicare & Medicaid Services (CMS)
- DSRIP initiatives provide states with funding that can be used to support providers in changing how they provide care to Medicaid beneficiaries.
- DSRIP initiatives are part of broader Section 1115 Waiver programs.

DSRIP Initiatives

Figure 2

States are using DSRIP waivers to help achieve larger health system and Medicaid goals for delivery system reforms.



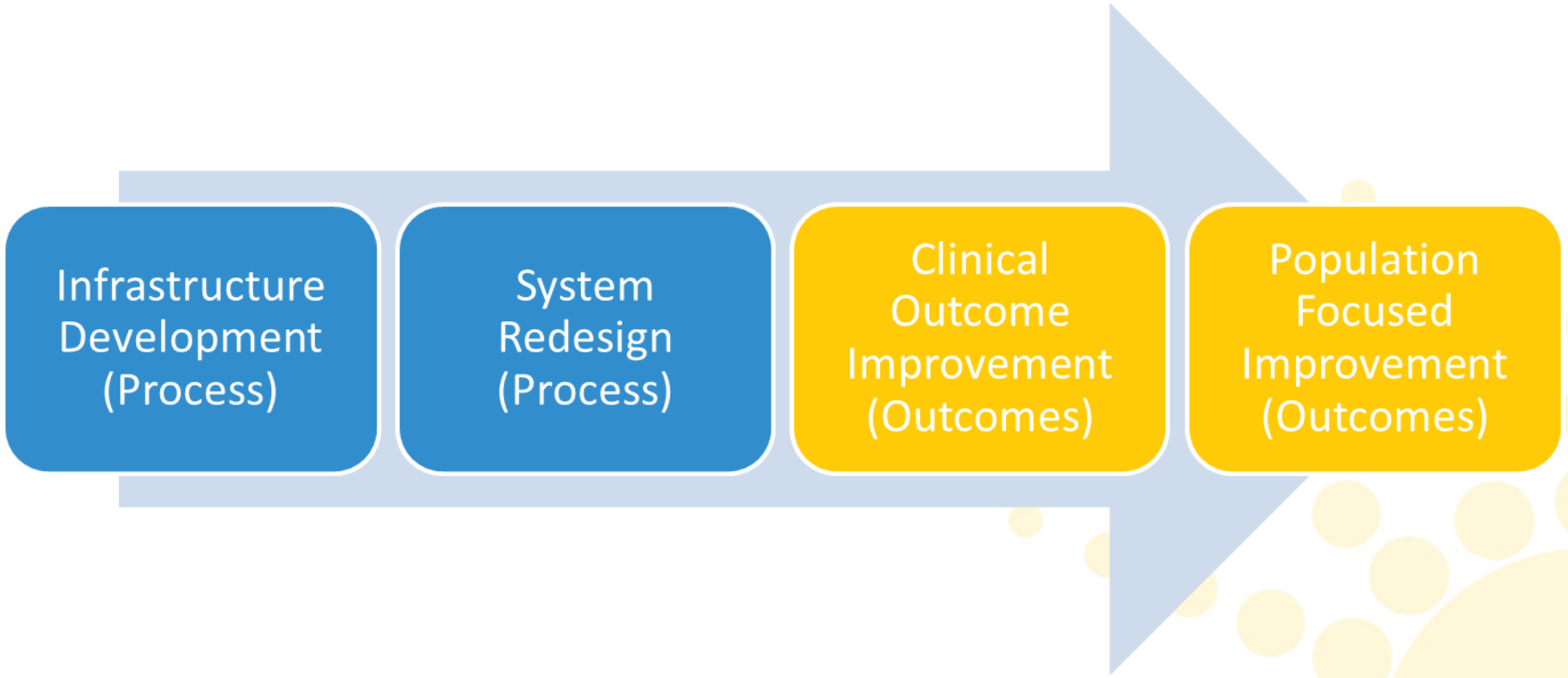
DSRIP Initiatives

- Five years long.
- There is no official federal criteria for DSRIP program qualification.
- States have taken varying approaches.
- Federal funds are matched to state funding for certain qualifying health programs

DSRIP Initiatives (con't)

- DSRIP is an incentive program where payment incentives are distributed for meeting performance outcome requirements.
- Providers can use funds to develop systems, infrastructure, and/or processes.

DSRIP Focus on Four Main Areas



Arizona's DSRIP Proposal

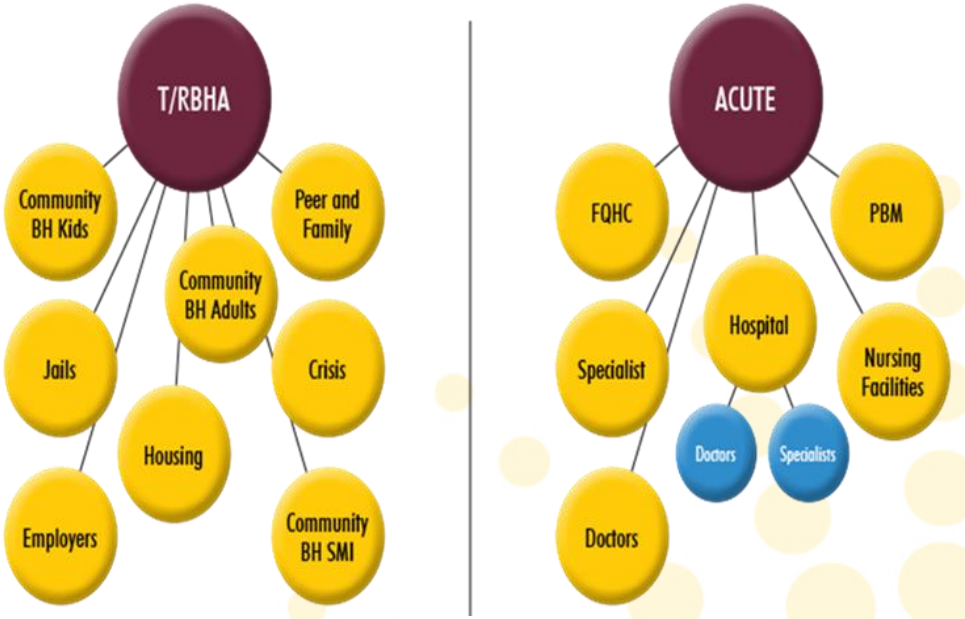
Focuses on targeted populations of vulnerable Medicaid members, where care integration, coordination, and data exchange will likely have an immediate positive impact for enrollees and providers.

Delivery System Limitations and Challenges

Medical care providers, behavioral health care providers, and social service organizations rarely collaborate in a way that addresses complex needs of members.

Due to fragmented funding streams providers have little or no relationship or recognition of critical potential partners.

Previous system design really limited ability to drive toward alternative payment models. Because of fragmentation providers do not have the network, capacity or infrastructure to manage risk.



Arizona's 4 DSRIP Strategic Focus

- Individuals enrolled in the American Indian Health Program (AIHP)
- Adults Transitioning from the Justice System

Arizona's DSRIP Strategic Focus

- Children with Behavioral Health Needs, Children with and At-Risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System

- Adults with Behavioral Health Needs

AIHP Efforts to Date

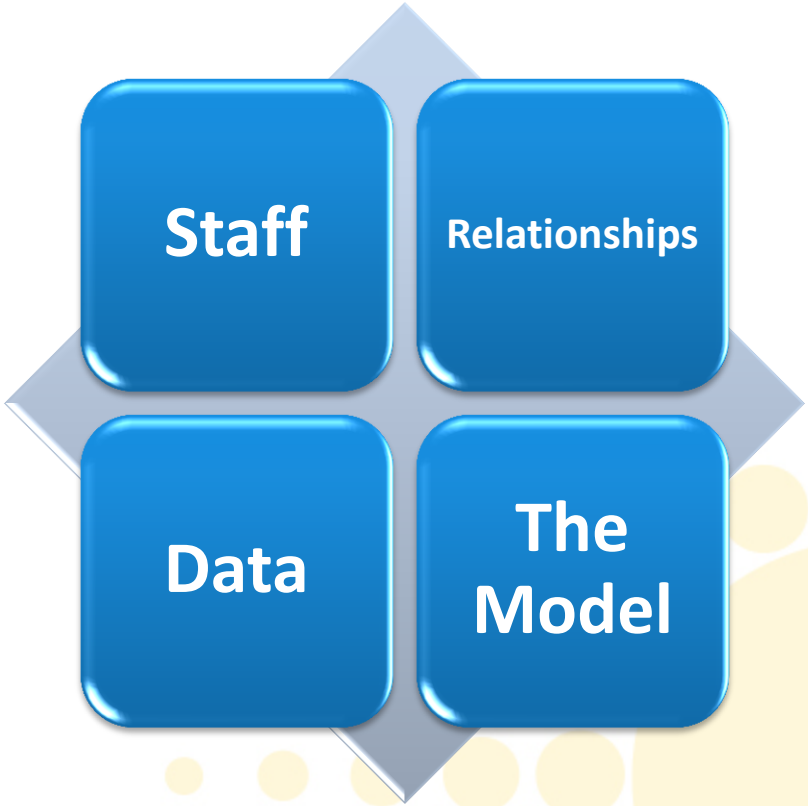
Staff – added new resources including BH manager and physician

Relationships–Have traveled statewide to visit Tribal providers and stakeholders

Data – Sharing data with 14 different organizations on member utilization

Model – Have 130 members in active care management with providers

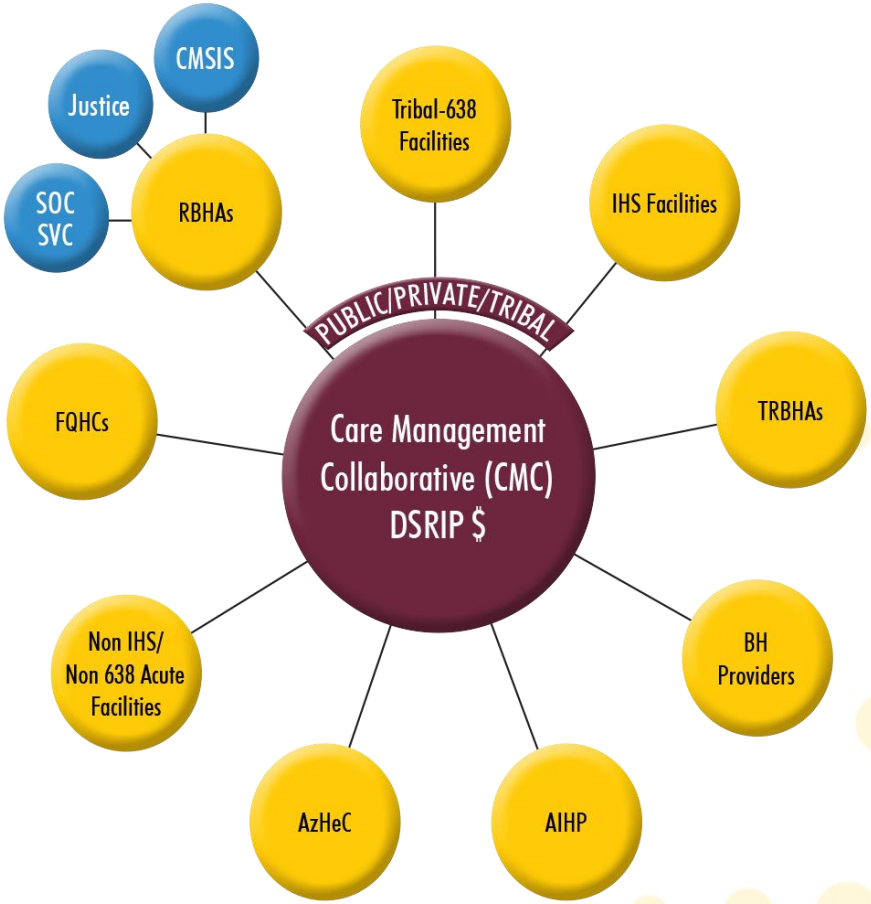
Care Management Model



AIHP CMC DSRIP Proposal

- Project 1 – Care Management Collaboration Formation
- Project 2 – Care Management System Development
- Project 3 Care Management and Data Infrastructure
- Primary Care site transformation to Patient Centered Medical Homes (Optional)

AIHP DSRIP Framework



Justice System Efforts to Date

- Daily match with county jails >90% population and DOC to suspend/reinstate – saved >$30m cap
- Make incarceration data available to plans daily
- RBHAs staff established in jails – Creating reach in requirements for other MCOs
- Partnering with DOC/Jails resulted in 1,500 pre-release apps processed
- 1,100 transitions included select care coordination efforts through manual process

Current System Challenges

- Continue to improve partnership with Justice System
- Need to be more strategic in delivering services – right service – right place – right time
- Need ability to make more scalable

Justice Transitions DSRIP Proposal

- Project 1- Develop an integrated health care setting within select county probation offices or Dept. of Corrections parole offices to address health needs of individuals transitioning from incarceration upon release and throughout the term of probation/incarceration

Children with Behavioral Health Needs, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System

- Behavioral health care accounts for approximately 38 percent of Medicaid expenditures for children
- Children in child welfare system represent one-third of the Medicaid child population using behavioral health care, but represent 56 percent of total behavioral health expenses
- Almost 50 percent of children in Medicaid prescribed psychotropic medications receive no accompanying identifiable behavioral health services, such as medication management

Children with Behavioral Health Needs

- Project 1: Integrate behavioral health services within the primary care site
- Project 2: Integrate primary care services into the community behavioral health care site for better care management of the preventive and chronic illness care for children

Children with Behavioral Health Needs

- Project 3: Improving Treatment for the Care of Children with and At-risk for Autism Spectrum Disorders (ASD) (primary care site)
- Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Children with Behavioral Health Needs

- Project 5: 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.

Adults with Behavioral Health Needs

GAO Report:

- 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
- Although individuals with mental health conditions have some of the greatest health care needs the health care system is often too fragmented to effectively and efficiently serve them

Adults with Behavioral Health Needs

- Project 1: Integrate behavioral health services into the primary care site
- Project 2: Integration of Primary Care and Behavioral Health Services in community behavioral health care sites

Adults with Behavioral Health Needs

- Project 3: Achieve maximum impact from integration of primary care and behavioral health services and maximize the impact of service co-location to better address mental and physical health and addiction disorders.
- Project 4: More effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient behavioral health stay.

Arizona DSRIP-Additional Information

- https://www.azahcccs.gov/AHCCCS/Initiatives/DSRIP/
- http://kff.org/report-section/an-overview-of-delivery-system-reform-incentive-payment-waivers-issue-brief/
- https://www.azahcccs.gov/shared/fiveyear.html

Questions?

Thank You.

Delivery System Reform Incentive Payment (DSRIP) Program

Stakeholder and Public Comments: Common Themes and State Responses

In order to achieve Arizona's State Innovation Plan's vision of accelerating the State's delivery system transformation towards value-based integrated models that focus on whole person health throughout the continuum in all settings, the State has sought broad-based stakeholder input and support from payers, providers, community organizations, and consumers. Stakeholders and members of the public had multiple ways to receive information and provide feedback on the proposed DSRIP program:

- The State held numerous stakeholder meetings to share information and gather input.[1]
- On June 2, 2016, AHCCCS posted for public review and input the draft DSRIP proposal and draft milestones and measures related to the four strategic focus areas:
  - Adult projects.
  - American Indian Health Program projects.
  - Justice system projects.
  - Pediatric projects.
- The State hosted two public forums on June 6, 2016 and June 7, 2016.[2] The public comment period lasted from June 2, 2016 to July 5, 2016.
- The State created dedicated mailing and e-mail addresses for members of the public to send letters and e-mails.

The State received comments from 20 entities that included managed care organizations, professional membership organizations, state and county agencies, providers, and nongovernmental organizations. This document highlights many common themes found throughout stakeholder feedback and public comment period and offers the State's responses, clarification, and how the comments may have shaped the State's proposal.

1. **Target Population.**
   In addition to targeting individuals with behavioral health needs, involved in the justice system, or receiving services through the American Indian Health Program, the State has been asked to consider expanding the target population as follows:
   - Women with high-risk pregnancies.
   - Women of child-bearing years to address the importance of prenatal and postpartum care.
   - Veterans.
   - Older adults with cognitive and functional impairments.
   - Patients appropriate for palliative and/or receiving end-of-life care.

[1] Stakeholder meeting dates and materials are available at https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/SIM.html.
[2] DSRIP public hearing information is available at https://www.azahcccs.gov/AHCCCS/Initiatives/DSRIP/.

- Children with complex medical conditions.
- Children engaged in the child welfare system.
- Children who are at-risk for Autism Spectrum Disorder.
- Individuals with intellectual and developmental disabilities.

Taking into consideration the State's focus on reducing fragmentation through developing an integrated system and resources related to DSRIP projects, the State decided to expand the target population to include children engaged in the child welfare system, children who are at-risk for Autism Spectrum Disorder, and children with intellectual and developmental disabilities.

2. **DSRIP Entity Geographic Region, Composition, and Patient Attribution.**
Given distinct target population, strategic focus areas, and already defined geographic regions for managed care organizations, defining geographic regions for DSRIP provider entities ("DSRIP entity") is challenging. Consequently, stakeholders have asked for flexibility for DSRIP entities to define their own geographic service area. In order to inform the State's planning activity, the State has invited interested parties to provide responses to an RFI to define geographic regions, as well as provide examples of primary care organizations, behavioral health organizations, and hospitals that would be included as DSRIP entity participants. It is the State's intent to finalize the DSRIP entity geographic region definition, their provider composition, and a patient attribution methodology(ies) with stakeholders' input.

3. **Social Services**
The State has received numerous comments about addressing social determinants of health to assist members to attain their full health potential. To that end, the State is strongly encouraging DSRIP entities through project milestones to form relationships with community-based social service resources, including self-help referral connections, community group resources, 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 in all strategic focus areas.

4. **Individuals Transitioning from the Justice System**
The objective of this strategic focus area is to develop an integrated health care setting within selected probation and parole offices. Stakeholders provided the following suggestions:
   - Coordinate eligibility and enrollment activities to maximize access to services.
   - Assist with health care system navigation.
   - Perform health care screenings.
   - Provide physical and behavioral health care services.
   - 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.
   - Assist individuals with arranging and coordinating continuing care once the individual is no longer required to participate in probation/parole activities.

Based on stakeholder comments received, DSRIP entities will have the flexibility to provide integrated care in selected county probation offices or Department of Corrections (DOC) settings, clinics in close proximity to probation offices and/or DOC parole offices, or mobile clinics. Also, additional core competencies will be added related to criminogenic risks screening, participation in Regional Behavioral Health Authority (RBHA) training and education, and health literacy and health financial literacy training for members.

In addition to addressing adults transitioning from the justice system, stakeholders suggested that a project targeting youth transitioning from the justice system would benefit from conducting reach-in coordination, increasing workforce for those serving individuals involved with the justice system, and coordinate eligibility and enrollment activities for continuity of care. The State will convene additional stakeholder meetings to continue developing this project.

5. American Indian Health Program (AIHP) Care Management

The objective of this strategic focus area[3] to improve health outcomes for American Indians by creating more robust care coordination and care management in the AIHP program where American Indians receive care from both Indian health and non-Indian health providers. Stakeholders provided the following suggestions:

- Participating in all Steering Committee and work group meetings is not practicable since participants may have varying degrees of interest and capacity for work group participation.
- It is challenging to find qualified staff in rural communities to provide care management. The State should explore employing alternative resources to perform care transition functions including, but not limited to, community paramedicine.
- For post-discharge follow-up visit and medication reconciliation, a shorter timeframe is recommended to ensure member safety.

6. Behavioral Health and Physical Health Integration for Adults and Children

The objective of this strategic is to provide a comprehensive approach to integrated care in any care setting in which a member may receive either physical health or behavioral health services to better address mental and physical health and addiction disorders.

It should be noted that behavioral health and physical health integration has two focus areas: adults and children. Within these two focus areas, there are distinct projects for adults and children with many overlapping project requirements.

Based on stakeholder input, the State is making the following changes for projects for adults and children:

[3] Based on the Centers for Medicare and Medicaid Services' most recent feedback regarding AIHP care management activities, the State is currently exploring an alternative method(s), including alternative payment model, to fund these activities.

- The State is researching possible toolkits practices should consider utilizing, for behavioral health/physical health integration.
- The State is engaging Arizona Health-e Connection to define the shared integrated clinical record, core components of a common care plan, and associated measures, as well as common social determinants variables.

Based on stakeholder input, the State is making the following change for projects that apply to adults only:

- The State is expanding post-discharge follow-up care to all inpatient stays.

Based on stakeholder input, the State is making the following changes for projects that apply to children only:

- Since children and families can engage with the child welfare system to receive assistance for various reasons, the State is clarifying that for the purpose of DSRIP, we are focusing on children who have been removed and placed in foster care or other residential placement outside their home.
- Concerns have been raised about requiring that a comprehensive child abuse and neglect screening be conducted at every visit since this could re-traumatize the child. Instead, it was recommended that practices should review the care plan from the Department of Child Safety (DCS) prior to the visit. The State will incorporate this recommendation.

7. **DSRIP Milestones and Metrics.**
   The State has received numerous comments about the importance of having opportunities to share experiences to identify and capture key lessons for successful implementation, as well as participate in DSRIP entity-offered training and education related to strategic focus areas. In addition, the State has received numerous suggestions on additional performance measures in all four strategic focus areas. The State will consider all the suggestions on performance measures and select appropriate measures to evaluate the State's goals of accelerating the State's delivery system transformation towards value-based integrated models through the DSRIP program.

Summit Healthcare
REGIONAL MEDICAL CENTER

FOUNDED ON CARE • BUILT ON TRUST

June 27, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for Summit Healthcare. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. Summit Healthcare welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Summit Healthcare looks forward to participating in this exciting initiative.

Sincerely,

Ronald L. McArthur
CEO

CENTENE® Corporation

July 7, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application on behalf of the Centene AHCCCS health plans. Several strategic focus areas described in the application - care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for us. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS and positioning health care stakeholders for the future.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs.

The Arizona Centene plans welcome this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

We look forward to participating in this exciting initiative.

Sincerely,

Paul D. Barnes, Ph.D.
Arizona Plan President
Centene
1850 W Rio Salado Parkway, Suite 201
Tempe, AZ 85281

Health System Alliance of Arizona

July 7, 2016

Mr. Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

The Health System Alliance of Arizona is an advocacy organization that represents the interests of large integrated health systems in Arizona, including Abrazo Community Health Network, Banner Health, Dignity Health, and HonorHealth. As the Board of Directors for the Alliance, and the largest employers and providers in the State, it is with pleasure that we submit this letter of support for the AHCCCS Delivery System Reform Incentive Payment (DSRIP) waiver application.

One of our 2016 Policy Priorities is to identify ways to support and engage in care delivery integration for adults and children with behavioral health needs. Several of our facilities also serve underserved populations across the State, including American Indians and those who have exited the Justice System. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of these Arizonans who are enrolled in the AHCCCS program.

Health care is entering an important new phase: the move from "volume to value". This has been a special area of focus for our industry and we sincerely appreciate AHCCCS's leadership and innovation in this arena. We agree with this vision and are deeply committed to identifying ways to improve the outcomes of our patients, while also identifying practices that will not only bend the cost curve in the short-term, but also have an impact on raising the long-term sustainability of our delivery system as a whole.

The projects identified in the AHCCCS DSRIP application are an important part of this effort. We believe it will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation, while also achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. The Health System Alliance of Arizona welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

The systems represented in the Alliance look forward to participating in this exciting initiative.

Sincerely,

Peter Fine
President & CEO, Banner Health
Chairman, Health System Alliance of Arizona

Jennifer A. Carusetta
Executive Director, Health System Alliance of Arizona

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creating healthier communities
www.northcountryhealthcare.org

July 7, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. The strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for North Country HealthCare. The projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation - with clear milestones and metrics - that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. North Country HealthCare welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

North Country HealthCare looks forward to participating in this exciting initiative.

Sincerely yours,

Anne Newland, MD, MPH
Chief Executive Officer

2920 N. 4th Street • Flagstaff, AZ 86004 • 928.522.9400 ph • 928.522.9502 fax

Southwest Network

CREATING PARTNERSHIPS ▪ INSPIRING HOPE ▪ CHANGING LIVES

July 7, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for Southwest Network. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. Southwest Network welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Southwest Network looks forward to participating in this exciting initiative.

Sincerely,

Amy B. Herming
President and Chief Executive Officer

2700 North Central Ave., Suite 1050
Phoenix, AZ 85004
O. 602.266.8402
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www.southwestnetwork.org

July 6, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

Health Choice Arizona, Inc. (Health Choice) is pleased to offer this letter in support of the Arizona Health Care Cost Containment System's (AHCCCS) Delivery System Reform Incentive Payment (DSRIP) waiver application.

As a URAC-accredited, provider-owned managed care organization responsible for the provision of quality care and services to over 240,000 Arizona Medicaid and Medicare D-SNP beneficiaries, Health Choice applauds AHCCCS's most recent innovative approach in the development of a delivery system designed to ensure and facilitate prompt and appropriate access to care for Arizona's most vulnerable populations, including American Indians, justice system transition populations, and adults and children with behavioral health needs or other special needs.

Over the last three decades, AHCCCS has successfully promoted numerous initiatives in response to a rapidly evolving industry, resulting in positive transformations to the health care delivery system and improved health outcomes. The introduction of the DSRIP program enhances AHCCCS's continuous commitment to innovation. Specifically, DSRIP serves as a viable mechanism for investment in infrastructure, integrating care across multi-disciplinary providers and various settings, and advances the "Triple Aim" of providing better care and better health at reduced costs.

Health Choice recognizes that coordination of care and value based payments are the cornerstone of comprehensive health care reform. To that end, our endorsement of the DSRIP program also includes our additional support as an AHCCCS-partner in providing specialized expertise as a managed care organization with competencies in population health and medical risk management, operational efficiency, and analytics to further ensure the overall success of this new program.

Sincerely,

Mike Uchrin
CEO, Health Choice

Katrina Cope
VP Operations, Health Choice Arizona

Arizona Alliance
FOR COMMUNITY HEALTH CENTERS
Primary Healthcare for All

July 6, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application are of special interest for the Arizona Association of Community Health Centers (AACHC, dba Arizona Alliance for Community Health Centers). Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS, which is in alignment with the goals of AACHC and its affiliated integrated provider group who work together towards achieving Value Based Care.

AACHC has served as Arizona's Primary Care Association (PCA) since 1985 and strives to promote and facilitate the development and delivery of affordable and accessible community-oriented, high quality, culturally effective primary healthcare for everyone in the state of Arizona through advocacy, education, and technical assistance. AACHC is committed to serving as a resource for organizations providing primary health care to the underserved, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Tribal organizations, behavioral health facilities, and others with a vested interest in the primary care safety net. AACHC comprises the state's largest network of primary care providers and is committed to working with a variety of partners to expand tools that health centers and organizations serving those in need can utilize to address the needs of their patient populations and improve health outcomes while continuing to demonstrate a cost savings.

AACHC commends AHCCCS' efforts toward integrating care for Arizona's Medicaid populations. The transformation from "volume to value" requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches must be collaborative in nature, developed across and among organizations that collectively participate in an individual's primary health care. The projects identified in the AHCCCS DSRIP application will accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs while improving quality of care. AACHC welcomes this opportunity to develop the operational processes and capabilities that will achieve and sustain such Triple Aim goals for AHCCCS members and will be sustainable.

Respectfully,

John C. McDonald, RN, MS, CPHQ
Chief Executive Officer

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Phoenix, AZ 85034
602.253.0090 • Fax 602.252.3620
AACHC.org

ADULT PROBATION DEPARTMENT

A Force for Positive CHANGE.

BARBARA A. BRODERICK, CHIEF PROBATION OFFICER
SUPERIOR COURT OF MARICOPA COUNTY

P.O. Box 3407, Phoenix, AZ 85030-3407 602.506.3581 www.superiorcourt.maricopa.gov/adultprobation

June 28, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

As health care continues to evolve rapidly in Arizona, I am pleased to offer my support for the AHCCCS DSRIP waiver application. The strategic focus areas described in the application are of special interest to the Maricopa County Adult Probation Department, especially the strategic focus placed on the care of AHCCCS members transitioning from the justice system. The projects outlined in the application will build on existing relationships and initiatives and will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

The Maricopa County Adult Probation Department supervises an active probation population of 28,000, and at any given time, significant numbers of probationers are transitioning out of the local jail and state prison systems. Approximately 54% of probationers have an identified need for mental health or substance abuse treatment, or both. Probationers have historically been an uninsured population. Our department established partnerships with various non-profit community-based organizations to provide direct health care outreach, education, and enrollment services to probationers. In 2013, only 10 percent of probationers reported having health insurance. In 2016, eight in 10 are self-reporting that they are insured, with 60 percent of those with coverage reporting they are enrolled in AHCCCS.

The mission of the Maricopa County Adult Probation Department is to enhance the safety and well-being of our neighborhoods. We recognize that physical and behavioral health impact public safety and community well-being. Just one example of our current activities related to health care is an innovative Medication Assisted Treatment (MAT) collaboration that enables participants in our drug court who receive MAT in the community for opioid addiction to continue receiving MAT while in the local jail and for drug court participants who receive MAT in the jail to have a smooth transition to community-based MAT services upon their release. This project demonstrates collaborative processes across and among organizations that collectively participate in a justice-involved individual's care.

The Regional Behavioral Health Authority (RBHA) in Maricopa County has been instrumental in the coordination of care for individuals with substance use disorders and/or serious mental illness as they transition from incarceration. Our relationship with the RBHA and AHCCCS continues to evolve with rapid changes in the health care landscape and we welcome changes to better serve our mutual clients.

The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation that will be critical to achieving goals of improved individual health, better population health, and reduced health care costs.

We believe the projects will also enhance public safety. The Maricopa County Adult Probation Department welcomes this opportunity to develop operational processes and capabilities to achieve these goals and is open to the co-location of health care services at or near probation facilities.

The Maricopa County Adult Probation Department looks forward to participating in this exciting and innovative initiative.

Sincerely,

B Broderick by DWagner

Barbara A. Broderick
Chief Probation Officer

July 1, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

Health Choice Integrated Care, LLC. (HCIC) is pleased to offer this letter in support of the Arizona Health Care Cost Containment System's (AHCCCS) Delivery System Reform Incentive Payment (DSRIP) waiver application.

HCIC manages behavioral health and substance abuse coverage for over 220,000 Arizona Medicaid and Medicare D-SNP beneficiaries across six counties in Northern Arizona. We also manage integrated physical and behavioral health services for approximately 5,500 of our members who are living with serious mental illness.

HCIC has been involved in the discussions with AHCCCS regarding its proposals to implement delivery system reform for Arizona's most vulnerable population from the outset, and we are pleased to support these efforts. Given our location in Northern Arizona, we are acutely familiar with the needs of our American Indian population and strongly believe that the proposed programs will significantly benefit them. Likewise, we have participated for many years with justice system transition populations in rural areas, and worked closely with AHCCCS and our sister organization, Health Choice Arizona, to develop integrated health programs for adults and children with behavioral health needs or other special needs.

We believe that the DSRIP projects proposed by AHCCCS represent logical next steps in innovations that AHCCCS has already brought to Arizona's health care system. We see the programs as setting the stage for both evolutionary and revolutionary changes that could come from enhanced investments in integrated infrastructure and care management across providers.

We look forward to having the opportunity to support AHCCCS as a partner in pursuing the Triple Aim, through the population health, predictive analytics, medical risk management we officer to participate in the overall success of Arizona's innovative DSRIP program.

Sincerely,

Shawn Nau, Chief Executive Officer
Health Choice Integrated Care, LLC

Arizona Department of Corrections

1601 WEST JEFFERSON
PHOENIX, ARIZONA 85007
(602) 542-5497
www.azcorrections.gov

DOUGLAS A. DUCEY
GOVERNOR

CHARLES L. RYAN
DIRECTOR

June 29, 2016

Thomas J. Betlach, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS Delivery System Reform Incentive Payment (DSRIP) waiver application. All of the strategic focus areas described in the application - care management systems for American Indian Health Program members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of interest to the Arizona Department of Corrections (ADC), especially the focus on inmates transitioning from prison to the community. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires new approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. ADC welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

The Arizona Department of Corrections looks forward to participating in this exciting initiative.

Sincerely,

Charles L. Ryan
Director

file

ARIZONA'S CHILDREN ASSOCIATION

www.ArizonasChildren.org

Tucson Corporate • 3716 E. Columbia St., Suite 120, Tucson, AZ 85714 • Phone: 520.622.7611 • Fax: 520.624.7042
Phoenix Corporate • 711 E. Missouri, Suite 200, Phoenix, AZ 85014 • Phone: 602.234.3733 • Fax: 602.234.1252

June 28, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. The strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system – are important ones for the state of Arizona and our system of care. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. As a provider agency that has been in existence as long as the state of Arizona we've seen many changes. I believe the projects outlined and the collaborative innovation needed will truly make a sustainable difference in the system of care and for those we serve. Arizona's Children Association welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Arizona's Children Association looks forward to participating in this exciting initiative.

Sincerely,

Denise Ensdorff, LCSW
President & CEO
Arizona's Children Association
3716 E. Columbia Street, Tucson, AZ 85714
711 E. Missouri Avenue, Suite 200, Phoenix, AZ 85014

Northern Arizona Healthcare

1200 North Beaver Street
Flagstaff, Arizona 86001
NAHealth.com

269 S. Candy Lane
Cottonwood, Arizona 86326
NAHealth.com

June 24, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for Northern Arizona Healthcare. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. Northern Arizona Healthcare welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Northern Arizona Healthcare looks forward to participating in this exciting initiative.

Sincerely,

Florence Spyrow, M.S.N., M.P.A./M.H.A., J.D., F.A.C.H.E
Executive Vice President and Chief Administrative Officer, Flagstaff Medical Center

Northern Arizona Healthcare

1200 North Beaver Street
Flagstaff, Arizona 86001
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Richard Neff, M.D.
Interim Chief Medical Officer, Flagstaff Medical Center

Jeffrey Treasure
Vice President/ Chief Financial Officer, Northern Arizona Healthcare

PHOENIX CHILDREN'S Hospital

June 27, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

Phoenix Children's Hospital is pleased to offer this letter of support for the AHCCCS DSRIP waiver application. The strategic focus areas described in the application including care management systems for American Indian Health Program (AIHP) members and care delivery integration for adults and children with behavioral health needs are of special interest for Phoenix Children's Hospital. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. Phoenix Children's Hospital welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Phoenix Children's Hospital looks forward to participating in this exciting initiative.

Sincerely,

Robert L. Meyer
President and Chief Executive Officer

UnitedHealthcare®
Community Plan

1 East Washington
Suite 900
Phoenix, AZ 85004

June 23, 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for UnitedHealthcare. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. UnitedHealthcare welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

UnitedHealthcare looks forward to participating in this exciting initiative.

Sincerely,

Joseph Gaudio
CEO

NCADD

June 23, 2016

Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for (*Your Organization Name)*. Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from "volume to value". This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual's care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. (*Your Organization Name)* welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

The National Council on Alcoholism and Drug Dependence looks forward to participating in this exciting initiative.

Sincerely,

Thelma Ross

Thelma Ross CEO

4201 N. 16th Street, Ste 140, Phoenix AZ 85016
602-264-6214

Valle del Sol
LIVE LIFE INSPIRED

June 22. 2016

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

I am pleased to offer this letter of support for the AHCCCS DSRIP waiver application. One or more of strategic focus areas described in the application - care management systems for American Indian Health Program (AIHP) members, care delivery integration for adults and children with behavioral health needs, and care of AHCCCS members transitioning from the justice system - are of special interest for (Your Organization Name). Projects outlined in the application will advance integrated care processes and infrastructure that are vital to improving the health of Arizonans enrolled in AHCCCS.

Health care is entering an important new phase: the move from “volume to value”. This transformation requires whole-person and patient-centered approaches to care that are evidence-based, data-informed, and consistently delivered. Such approaches and processes must be collaborative in nature, developed not just within individual provider organizations but across and among organizations that collectively participate in an individual’s care. The projects identified in the AHCCCS DSRIP application will enable and accelerate integrated models of care for AHCCCS members, bringing timely investment to collaborative innovation – with clear milestones and metrics – that will be critical to achieving the Triple Aim goals of improved individual health, better population health, and reduced health care costs. Valle del Sol welcomes this opportunity to develop the operational processes and capabilities that will achieve such Triple Aim goals for AHCCCS members and will be sustainable beyond the DSRIP funding period.

Valle del Sol looks forward to participating in this exciting initiative.

Sincerely,

Kurt R. Sheppard
President and CEO
Valle del Sol, Incorporated