

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. | <i>N/A: The CMC will document that an agreement has been signed between the participating provider and the regional CMC.</i> |
| 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. | <i>N/A: The CMC will document that all Steering Committee meetings have been attended by a provider executive, or by a designated representative.</i> |
| 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. | <i>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.</i> |

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| 6 | The participating provider will participate in education and training offered by the CMC. | <i>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.</i> |

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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 |
|------|--|---|--|
| 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. | <i>N/A: The CMC will report the participation levels of participating providers.</i> | <i>N/A: The CMC will report the participation levels of participating providers.</i> |

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|------|--|---|--|
| | | 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. | <p>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.</p> <hr/> <p>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.</p> <hr/> | Work with all practices for which an agreement is in 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. |

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|------|--|--|---|
| 7 | <p>For hospitals, primary care practices and community mental health practices: Develop protocols for transition planning and collaborative care management for AIHP members:</p> <p><u>(a) leaving the justice system.</u> (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.)</p> <p><u>(b) being discharged from inpatient care.</u> (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.)</p> <p><u>(c) being discharged from crisis stabilization services.</u> (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.)</p> | <p>Document the staffing plan for 24/7 care management coverage.</p> <p>Document that policies and procedures have been developed to provide transition planning and collaborative care management for AIHP members.</p> | <p>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.</p> |

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|------|---|--|---|
| | <p><u>(d) entering the foster care system or transitioning from the foster care system (due to family reunification, adoption or aging-out).</u> (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.</p> | | |
| 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 |

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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.

| CC # | Core Component | DY 1 | DY 2 |
|------|--|---|---|
| | | 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. | <i>N/A: The CMC will report whether the participating hospital has provided ADT and ED discharge summaries to AzHeC.</i> | <i>N/A: The CMC will report whether the participating hospital has provided ADT and ED discharge summaries to AzHeC.</i> |

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| | | 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.

| 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 |
|-------------------------------------|--|---|---|---|
| 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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|---|---|--|---|---|
| 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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|--|--|---|---|--|
| 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. <i>Complementary to Project 2.</i> | 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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|-------------------------------|--|---|--|--|
| Organized Evidence-based Care | | | | |
| 8 | Assure well-coordinated, evidence-based care for highest-risk patients. <i>Complementary to Project 2.</i> | 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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|------------------------|--|---|---|---|
| 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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| 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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| 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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|--------------------------|--|--|--|---|
| 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 |

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| 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. <i>Complementary to Project 2.</i> | 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 |

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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 <i>or</i> 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 |

Strategic Focus Area: Members Served by the American Indian Health Program - **DRAFT**

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 |