Provider Type: Behavioral Health Providers
Area of Concentration: Adults with Behavioral Health Needs

Project: Ambulatory

Area of Concentration: Adults with Behavioral Health Needs

Provider Type: Adult Behavioral Health Provider

Objective: To integrate primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Unless otherwise stated, demonstration that the practice has met the criteria listed in each Milestone Measurement is due by September 30th of the respective Milestone Measurement Period.

Adult BH Ambulatory Project		
Core Component	**Milestone**	**Due Date**
1	Utilize a behavioral health integration toolkit and action plan and determine level of integration	12/31/18 7/31/19 9/30/19
2	Implement the use of an integrated care plan	9/30/19
3	Screen members using SDOH and develop procedures for intervention	9/30/19
4	Develop communication protocols with MCO's and providers	9/30/19
5	Participate in the health information exchange with Health Current	9/30/19
6	Identify community based resources	9/30/19
7	Participate in relevant TI program-offered training	N/A

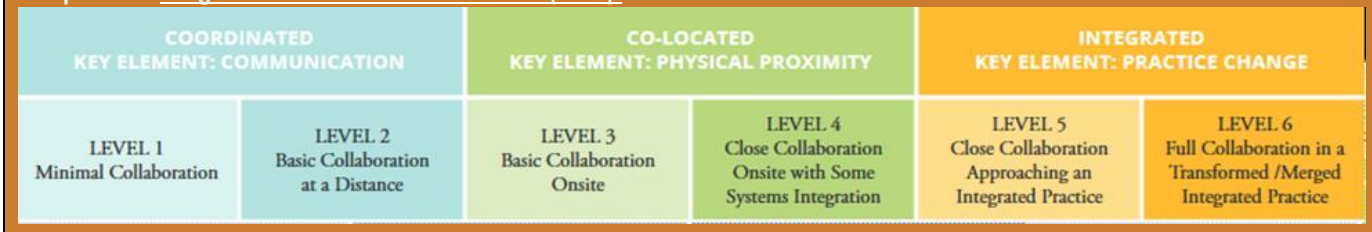
Provider Type: Behavioral Health Providers
Area of Concentration: Adults with Behavioral Health Needs

1.

1. Utilize a behavioral health integration toolkit, to develop a practice-specific action plan to improve integration, building from the self-assessment results that were included in the practice's Targeted Investment application.

One of the three toolkits listed here [Organizational Assessment Toolkit (OATI) ; Massachusetts Behavioral Health Integration Toolkit(PCMHI) and the PCBH Implementation Kit] may be used to inform the development of a practice action plan to improve integration. Practices are welcome to use a behavioral health integration toolkit with which they may have already been working, or find one that fits their needs and practice profile.

2. Identify where along the *Levels of Integrated Healthcare* continuum the practice falls (see table below). To do so, please complete the Integrated Practice Assessment Tool (IPAT).



Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
By May 31, 2018, identify the name of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines, **AND** By May 31, 2018, report the practice site's level of integration using the results of the IPAT level of integration tool to AHCCCS by submitting your **IPAT results here.**	By December 31, 2018, demonstrate substantive progress has been made on the practice-specific action plan and identify barriers to, and strategies for, achieving additional progress by updating the practice action plan, **AND** By July 31, 2019, report on the progress that has been made since January 1, 2019 and identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit an updated IPAT score[1] between August 1, 2019 and Sept 30, 2019 and report the practice site's level of integration using the results of the IPAT level of integration tool to AHCCCS. *****Resources available on the last page of this document*****

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

2.	**Implement the use of an integrated care plan[2] using established data elements[3].**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	By September 30, 2018, demonstrate that the practice has begun providing input to communicate relevant clinical data into integrated care plans initiated by physical health providers with whom communication protocols have been established per Core Component #4.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% of the time[4].

3.	**Screen all members to assess the status of common social determinants of health (SDOH), and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool.** **Tool examples include but are not limited to: the Patient–Centered Assessment Method (PCAM) , the Health Leads Screening Toolkit , the Hennepin County Medical Center Life Style Overview and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** **(October 1, 2018–September 30, 2019*)** **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify which SDOH screening tool is being used by the practice, **AND** B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 6, based on information obtained through the screening.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool. *****Resources available on the last page of this document*****

[2] An integrated care plan is one that prioritizes both physical and behavioral health needs, and reflects the patient and provider's shared goals for improved health. It includes actionable items and linkages to other services and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, the family, and when appropriate, the Child and Family Team. Can include scanned documents
[3] Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc.
[4] Integrated care plans may be effectively shared via secure email-consult Health Current with questions

4.

A. Develop communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.

1) Behavioral health providers must also have protocols that help identify a member's need for follow-up physical health care with his/her primary care provider, and conduct a warm-hand off if necessary.

B. Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider.

C. Develop protocols for communicating with managed care organization-(MCO) level care managers to coordinate with practice-level care management activities.

An example of a protocol can be found at: Riverside Protocol Example; Riverside Protocol Example (Word Version)

Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
A. By September 30, 2018, identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND** B. By September 30, 2018, document that the protocols cover how to: 1) Refer members, 2) Conduct warm hand-offs, 3) Handle crises, 4) Share information, 5) Obtain consent, and 6) Engage in provider-to-provider consultation.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members whom the practice has newly identified as having received or referred to primary care services: If the practice is co-located [including co-located via telehealth] attest that a warm hand-off [5] by a provider or care manager, or other licensed professional [6] to a licensed professional, consistent with the practice's protocol, occurred 85% of the time. Appointments scheduling may be conducted by whomever the practices determine. If the practice is not co-located attest that, 85% of the time referrals are made within 72 hours by a provider or the care manager, or other licensed professional to a licensed professional[6], the information specified in the practice's communication protocol is provided at the time of the referral, and that the member is outreached in person or telephone regarding the shared information and the referral status. Appointments scheduling may be conducted by whomever the practices determine. *****Resources available on the last page of this document*****

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

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

5.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (that is, both sending and receiving data), which includes transmitting data on core data set for all members to Health Current.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	By September 30, 2018, develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the practice's management of high-risk members.	By September 30, 2019, attest that the practice is transmitting data on a core data set for all members to Health Current.[7] **AND** Implement policies and procedures that describe how longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members.

6.	**Identify community-based resources, at a minimum, through use of lists maintained by the MCOs. Utilize the community-based resource list(s) and pre-existing practice knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources.** **At a minimum, if available, practices should establish relationships with:** **1) Community-based social service agencies.** **2) Self-help referral connections.** **3) Substance misuse treatment support services.** **4) When age appropriate, schools and family support services (including Family Run Organizations).**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify the sources for the practice's list of community-based resources, **AND** B. By September 30, 2018, identify the agencies and community-based organizations to which the practice has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the practice and the community-based resource.	By September 30, 2019, attest that the A. Practice has implemented the AHCCCS defined member and family experience survey questions[8] geared toward evaluating the success of referral relationships, and B. Document that the information obtained from the surveys is used to improve the referral relationships with an action plan summarizing the survey results including addressing response trends that indicate a need for process improvement. English Version: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/Member_and_family_experience_survey.docx Spanish Version: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/PO_70708_Member_and_family_experience_surv

[7] A core data set will include a patient care summary with defined data elements.
[8] Survey questions can be added to existing survey if analysis can be segregated.

		ey-SP.docx

7.	**Participate in any Targeted Investment program-offered learning collaborative, training and education that is relevant to this project and the provider population, and is not already required in other Core Components. In addition, utilize any resources developed or recommendations made during the Targeted Investments period by AHCCCS to assist in the treatment of AHCCCS-enrolled individuals.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.

Resource Links

Core Component #1:

Integrated Practice Assessment Tool (IPAT)

Core Component #3:

Patient–Centered Assessment Method (PCAM)

The Health Leads Screening Toolkit

Hennepin County Medical Center Life Style Overview

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).

Core Component #4:

Riverside Protocol Example

Riverside Protocol Example (Word Version)