

Provider Type: Primary Care Provider
Area of Concentration: Adults with Behavioral Health Needs

Project: Ambulatory

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Provider Type: Adult Primary Care 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.

1. Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by the Arizona State University College of Health Solutions. The QIC will support TI Program participants by providing interim updates on their Year 5 Milestone Performance Measures, assist with quality improvement, offer HEDIS™ technical assistance, and facilitate peer learning.

Milestone#1
(October 1, 2021–September 30, 2022)
15%

By September 30, 2022, attest that:

- A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site participating in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities.
- B. The organization’s administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees attend **four** of the Year 6 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.

Alternatively, organizations may complete the milestone by attending **three** QIC virtual meetings and **two** Quality Improvement Workgroups.

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).

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

Milestone#2
(October 1, 2021–September 30, 2022)
5%

Complete an updated IPAT score between August 1, 2022 and Sept 30, 2022 and report the practice site’s level of integration using the results of the IPAT level of integration tool to AHCCCS (participants will be inputting the score in the Attestation Portal).

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Performance Measure Targets: Established per organization based on baseline performance

Performance Measure	Measure Description	Measure Weighting	Measure Sets
Follow up after hospitalization for mental illness: 18 and older (30 - Day)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner within 30 days after discharge.	15%	
Follow up after hospitalization for mental illness: 18 and older (7 - Day)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner within 7 days after discharge.	50%	
Diabetes Screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications	Percentage of beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	15%	

Measure Sets Key (Hyperlinked)			
CMS Core Set Adult	CMS ScoreCard	Statewide (STCs)	NCQA HEDIS
			