AHCCCS Targeted Investments Program
Core Components and Milestones

Project: Ambulatory

Area of Concentration: Children/Youth with Behavioral Health Needs –

Provider Type: Pediatric 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 and children/youth with behavioral health needs and children/youth in the child welfare system.

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. *

1.	**Utilize a behavioral health integration toolkit, to develop a practice-specific course of action to improve integration, building from the self-assessment results that were included in the practice's Targeted Investments application.** **Behavioral health integration toolkit examples can be found through the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions (see www.integration.samhsa.gov/operations-administration/assessment-tools).**	
	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 December 31, 2017, 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.	By October 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 July 31, 2019, report on the progress that has been made since November 1, 2018 and identify barriers to, and strategies for achieving additional progress.

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2.	**Implement the use of an integrated care plan[1] using established data elements[2], for members identified as part of Core Component 2.**	
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	By September 30, 2018, demonstrate that the practice has begun using an integrated care plan.	Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received mental health services during the past 12 months, attest that the integrated care plan, which includes established data elements, is documented in the electronic health record 85% of the time.

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 the Patient-Centered Assessment Method (PCAM), which can be found at www.pcamonline.org/about-pcam.html, the Health Leads Screening Toolkit (which includes a screening tool), which can be found at: https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/), and the Hennepin County Medical Center Life Style Overview which can be found at: Hennepin County Life Style Overview Tool,** the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE), which can be found at: www.nachc.org/research-and-data/prapare, and the Accountable Health Communities Screening Tool, which can be found at: **Accountable Health Communities Screening Tool**.	
	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. Identify which SDOH screening tool is being used by the practice. B. Develop policies and procedures for intervention or referral to	Based on a practice record review of a random sample of 20 members, attest that:

[1] 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 consultation with all members of the clinical team, the patient, the family, and when appropriate the Child and Family Team.
[2] Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc. AHCCCS will lead a stakeholder process to identify a set of established data elements that should be included in an integrated care plan.

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	specific resources/agencies, consistent with Core Component 9, based on information obtained through the screening.	A. 85% of members were screened using the practice-identified screening tool. B. 85% of the time, results of the screening were contained within the integrated care plan. C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).

4.	**A. Develop communication protocols with physical health, behavioral health, and (if appropriate) developmental pediatric 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**	
	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. Identify the names of providers and MCOs with which the site has developed communication and care management protocols. B. 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.	Based on a practice record review of a random sample of 20 members whom the practice has identified as having received mental health services during the past 12 months, attest that a warm hand-off, consistent with the practice's protocol, occurred 85% of the time.

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5.	**For practices delivering mental health services for children/youth:** **Routinely[3] screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII) to assess what intensity of services are needed to assist them with their emotional, behavioral, and/or developmental needs and to inform service recommendations into the integrated care plan. More information on the ECSII available at:** www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/ecsii/Information_sheet_ECSII.pdf **The practice must develop procedures for interventions and treatment, including periodic reassessment.**	
	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. Document the practice's policies and procedures for use of the ECSII. B. Attest that the results of the ECSII are in the electronic medical record.	Based on a practice record review of a random sample of 20 members ages 0–5, attest that the practice performed the ECSII 85% of the time and incorporated service intensity recommendations into the integrated treatment plan.

6.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (for example, 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**
	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.	A. Attest that the practice is transmitting data on a core data set for all members to Health Current.[4] B. Attest that longitudinal data received from Health Current are routinely accessed to inform care management of high-risk members. C. Provide a narrative description of how longitudinal data are informing the care management of high-risk members.

[3] "Routinely" will be further defined to provide additional guidance during the course of the Targeted Investment.
[4] A core data set will include a patient care summary with defined data elements.

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7.	**Identify community-based resources, at a minimum, through use 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, the Arizona Early Intervention Program (AzEIP) 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. Identify the sources for the practice's list of community-based resources. B. 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.	Document that the practice has conducted member and family experience surveys specifically geared toward evaluating the success of referral relationships, and that the information obtained from the surveys is used to improve the referral relationships.

8.	**For practices delivering behaviral health services for children/youth:** **Develop protocols for utilizing the AHCCCS defined standardized[5] suite of evidence-based practices and trauma-informed services.**	
	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**

[5] AHCCCS is leading a multi-stakeholder process to identify a standardize suite of evidence-based practices for trauma-informed services and will finalize the suite during the Targeted Investment Program.

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	A. Identify which AHCCCS-defined evidence-based practices will be implemented. B. By September 30, 2018, demonstrate that all staff AHCCCS-requires to be trained and have participated in an AHCCCS-identified Trauma-Informed Care training program.	Document the protocols for utilizing the AHCCS-defined evidence-based practices that were identified in MMP1.

9.	**A. Follow Arizona-established diagnostic and referral pathways for any member that screens positive on the Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R), Ages & Stages Questionnaires® (ASQ) or Parents' Evaluation of Developmental Status (PEDS) tool created by the ASD Advisory Committee.** **B. Develop communication protocols[6] and referral agreements with autism spectrum disorder (ASD) Specialized Diagnosing Providers to facilitate referral and diagnosis for members who have screened positively on the M-CHAT-R, PEDS or ASQ.**	
	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**
	N/A	A. Based on a practice record review of a random sample of 20 members screened as positive on the M-CHAT, ASQ or PEDS tool, attest that 85% were referred to the appropriate providers, consistent with the Arizona established diagnostic and referral pathways. B. Identify the name(s) of the ASD Specialized Diagnosing Providers with which the primary care or mental health site has developed a communication protocol and referral agreement.

[6] Communication may be facilitated with the use of telehealth.

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10.	**Develop procedures to provide information regarding parent support and other resources for families and other caregivers of children/youth with ASD, which include practice use of available resource lists.**	
	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**
	N/A	Document the policies and procedures that guide the practice in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD.

11.	**Develop protocols for teenagers/young adults with ASD to facilitate smooth care transitions from pediatric to adult providers.**	
	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**
	N/A	Document the policies and procedures that guide the practice in facilitating the transition of care for teenagers and young adults with ASD, who will be aging out of pediatrics and seeking care from adult primary care providers.

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<table>
<tr><td rowspan="3">12.</td><td colspan="2">A. Develop a protocol for obtaining records for children/youth in the child welfare system prior to and after the first visit, which specifically prioritizes identifying the psychotropic medication history of the member. The protocol should include:
1) Obtaining the proper consent for accessing behavioral health and substance use records, and
2) Utilization of multiple resources to identify past medical and behavioral health providers, including the HIE, information obtained from the Arizona Department of Child Safety (DCS) case worker, and the Comprehensive Medical and Dental Program (CMDP).

B. Develop a protocol for addressing medication needs of children/youth in the child welfare system during the first visit, which includes how the practice will:
1) Make efforts to consult with the most recent prescriber of psychotropic medication, to understand the child's baseline, response to treatment, side effects and ongoing plan of care, and
2) Follow the American Academy of Child and Adolescent Psychiatry (AACAP) recommendation about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems.[7]</td></tr>
<tr><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018**)

Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019**)

Practice Reporting Requirement to State</td></tr>
<tr><td>N/A</td><td>A. Document protocols used for obtaining records for children/youth engaged in the child welfare system, prior to and after the first visit, and for addressing their psychotropic medication needs.
B. Document protocols for addressing any medication needs of children/youth engaged in the child welfare system, consistent with this Core Component.</td></tr>
</table>

7 www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf

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<table>
<tr><td rowspan="3">13.</td><td colspan="2">A. Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the child welfare case worker and the Child and Family Team, as appropriate, to assist foster parents/guardians and case workers in following-up on referrals and recommendations. An example of a visit discharge and referral summary for families can be found here: http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx
B. The comprehensive after-visit summary should include recommendations for foster parents/guardians to assess safety risk and monitor the child’s medical or behavioral health issues at home. Parenting support should include education about the child’s physical and emotional needs at the time of the initial visit, and as required in follow-up visits, to assist the child and family in understanding the care plan.
C. Develop and implement a policy that the comprehensive after-visit summary should not divulge confidential information between the member and provider, particularly for teens engaged in the child welfare system. [8,9]</td></tr>
<tr><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018**)

Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019**)

Practice Reporting Requirement to State</td></tr>
<tr><td>N/A</td><td>A. Document policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations,
B. Document protocols for assessing risk and educating foster parents/guardians on the child's needs, and
C. Document protocols that ensure confidentiality between the member and provider.</td></tr>
</table>

[8] See “Consent & Confidentiality in Adolescent Health Care: A Guide for the Arizona Health Practitioner. http://www.azmed.org/resource/resmgr/Publications/2015_Adol_Consent_Conf_Bookl.pdf?hhSearchTerms=%22confidentiality%22

[9] For additional resources for teens, see the following DBHS Practice Tools: Youth Involvement in the Arizona Behavioral Health System (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/YouthPracticeProtocol.pdf) and Transition to Adulthood (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/tas.pdf)

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14.	**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 Investment 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.

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