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Strategic Focus Area: Children with Behavioral Health Needs - 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		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**	**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. Self-assessment tools and behavioral health integration toolkits can be found through SAMHSA-HRSA Center for Integrated Health Solutions. See www.integration.samhsa.gov/operations-administration/assessment-tools.	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	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. Self-assessment tools and behavioral health integration toolkits can be found through SAMHSA-HRSA Center for Integrated Health Solutions. See www.integration.samhsa.gov/operations-administration/assessment-tools.	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	N/A	N/A

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	Management of members with high risk						
3	Utilize care managers [1] at a maximum caseload of 1:100 (unless otherwise specified by AHCCCS) 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. Indicate the caseload level per care manager.	Percentage of practices that have identified a care manager for each practice site; Percentage of practices that have met the caseload level standards.	N/A	N/A	N/A	N/A
		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	N/A	N/A
		Document that care managers have been trained in motivational interviewing for patient self-management support.					

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4	Track members with high risk to assist efforts to address their needs and coordinate their care. Members with high risk can be identified by using the CASII, but may also 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. [3]	Develop a registry of members with high risk 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 members with high risk and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry.	N/A	N/A
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	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 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 members with high risk have care	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.	N/A	N/A

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		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.	plans consistent with the required elements.				

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		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.	N/A	N/A

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8	Screen all patients to assess their complexity and what factors are affecting their health by using a tool that addresses common social determinants of health. (One such tool is the Patient Centered Assessment Method (PCAM) which can be found at www.pcamonline.org/about-pcam.html.)	(1) Identify what screening tool is used. (2) Confirm that the results of all screening tool assessments are contained in the electronic health record.	(1) Frequency distribution of SDOH screening tools (2) Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that 90% of patients are screened using the practice-identified screening tool.	Percentage of practices that meet the requirement to screen 90% of their patients using the practice-identified screening tool.	N/A	N/A
9	Develop procedures for intervention or referral based on the result of the practice-identified SDOH screening tool.	Document policies and procedures for intervention or referral to resources / agencies as the result of the screening. Referrals to community-based organizations should be consistent with protocols established in the Core Component 13 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	N/A	N/A

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	Relationships with Behavioral Health Providers						
10	Develop referral agreements with mental health and substance use providers in the community and within the tribes 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.	N/A	N/A

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	Clinical Care within the Primary Care Office						
11	In addition to the routine use of screening tools that are approved by AHCCCS (PEDS, ASQ and M-CHAT) to identify developmental delays, routinely screen patients (at the age-appropriate time, using the age-appropriate tool) for cognitive, emotional, and behavioral problems, including for depression, and drug and alcohol use. To assess cognitive, emotional, and behavioral health problems for adolescents, practices should use the Y-PSC. 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 policies and procedures for administration of screening tools.	Percentage of practices that have adopted all of the required screening tools; Frequency distribution of developmental screening tools used by practices.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	Percentage of practices that have documented that the results of the screening tool are being tracked over time and that treatment is being adjusted based on the results of the screening tool.	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
12	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	N/A	N/A
13	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. [2]	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	N/A	N/A

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	Integrated Clinical Records						
14	Establish and implement integrated access to clinical information from primary care providers in BH records, as appropriate and permissible.	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	N/A	N/A
15	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (i.e., both sending and receiving data).	Document a) a written agreement with AzHeC has been executed and b) that the practice is routinely receiving AzHeC ADT feeds.	Percentages of practices a) with a signed agreement with AzHeC, and b) routinely receiving AzHeC ADT feeds.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into clinical care planning and treatment.	Percentages of practices a) routinely supplying EHR data to AzHeC , and b) incorporating AzHeC data into clinical care planning and treatment.	N/A	N/A
16	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.	N/A	N/A	N/A	N/A	Document whether the practice maintains a single primary care and behavioral health care plan (treatment plan) for all patients.	Percentages of practices with a) a single primary care and behavioral health care plan (treatment plan) for all patients.

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	Community-based Supports						
17	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.	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	N/A	N/A
		Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.				N/A	N/A
	E-Prescribing						
18	Consult Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as per established clinical protocols, 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.	N/A	N/A
19	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.	N/A	N/A

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	Involvement with DSRIP Entity						
20	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.	N/A	N/A

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.

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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.

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	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	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	N/A	N/A
	Management of members with high risk						
3	Utilize care managers [1] at a maximum caseload of 1:100 (unless otherwise specified by AHCCCS) 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. Indicate the caseload level per care manager.	Percentage of practices that have identified a care manager for each practice site; Percentage of practices that have met the caseload level standards.	N/A	N/A	N/A	N/A
		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	N/A	N/A

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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.

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		Document that care managers have been trained in motivational interviewing for patient self-management support.					
4	Track members with high risk to assist efforts to address their needs and coordinate their care. Members with high risk can be identified by using the CASII, but may also 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. [3]	Develop a registry of members with high risk 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 members with high risk and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry.	N/A	N/A
5	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.	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	N/A	N/A

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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. 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. 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.	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 members with high risk 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 behavioral health providers and primary care providers both have access.	Percentage of practices that have integrated care plans documented in an electronic medical record.	N/A	N/A

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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.	N/A	N/A
8	Screen all patients to assess their complexity and what factors are affecting their health by using a tool that addresses common social determinants of health. (One such tool is the Patient Centered Assessment Method (PCAM) which can be found at www.pcamonline.org/about-pcam.html.)	(1) Identify what screening tool is used. (2) Confirm that the results of all screening tool assessments are contained in the electronic health record.	(1) Frequency distribution of SDOH screening tools (2) Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that 90% of patients are screened using the practice-identified screening tool.	Percentage of practices that meet the requirement to screen 90% of their patients using the practice-identified screening tool.	N/A	N/A
9	Develop procedures for intervention or referral based on the result of the practice-identified SDOH screening tool.	Document policies and procedures for intervention or referral to resources / agencies as the result of the screening. Referrals to community-based organizations should be consistent with protocols established in the Core Component 13 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	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - 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		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	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Relationships with Primary Care Providers						
10	Develop referral agreements with primary care providers in the community and within the tribes 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 schedules will be shared after each visit.	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.	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - 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		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**	**Practice Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**
	Clinical Care within the Primary Care Office						
11	In addition to the routine use of screening tools that are approved by AHCCCS (PEDS, ASQ and M-CHAT) to identify developmental delays, routinely screen patients (at the age-appropriate time, using the age-appropriate tool) for cognitive, emotional, and behavioral problems, including for depression, and drug and alcohol use. To assess cognitive, emotional, and behavioral health problems for adolescents, practices should use the Y-PSC. 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). [2]	Identify the practice's policies and procedures for administration of screening tools.	Percentage of practices that have adopted all of the required screening tools; Frequency distribution of developmental screening tools used by practices.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	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
12	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	N/A	N/A
13	Follow the American Academy of Child and Adolescent Psy[CASII tool]CAP) clinical guidelines for the treatment of chi[...]ADHD, anxiety and mild depression, including the use of psychotropic medications and appropriate consultation with behavioral health providers to assist with diagnosing. [2]	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	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - 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		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	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Integrated Clinical Records						
14	Establish and implement integrated access to clinical information from primary care providers in BH records, as appropriate and permissible.	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	N/A	N/A
15	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (i.e., both sending and receiving data).	Document a) a written agreement with AzHeC has been executed and b) that the practice is routinely receiving AzHeC ADT feeds.	Percentages of practices a) with a signed agreement with AzHeC, and b) routinely receiving AzHeC ADT feeds.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into clinical care planning and treatment.	Percentages of practices a) routinely supplying EHR data to AzHeC , and b) incorporating AzHeC data into clinical care planning and treatment.	N/A	N/A
16	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.	N/A	N/A	N/A	N/A	Document whether the practice maintains a single primary care and behavioral health care plan (treatment plan) for all patients.	Percentages of practices with a) a single primary care and behavioral health care plan (treatment plan) for all patients.
	Community-based Supports						
17	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 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	N/A	N/A

Strategic Focus Area: Children with Behavioral Health Needs - 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		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	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	E-Prescribing						
18	Consult Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as per established clinical protocols, 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.	N/A	N/A
17	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.	N/A	N/A
	Involvement with DSRIP Entity						
19	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.	N/A	N/A

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 - 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 social service resources for improved care.

		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 Multidisciplinary 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

		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
	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.

		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
	Relationships with ASD Treatment Providers / Team				
4	Develop referral agreements with ASD Multidisciplinary Teams, programs, or providers who are trained to evaluate children for autism and provide early intensive behavioral therapy to families and children.	Identify the names of the ASD Multidisciplinary 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 Multidisciplinary Teams/programs with whom agreements have been executed.	N/A	N/A
	Each referral agreement must include:				
	(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.				

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
	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 - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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 - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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 T/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] An example of a consent form can be found here: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Consent_Obtain_Form.pdf	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, <u>and</u> 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 - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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	Routinely screen patients for trauma utilizing a standardized and age-appropriate screening tool. Appropriate tools include: the UCLA Post Traumatic Stress Disorder Reaction Index (UCLA PTSD-RI) (ages 7+); the Abbreviated UCLA PTSD RI (ages 3 - 16); and the Trauma Symptom Checklist for Children (TSC-C) (ages 3-16).	Identify the practice's adopted trauam screening tool, and policies and procedures for administration of that tool.	Percentage of practices that have adopted the required screening of patients for trauma; Frequency distribution of trauma 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

Strategic Focus Area: Children with Behavioral Health Needs - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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**
6	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. 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:	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 - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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	In accordance with AAP's standards of health care for children and adolescents in foster care, at every visit, conduct a comprehensive child abuse and neglect screening, including 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 (if indicated). For more information see: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx. 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 visits for children and adolescents in foster care including a child abuse and neglect screening.	Percentage of practices that met this requirement at a level to be determined by AHCCCS.
8	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. An example of a visit discharge and referral summary for families can be found here: http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx	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
9	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

Strategic Focus Area: Children with Behavioral Health Needs - 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 out-of-home placements in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in out-of-home placements in the child welfare system. [6]

		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
10	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], [5]	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
11	Coordinate care management with the T/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
	Involvement with DSRIP Entity				
12	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 - 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. [6]

		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 - DRAFT

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		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 - 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**
3	Ensure that all clinicians and case managers who treat children engaged in the child welfare system complete (when age appropriate) 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] [5]	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.

Strategic Focus Area: Children with Behavioral Health Needs - 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. [6]

		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] 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

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT
Project 6: Care Coordination for Children with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)
Objective: To more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient behavioral health stay.

		DY1		DY2	
CC #	**Core Component**	**Hospital Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**	**Hospital 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, including for their input on whether a patient is on a long-term injectable, when the last injection was, and when the next injection is due.	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) conducting a health literacy assessment to determine whether the parent or guardian has the capacity to obtain, process, and understand basic health information and services needed to follow the prescribed medication regime, and develop protocols for when the s/he does not pass the literacy assessment. Utilize one of the screeners available at http://healthliteracy.bu.edu/all;	N/A	N/A	Document policies and procedures for conducting health literacy assessment with one of the endorsed screeners, and document policies and procedures for providing medication management support and education to parents and guardians who do not pass the literacy assessment.	Percentage of hospitals with documented procedures for conducting and following-up on health literacy assessments.
3	(b) 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: Children with Behavioral Health Needs - DRAFT
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		DY1		DY2	
CC #	**Core Component**	**Hospital Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**	**Hospital Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**
4	(c) reconciling medications received in the hospital to what may be taken (or available) at home using any means necessary, including the HIE.	Document that a medication reconciliation took place immediately prior to discharge, and document that the HIE was consulted as part of medication reconciliation.	Percentage of hospitals with documented policies and procedures for performing medication reconciliation consistent with this Core Component.	Document that the HIE was consulted as part of the medication reconcilation process.	Percentage of hospitals with documented policies and procedures for consulting with the HIE as part of medication reconciliation.
5	(d) 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
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Discharge				
6	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.
7	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
8	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)

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		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
9	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.
10	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				
11	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
	Involvement with DSRIP Entity				
12	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.

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Strategic Focus Area: Children with Behavioral Health Needs - DRAFT

The DSRIP entity and individual practices participating in this strategic focus area will be held	
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
1392	Well-child visits within the first 15 months
N/A	Depression Screening by 13 Years of Age - Brand new HEDIS measure
0005	CG-CAHPS Child