New York State integrated care framework (three of eight domains are depicted, with the eight domains described below)

1-**Case finding, screening and referral to care**. This domain outlines steps to adopt universal screening of patients presenting for primary care (and, ultimately, apply population-based predictive models) and suggests a workflow process for assessing positively identified patients and linking them to care.

2-**Use of a multidisciplinary professional team.** The individuals on the team will vary according to the level of integration of the practice. Increased integration necessitates workflow changes such as increased contact between primary care and behavioral health care providers, for shared care planning and communication.

3-**Ongoing care management.** Refers to ongoing, proactive follow-up of patients - essential to combating fragmentation between providers and engaging patients in their care. While tools used for tracking follow up may vary, ongoing longitudinal assessment and communication with patients, focusing on both physical and behavioral health, are important aspects of an integrated approach. Care management entails a series of functions, not necessarily a single individual.

4-**Systematic quality improvement.** Quality improvement is key to the advancement of integration. Quality metrics encompassing both process and outcomes are necessary. Electronic data from registries and electronic health records (EHRs) can greatly assist in performance monitoring and improvement strategies.

5-**Decision support for measurement-based, stepped care**. This domain includes guidance on the use of evidence-based psychotherapy and psychopharmacology, including offsite partnerships and health information technology. It outlines the use of treatment protocols, monitoring of treatment and steps to take when patients do not show improvement.

6-**Culturally adapted self-management support.** This domain emphasizes exchange of information, enabling patients and their supports to understand their behavioral health condition. Tools such as motivational interviewing are described, with the goal of shared decision-making between patient and care provider, and an emphasis on overall health and wellness.

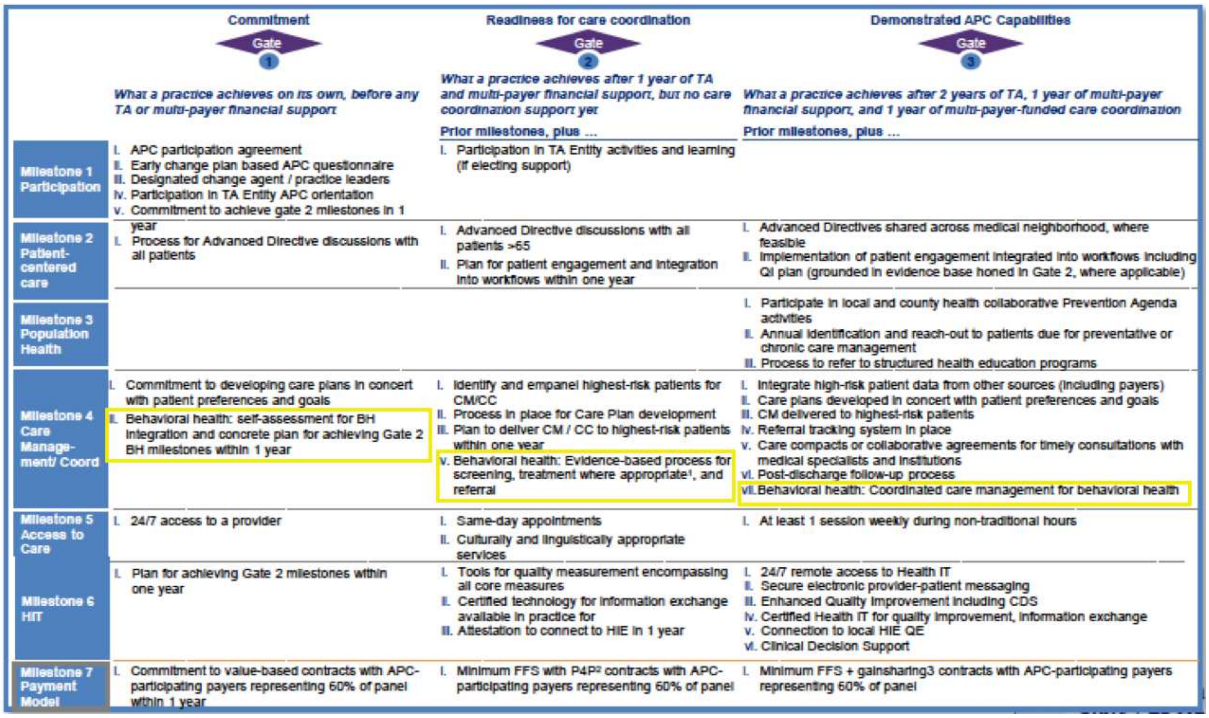
7-**Information tracking and exchange among providers.** This domain encompasses the development of tools for electronically tracking and coordinating information (e.g., formal patient registries or shared EMR systems), as well as protocols for when and how information is exchanged.

8-**Linkages with community/social services.** This domain focuses on steps for fostering effective linkages to housing, vocational, and other supportive social services and to

community organizations and resources, and for incorporation of relevant social determinants into care plans.

APC MODEL WITH STRUCTURAL MILESTONES

The figure below illustrates the Integrated Care Working Group's practice Milestones and Gates, with Behavioral Health elements highlighted.



	Commitment Gate 1 *What a practice achieves on its own, before any TA or multi-payer financial support*	Readiness for care coordination Gate 2 *What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet*	Demonstrated APC Capabilities Gate 3 *What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination*
Milestone 1 Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	**Prior milestones, plus …** i. Participation in TA Entity activities and learning (if electing support)	**Prior milestones, plus …**
Milestone 2 Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base honed in Gate 2, where applicable)
Milestone 3 Population Health			i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Milestone 4 Care Manage-ment/ Coord	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year v. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Milestone 5 Access to Care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
Milestone 6 HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Milestone 7 Payment Model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel