Targeted Investments Program Renewal Request (TI Program 2.0) Concept Paper

June 30, 2021

Targeted Investments Program Renewal Request (TI Program 2.0) Concept Paper

AHCCCS proposes a renewal of the Targeted Investments Program for the 2021-2026 waiver period. The program renewal will support and incentivize providers who did not participate in the original TI Program to better integrate care for AHCCCS members, and enable participants from the original TI Program to further develop more comprehensive whole person care systems that effectively address the social risk factors that adversely affect health. The Program aligns with and supports the AHCCCS strategic plan as well as the goals of AHCCCS' [Health Equity Committee](#).

OVERVIEW OF THE CURRENT TARGETED INVESTMENTS PROGRAM (2016-2021)

Arizona's health care system has historically been fragmented, due to a siloed system of care prior to the state's participation in Medicaid and the establishment of a delivery system model within the Medicaid program in which members accessed physical health services through an acute care health plan and behavioral health services through a behavioral health care plan, known in Arizona as a Regional Behavioral Health Authority (RBHA). As a result of this delivery system division, AHCCCS members often interacted with multiple managed care entities and received care from myriad providers who were funded from different sources. This fragmentation has historically hindered effective care coordination, impacted members' health status, further perpetuated health disparities, and resulted in increased costs for members with complex behavioral and physical health needs.

Over the past decade, Arizona has taken significant steps to create systemic health equity by working to reduce these silos and advance integration at the administrative, payer, and provider levels. In 2016, the administration of behavioral health services that was formerly under the Arizona Department of Health Services (ADHS) merged with AHCCCS. In 2018, AHCCCS transitioned to the AHCCCS Complete Care (ACC) model which placed payment and provider network responsibility for AHCCCS members' physical and behavioral health under a single managed care plan. AHCCCS' effort to integrate care and improve health outcomes for members relies on the unique partnership between the managed care organizations (MCOs) and AHCCCS providers. The ability for the MCOs to effectively coordinate care and provide integrated care is directly linked with the providers' ability to participate in that process. The TI Program is an important component of AHCCCS' initiative to integrate physical and behavioral health at the provider level. The providers who deliver services are in a better position to coordinate care in real time, but to do so effectively, many need infrastructure support to build data sharing and analysis capabilities, to integrate team-based care, and to create workflows that connect members to social services (i.e., to better identify and address societal factors that are adversely impacting member health outcomes).

Through its Targeted Investments (TI) Program, AHCCCS supports participating providers in moving toward more integrated and coordinated care. The program aims to reduce fragmentation between physical and behavioral health providers, increase efficiencies in integrated service delivery, and improve health outcomes for targeted populations including those who face challenges in accessing health care coverage and quality health care services. The TI Program has incentivized requirements aimed at building the necessary infrastructure to enable an integrated and high-performing health care delivery system that enhances care coordination and improves health and financial outcomes. Targeted populations include adults and children with behavioral health needs who are at high risk for complex care, including justice involved individuals. In the first three years of the five-year, $300 million program, participating providers received payments for achieving milestones focused on development of infrastructure, and implementation of processes and policies that support behavioral health and physical health integration and coordination. In years four and five, providers are eligible to receive performance-based incentive payments based on quality measures for specific populations. Figure 1

illustrates the number of participating providers, by area of concentration, at the end of year four of the Demonstration.

Figure 1: TI Program Providers:

Figure 1 Participating Area of Concentration	Number of Sites
Adult Behavioral Health	153
Adult Primary Care	163
Pediatric Behavioral Health	117
Pediatric Primary Care	91
Hospital	21
Justice Co-located Clinics	13

The TI Program has achieved noteworthy accomplishments in several areas of concentration, as discussed below.

JUSTICE INVOLVED INDIVIDUALS

Numerous studies have shown that individuals who are incarcerated have a high prevalence of undiagnosed or underdiagnosed behavioral health conditions. In addition, research on recidivism indicates that three out of four incarcerated individuals are re-incarcerated over the course of five years[1]. The inability to access behavioral health services, including treatment to address substance use disorder, is a contributing factor to recidivism.

Recognizing the unique circumstances, potential challenges in accessing quality health care services, and extensive social needs of this population, in addition to incentivizing integrated care within traditional clinic settings, the TI Program supported the establishment of 13 co-located, integrated clinics where primary care and behavioral health providers deliver services to justice-involved individuals. The co-located clinics are located with, or adjacent to, probation and/or parole offices that collaborate with providers to meet the members' health and social needs, a requirement meant to address existing barriers to accessing quality health care for this population. The co-located justice clinics prioritize access to appointments for individuals with complex health conditions, with a specialized focus on ensuring that this population has same-day access to appointments on the day of release and during visits to a probation or parole office. AHCCCS non-emergency medical transportation (NEMT) coverage for medically necessary services available at these clinics offers the added benefit of supporting members' ability to keep appointments with probation and parole officers thus contributing to efforts to reduce recidivism. This strategy directly ties to creating health equity as research demonstrates that lack of

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[1] Durose, Matthew R.. *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010* Alexia D. Cooper, Howard N. Snyder. Bureau of Justice Statistics Special Report. April 2014, NCJ 244205.

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transportation creates inequitable health outcomes.[2] In FFY 2019, 4,272 formerly incarcerated members received services through the integrated justice clinics.

In addition, AHCCCS has established Medicaid suspension agreements with the majority of counties such that individuals who become incarcerated (for less than one year) while enrolled in AHCCCS are suspended from Medicaid eligibility and then reinstated upon release from incarceration, rather than having to complete a new eligibility application. These individuals are automatically re-enrolled with the MCO they were enrolled in at the time of the suspension. Recognizing the health disparities with this population, AHCCCS requires the MCOs to have reach-in policies, mandating that they engage these individuals with complex health conditions and high criminogenic needs prior to release, ensuring that they are able to access care immediately upon transition back into the community. Many of the members identified through these processes are referred to TI justice clinics. This is a critical foundational step to ensure that individuals transitioning into the community from incarceration have immediate access to health care including substance use and behavioral health services.[3]

IMPROVEMENTS IN PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION FOR TI PARTICIPATING PROVIDERS

To address the challenges associated with fragmentation at the point of service, the TI Program incentivizes and supports a comprehensive approach to integrated care in any care setting in which an AHCCCS member may receive either physical or behavioral health services. For that reason, TI Program participants are financially incentivized to establish numerous protocols, policies, and systems of care that support the provision of person centered integrated care, such as:

- Integrated care plans for members with behavioral health needs,
- Primary care screening for behavioral health using standardized tools for depression, SUD, anxiety, and suicide risk,
- Primary care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems,
- Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care,
- High risk registries, health risk assessment tools, predictive analytic systems, and other data mining structures to identify individuals at high risk of a decline in acute and/or behavioral health status,
- Trauma-Informed care protocols including screening for adverse childhood events (ACEs), referral processes for children that screen positive, and use of evidence-based practices and trauma-informed services, and
- Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (HIE) (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are in the hospital.

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[2] Syed, S.T., Gerber, B.S. & Sharp, L.K. "Traveling Towards Disease: Transportation Barriers to Health Care Access." *J Community Health*. Oct. 2013, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/?utm_source=EWSE+March+2017+Newsletter&utm_campaign=EWSE+Mar+2016&utm_medium=email

[3] Guyer, Jocelyn, et al. "State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid." Commonwealth Fund.Org, Jan. 2019, www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib.pdf.

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Additionally, TI Program participants (except hospitals) are required to complete the Integrated Practice Assessment Tool (IPAT) to assess their level of integration on the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare continuum at the end of each program year. SAMHSA defines six levels of coordinated/integrated care grouped into three broad categories, ranging from minimal collaboration to co-located care to fully integrated care (Figure 2).

Figure 2 SAMHSA Six Levels of Collaboration/Integration					
Coordinated Care Key Element: Communication		Co-Located Care Key Element: Physical Proximity		Integrated Care Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	**LEVEL 2** Basic Collaboration at a Distance	**LEVEL 3** Basic Collaboration On site	**LEVEL 4** Close Collaboration On site with Some Systems Integration	**LEVEL 5** Close Collaboration Approaching an Integrated Practice	**LEVEL 6** Full Collaboration in Transformed/ Merged Integrated Practice

Early results indicate the TI Program funding was important in increasing the levels of integrated care for participating providers. The majority of TI Program participants reported having a higher level of integration after implementing the protocols associated with the TI Program between demonstration years (DYs) two and three. Sixty percent of unique provider sites reported an increase in integration by at least one IPAT level, and 38 percent of provider sites reported an increase by at least two IPAT levels. Most notably, nearly 25 percent (46 clinics) of PCP participants attested to increasing their IPAT scores by four or more levels—transitioning from levels one or two (minimal coordination) to levels five or six (fully integrated care), within one year. This higher level of integration among participating PCPs means members are able to consistently access behavioral health services when the PCP's screening identifies a need within the integrated practice setting.

In addition, many participating behavioral health providers successfully transitioned to a higher level of integration. The number of providers that reported successfully transitioning to co-located care (levels three or four) or fully integrated care (levels five or six) increased by threefold in year three. AHCCCS anticipates that additional providers will achieve greater levels of integration by years four and five.

These results illustrate the important role the TI Program has played in incentivizing and supporting providers to transform their practices. Some TI providers have transitioned to offering primary care and behavioral health services in their participating sites.

The TI Quality Improvement Collaborative (QIC) assisted participants with improving processes that support the provision of whole person care. The QIC was established in program year four in partnership with the College of Health Solutions and the Center for Health Information and Research at Arizona State University (ASU). It provides TI participants with data driven performance improvement strategies and peer learning through monthly virtual collaboratives, current performance-measure dashboards, and tailored technical assistance. QIC attendance is included in the years four and five participant milestones.

Opportunities and Challenges Going Forward

The Targeted Investments Program is now in its fifth and final year. The program participants regularly report that they have changed "how they do business" due to the systems of care they have established as a result of implementing TI Program requirements and the resources they have earned through meeting required milestones. Processes such as universal behavioral health screening and intervention by primary care participants have been embraced, and are being continued even after milestone incentives for the protocol are no longer in place. Participants also report improved quality in service delivery and coordination as a result of required high risk registries, exchanging data with the health information exchange, and enhanced communication protocols with their primary care and behavioral health counterparts. Many participants working toward more integrated practices prior to Targeted Investments report that the structure and deadlines required by the program accelerated and improved their integration efforts.

With the increased focus on the comprehensive needs of the AHCCCS members they serve, program participants have identified opportunities to achieve greater integration and coordination particularly related to the identification of social risk factors and the establishment of corresponding interventions. By transforming the way providers interact with Medicaid members, providers are better able to identify health disparities and connect them to resources to more effectively improve health outcomes.

 The healthcare environment, particularly health information systems capabilities, has evolved since implementation of the TI Program. This has increased the potential for TI participants to sustain and enhance the delivery of more comprehensive, whole person care. Health information systems transformation was also cited as a continuing priority in AHCCCS' Health Equity forums, reflecting the lack of access to broadband and technological tools in Arizona's rural and frontier geographic areas. Stakeholders requested that AHCCCS continue to focus on the modernization of health technology in order to equitably meet the needs of all AHCCCS members.

The TI Program's impact has been limited to members served by TI participating providers. Many AHCCCS providers who were either not ready or unable to participate in the original TI Program have expressed the desire to achieve improved coordination and integration for their patients through the opportunity to access the TI Program blueprint and resources. Expanding provider participation in the TI Program will enable more AHCCCS members to receive the greater levels of point of care coordination and integration currently available from the program's existing providers. The ongoing public health emergency has intensified the need to effectively address, as one of the program's PCP participants noted, the "epidemic of anxiety and depression." In addition,COVID-19 has exacerbated social risk factors such as housing instability, unemployment or under-employment, and food insecurity, highlighting the urgency with which health care delivery systems must act to address social risk factors so as to not further perpetuate known existing health disparities.[4]

TARGETED INVESTMENTS PROGRAM 2.0 PURPOSE AND GOALS

Original TI Program Goals:
- Reduce fragmentation between acute and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs by improving integration at the provider level, and

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[4] Abrams, Elissa M., and Szefler, Stanley .J. *COVID-19 and the impact of social determinants of health.* The Lancet Respiratory Medicine, May 2020. https://doi.org/10.1016/S2213-2600(20)30234-4.

- Improve health outcomes for members with physical and behavioral health needs.

AHCCCS's multi-year strategic priorities align with TI:
- Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes,
- Pursue continuous quality improvement, and
- Reduce fragmentation driving toward an integrated and sustainable healthcare system.

TI Program Renewal Proposal Goals:
- Sustain: TI participants' point of care integration achievements,
- Expand: the opportunity to implement the program's integrated care systems to new providers that did not participate in the original program, and
- Improve: the program requirements to more comprehensively address health equity by providing whole person care through enhanced social risk screening and intervention with milestone updates that reflect developments since the advent of the original TI Program.

Since its inception, the Targeted Investments Program has included a focus on health equity by concentrating many of its core components and milestones on improving care outcomes for populations who have historically faced challenges in accessing quality care that effectively meets their needs. . The original program specifically focused on adults with behavioral health conditions[5] and adults involved with the criminal justice system[6] as well as children and adolescents with Autism Spectrum Disorder[7] and children and adolescents within the foster care system.[8]

While TI 1.0 focused on integrating behavioral and physical health, mirroring AHCCCS' integration efforts at the time, the TI Renewal seeks to extend the agency's understanding of integrated care beyond clinical interventions to address social inequities that can also play a prominent role in determining individual health outcomes. As stated by the CDC's Office of Health Equity, "addressing social determinants of health is a primary approach to achieving health equity."[9] Only as members are able to receive meaningful assistance in addressing health-related risk factors like housing insecurity, food insecurity, and/or transportation assistance will their lives and health outcomes improve. For this reason, the Targeted Investments Program renewal seeks to build on the progress made with the current SDOH screening milestone by adding requirements for the Extension Cohort to connect and refer members to community based organizations who can help address social risk factors.

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[5] Alegría, Margarita et al. *Social Determinants of Mental Health: Where We Are and Where We Need to Go.* Current psychiatry reports, Sep. 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181118/

[6] Bui, Juliet, et al. "Understanding and Addressing Health Disparities and Health Needs of Justice-Involved Populations." Public Health Reports, May 2019. https://journals.sagepub.com/doi/10.1177/0033354918813089.

[7] Liptak, Gregory et. al. *Disparities in diagnosis and access to health services for children with autism: data from the National Survey of Children's Health.* Journal of Developmental and Behavioral Pediatrics, Jun. 2008. https://pubmed.ncbi.nlm.nih.gov/18349708/.

[8] Collins, Jennifer L. and Thomas, Laura J. *The influence of social determinants of health among young adults after they have left foster care in the US.* Journal of Clinical Nursing, Mar. 2018. https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.14317.

[9] Centers for Disease Control and Prevention. *NCHHSTP Social Determinants of Health: Frequently Asked Questions.* 2019. https://www.cdc.gov/nchhstp/socialdeterminants/faq.html.

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The program renewal also seeks to address health disparities within the clinical setting by incentivizing cultural competency training and protocols in line with the National Culturally and Linguistically Appropriate Services (CLAS) as identified by the U.S. Department of Health and Human Services Office of Minority Health (OMH). Other new core components aimed at reducing health disparities within specific populations and promoting patient-centered, culturally competent patient care include developing and implementing trauma-informed care protocols[10], utilizing the American Society of Addiction Medicine (ASAM) Continuum[11], and requiring nicotine cessation resources and referral for justice-involved members[12]. It is also anticipated that in years four and five of the program, one (or more) of the performance measures selected per area of concentration will be "disparities-sensitive," evidence-based interventions[13], with differentiation as appropriate between populations.

The TI Program Renewal (2.0) proposal supports Arizona's goal to fully transform the Medicaid delivery system to an integrated whole person care structure. AHCCCS can achieve this goal by adding providers to a renewed TI Program, and by supporting initial TI Program participants in their efforts to sustain the integration systems and protocols they've built, using these foundations to further the whole person care model. This will be achieved by:

- Sustaining integrated point of care infrastructure that improves: care coordination, social and financial outcomes for high-risk AHCCCS members (e.g., care management for high risk members), behavioral health screening and intervention, and effective use of telehealth services,
- Expanding AHCCCS members' accessibility to more fully integrated, whole person care through additional TI Program participants,
- Further extending point of care integration systems that include enhanced capabilities to successfully identify and address social risk factors,
- Developing and supporting strategies for effective and efficient use of technology including the health information exchange and closed loop referral systems that facilitate the information sharing needed to provide whole person care and to identify and address social determinants of health,
- Supporting provider and other stakeholder peer learning and sharing of process improvement strategies through a quality improvement/learning collaborative.,
- Engaging stakeholders from community based organizations, managed care organizations, and public and private sector subject matter experts to provide input on systems and

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[10] Levy-Carrick, Nomi C et al. *Promoting Health Equity Through Trauma-Informed Care: Critical Role for Physicians in Policy and Program Development.* Family & community health, 2019. https://pubmed.ncbi.nlm.nih.gov/30768474/.
[11] Crotty, Karen et. al. *Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.* Journal of Addiction Medicine, 2020. https://journals.lww.com/journaladdictionmedicine/Fulltext/2020/04000/Executive_Summary_of_the_Focused_Update_of_the.4.aspx.
[12] Lincoln, Thomas, et al. *Resumption of smoking after release from a tobacco-free correctional facility.* Journal of Correctional Health Care, 2009. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.965.1885&rep=rep1&type=pdf.
[13] The National Quality Forum's 2017 Roadmap for Promoting Health Equity and Eliminating Disparities contains a comprehensive list of possible measures in Appendix D: Examples of Disparities-Sensitive Measures (p. 48): https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx.

strategies that enable comprehensive and coordinated whole person care integration opportunities and strategies. This cross sector collaboration will help leverage resources to effectively address health disparities and improve health equity,

- Incorporating emerging evidence-based practices into program participant requirements and aligning with current AHCCCS and community initiatives, and
- Identifying and addressing health disparities by leveraging features of EHR systems to assess health equity efforts within the organizations and develop protocols to provide culturally competent services.

TI PROGRAM RENEWAL STRUCTURE AND CONTENT

In order to continue progress toward delivery system and payment reform, and to bring the current TI Program initiatives to scale, AHCCCS proposes renewing the TI Program from 2021 through 2026 to include two distinct participant cohorts –the "extension" and "expansion" cohorts.

The "extension" cohort will include current ambulatory TI Program providers. As the transition to integrate behavioral health and primary care continues for this cohort, their next step will be to incorporate non-clinical or social needs into point of care systems to provide a more holistic, person-centered approach to care while addressing health disparities. TI Program 2.0 requirements for this cohort will retain high value physical-behavioral health integration requirements from the original program. In addition, the extension cohort requirements will focus not only on identifying members with social risk factors (i.e., identifying underlying conditions that may be adversely impacting health outcomes), but also developing and implementing processes and workflows to effectively provide them with referrals to community based organizations, particularly those crucial to addressing needs related to housing, food, social isolation, and transportation for AHCCCS members. The extension cohort will also be incentivized to develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols. Each organization in the extension cohort will also be incentivized to complete a self-assessment of its efforts toward achieving health equity and cultural competency, deliver certain CLAS-aligned culturally competent services, and coordinate with contracted health plans to access health disparity data and resources to intervene where disparities are identified. The requirements will also include the effective identification of, and connection with, CBOs in the participants' communities. The incentive payments for this group of participants will be based on the continuation of high impact practices that support integration of physical and behavioral health, establishment of additional systems and infrastructure that support advancing whole person care and health equity, and the achievement of outcome measures. Participation eligibility requirements will include established HIE connectivity and successful implementation of previous TI integration systems and protocols. Anticipated extension cohort requirements for eligible provider types are included in Appendix 1.

The "expansion" cohort will consist of interested AHCCCS-enrolled primary care practices, behavioral health providers, and integrated clinics that did not participate in the original TI program. Qualified participants will meet requirements such as: a certified EHR that is capable of bi-directional data exchange, minimum volume thresholds, and submitting a plan to integrate behavioral and physical health services. The structure of the program for this cohort will be modeled on the original TI Program, including milestones such as establishment of a high risk registry, implementation of behavioral health screening and intervention, and active engagement with the HIE. These requirements will be updated to enhance SDOH screening, adverse childhood event screening and intervention, telehealth, data sharing, and emerging best practices in areas such as substance use disorder treatment and trauma informed care. The inclusion of SDOH screening is a foundational

component to meeting AHCCCS' health equity goals. The expansion cohort also contains core components related to the effective identification of community based organizations and the creation of protocols to refer and connect members based on identified social risk factors. Milestones in the fourth and fifth years of the Program will be based on performance against an established set of measures. Anticipated expansion cohort requirements for eligible provider types are included in Appendix 2.

Both cohorts will also include co-located justice clinics. Eligibility will generally align with the original program requirements, with enhanced emphasis on: justice partner commitment to coordination/co-location and data sharing, development in areas of the state currently underserved by this resource (e.g., rural/frontier counties), and inclusion of AHCCCS members adjudicated through diversion programs such as drug courts and veterans courts. The extension cohort will be offered the opportunity to suggest innovative, collaborative approaches with justice partners to enhance the ability to effectively engage justice-involved members in order to deliver integrated health services, including addressing social risk factors. The TI Renewal seeks to build on the progress made in providing integrated care to this population by including additional incentives for addressing social risk factors most impactful for individuals involved in the criminal justice system, such as housing instability/homelessness and employment instability.

AHCCCS proposes that the TI Program's original five-year structure be utilized for both cohorts in the TI Program renewal. Annual Requirements:

Program Year	Extension Participants	Expansion Participants
Year 1	Re-Establish TI 1.0 Systems and Processes Establish New Systems and Processes that support Whole Person Care/ Health Equity goals	Application & Onboarding
Year 2	Establish New Systems and Processes	Establishment of Systems & Processes
Year 3	Implementation and Evaluation of Systems and Processes, including evaluation of where to target health equity efforts in years 4 & 5	Implementation and Evaluation of Systems & Processes, including evaluation of where to target health equity efforts in years 4 & 5
Year 4	Performance/Outcome Measures	Performance/Outcome Measures

Year 5	Performance/Outcome Measures	Performance/Outcome Measures

Proposed core components for the extension cohort are detailed further in Appendix 1. Proposed core components and milestones for the expansion cohort are detailed further in Appendix 2.

PARTICIPANTS AND STAKEHOLDERS

In contrast with the original program, AHCCCS anticipates participation in both the extension and expansion cohorts will be at the organization level, rather than site specific. This means a multi-site provider practice or organization will apply for all eligible ambulatory sites, earning milestone achievement based on the organization's performance. Original program participants' sites that did not participate will be eligible to participate in the extension cohort. TI Justice participants are the exception to this change and will participate at the clinic-level.

Participants

Similar to the original program, participation will be limited to specific provider types:

- Primary Care: includes pediatric, adult, and family practice MDs, DOs, and nurse practitioners (both cohorts). Based on public comment, physician assistants will be an additional eligible provider type.

- Behavioral Health: includes ambulatory behavioral health clinics and providers that serve children, adults, or both children and adults (both cohorts).

- Integrated Clinics: provider organizations that provide both primary care and behavioral health care, licensed by the Arizona Department of Health Services as integrated clinics, and registered with AHCCCS as integrated clinic provider type (both cohorts).

- Co-located Justice Clinics: licensed and registered integrated clinics co-located with or adjacent-to probation and/or parole facilities, or probation and/or parole offices are located with or adjacent to the integrated clinic (both cohorts).

Additional participation has been considered with input from stakeholders for:

- IHS and Tribal 638 Ambulatory Facilities: AHCCCS maintains an American Indian Medical Home (AIMH) program, which offers incentive funding to IHS/638 facilities for their efforts to enhance care coordination and provide members with 24 hour access to a care team. The AIMH will continue to serve as the mechanism AHCCCS uses to partner with IHS/638 providers in improving the quality of care offered to members. AHCCCS is committed to coordinating TI efforts/lessons learned with its tribal and federal partners.

- Community Based Organizations (CBOs): AHCCCS is exploring options for engaging CBOs in the structure of the Program and supporting their participation in the closed loop referral system (extension cohort only).

- Peer and Family Run Organizations: AHCCCS will require participants to offer referrals to peer and family support services, including to AHCCCS-recognized Peer and Family Run Organizations (both cohorts).

Partners/Collaborators

The provider transformation supported by the TI Program also requires the support and collaboration of additional stakeholders to achieve program goals.

- Quality Improvement/Learning Collaborative (QIC): Partnership with Arizona State University's College of Health Solutions to continue support of program participants with process improvement guidance, data analysis support, and peer learning facilitation. Examples of anticipated topics include strategies for addressing health disparities, effective use of health data, and best practices for delivering telehealth services.

- Managed Care Organizations: As reflected in the 2019 TI sustainability plan, AHCCCS contracted MCOs will continue to seek alignment of value based arrangements with program participants in their networks to help sustain systems and protocols established through TI participation. AHCCCS contracted health plans will also continue processing incentive payments to their respective network of TI participating providers. In addition, MCOs will provide ongoing support and coordinate with participants in areas such as coordinated care management, risk assessment, vetting of community resources, and QIC participation. Discussions between AHCCCS and MCOs will continue regarding additional TI 2.0 engagement opportunities.

- Health Information Exchange (Health Current): Health Current, the state HIE, is administering the statewide closed loop referral system and will support and collaborate with TI 2.0 participants involving the closed loop referral system requirements. Health Current partnered with AHCCCS to support TI participants' ability to meet the original program data exchange capabilities including bi-directional data exchange with the HIE. Health Current will maintain this function.

- Community Based Organizations: AHCCCS is exploring CBO collaboration and engagement options as well as means to incentivize and support their closed loop referral system participation.

- Public Agencies: Engagement with county probation departments, courts, the Arizona Department of Child Safety (DCS), the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR), and others is underway to ensure there is effective coordination and leveraging of established systems and resources that interface with AHCCCS members who are served by TI Program participants.

- Other stakeholders/Subject Matter Experts: AHCCCS is engaged with advocacy groups such as the Autism Advisory Council, professional associations such as the Arizona Council of Human Service Providers, and AHCCCS subject matter experts, including health equity experts, to further inform program requirements.

FUNDING

TI 2.0 Program funding will direct incentive payments to participating providers to improve performance and increase physical and behavioral health care integration and coordination for individuals, and to identify and address social risk factors/ mitigate health disparities that improve the health outcomes and help achieve health equity for AHCCCS members.

AHCCCS anticipates funding TI 2.0 through a combination of state and federal sources. AHCCCS has identified the availability of $24 million in Designated State Health Programs (DSHP) funds to cover the

state contribution over the five year program period. AHCCCS proposes federal financial participation through the matching of permissible DSHP funds at the FMAP rate.

AHCCCS proposes that the maximum total funding for the program not exceed $250 million over five years including state and federal match contributions. This is contingent on the amount of allowable DSHP expenditures, with funds distributed in proportion to the level of effort required of participants in each of the five years. AHCCCS proposes 8 percent of the total funding be allocated to administrative expenses, eligible for federal financial participation at the administrative match rate of 50 percent.

APPENDIX A
Extension Cohort
Core Components

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

Project: Ambulatory
Area of Concentration: Adults with Behavioral Health Needs
Provider Type: Adult Behavioral Health Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Adult BH Ambulatory Project	
Core Components[1]	
1	Screen members using Social Determinants of Health (SDOH) assessments
2	Develop and implement SDOH screening protocols and associated workflows
3	Utilize the closed loop referral system (NowPow) to connect members to community resources
4	Perform analytics to assess the prevalence of social risk factors and to identify health disparities
5	Develop and implement a Health Equity Plan
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Screen members using the LOCUS (Level of Care Utilization System)
8	Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment
9	Develop protocols for Trauma Informed Care
10	Develop protocols to provide patient-centered, culturally competent services
11	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

[1] Milestone details for this cohort are anticipated to be completed in the Fall of 2021 as AHCCCS works with subject matter experts and stakeholders to solidify proposal details.

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

1.	**Screen members using Social Determinants of Health (SDOH) assessments**

Screen all members at least annually, or more frequently as determined by the provider, to assess the status of common social determinants of health (SDOH), develop procedures for intervention or referral based on screening results, document the intervention/referral in the member's care plan, upload the results to NowPow[2] as specified by AHCCCS, and submit Z codes on claims for all social risk factors identified by the tool. The screening tool must at least identify social risk factors in the following domains:
- Food insecurity
- Homelessness/Housing Instability
- Transportation Assistance
- Social Isolation

Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

2.	**Develop and implement SDOH screening protocols and associated workflows**

Develop and implement SDOH workflows that:
- Determine if SDOH screening needs to occur, including review of historical SDOH assessments in the EHR or NowPow[3];
- Govern how the SDOH screen is performed, including the screening instrument, available languages, modality, and timing;
- Identify staff responsible for reviewing and discussing the results of the SDOH screen with the member, family or guardian (as appropriate), including confirmation of member's desire for a social service referral;
- Identify local CBO partners that can provide resources to address social risk factors in each of the required domains;
- Develop and maintain referral & follow up procedures with CBO partners, including through NowPow;
- Ensure the practice incorporates results of the SDOH screen into clinical care;
- Record the results of the SDOH screen within NowPow and submit Z codes.

3.	**Utilize the closed loop referral system (NowPow) to connect members to community resources**

Connect and demonstrate effective use of NowPow[4] to connect members to community resources by:
- Completing a NowPow Scope of Work;
- Demonstrating workflow systems that effectively use NowPow, including EHR system interface, as determined by AHCCCS;
- Entering SDOH screening results and generating referrals, if desired by the member, to community based organizations;
- Demonstrating effective follow up on SDOH referrals consistent with CBO communication protocols as noted in Core Component 2, utilizing NowPow.

4.	**Perform analytics to assess the prevalence of social risk factors and to identify health disparities**

For qualifying participants as identified by AHCCCS, develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols by:
- Aggregating and analyzing SDOH screening results to assess the prevalence of SDOH within the organization's member population
- Stratifying screening results by race, ethnicity, and language to identify and intervene upon health disparities. Participants may use their EHR, NowPow and/ or collaborate with their MCOs to obtain this data.

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[2] Core components including usage of the Closed Loop Referral System platform NowPow are contingent upon the NowPow platform's anticipated capabilities/capacity. AHCCCS is currently engaging with Health Current and NowPow to gain more clarity on the platform's timeline.
[3] Id.
[4] Id.

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

5.	**Develop and implement a Health Equity Plan**

Using analysis from Core Components #4 and 10, develop a Health Equity Plan that, at a minimum:
- Identifies health disparities prevalent within the population of AHCCCS members served, and describes actions to address the disparities
- Assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a culture of equity[5].
- Implement a quality improvement initiative to address identified health disparities.

6.	**Develop communication protocols with physical health and behavioral health providers for referring members**

A. Develop communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.
- 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 meaningful hand-off if possible.
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 whole person care plan, to communicate relevant clinical data, social service needs and to identify whether the member has organizational-level care management services provided by another provider.
- Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)
C. Develop protocols for communicating with managed care organization(MCO)- level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

7.	**Screen members using the LOCUS (Level of Care Utilization System)**

Screen members to assess what intensity of services are needed to assist them with their emotional, behavioral, and/or medical needs and to inform service recommendations into the integrated care plan, using the LOCUS (Level of Care Utilization System).

The practice must develop procedures for interventions and treatment, including periodic reassessment.

8.	**Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment**

Demonstrate utilization of the American Society of Addiction Medicine (ASAM) Continuum Assessment for conducting substance use disorder and co-occurring disorder (substance use and mental health) assessments, and incorporate level of care recommendations and referrals.

9.	**Develop protocols for Trauma Informed Care**

Develop protocols for utilizing member-centered, culturally sensitive evidence-based practices in trauma-informed care as identified by AHCCCS, including:
- Identifying and utilizing the appropriate evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care
- Training all appropriate staff members in AHCCCS-identified Trauma-Informed Care training

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[5] Adapted from "A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity" developed for the Department of Health and Human Services by the National Quality Foundation in 2017: https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx .AHCCCS continues to work with stakeholder to identify validated health equity assessment toolkits for participants.

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

10.	**Develop protocols to provide patient-centered, culturally competent services**

- Develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.
  - Complete an Implementation Checklist for the National CLAS Standards
  - Create, implement and routinely update a CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
  - Document that CLAS standards are being used in the organization, including, at a minimum:
    1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
    2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
    3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
- Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS.

11.	**Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)**

Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

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

Project: Ambulatory
Area of Concentration: Adults with Behavioral Health Needs
Provider Type: Adult Primary Care Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Adult PCP Ambulatory Project	
Core Components[1]	
1	Screen members using Social Determinants of Health (SDOH) assessments
2	Develop and implement SDOH screening protocols and associated workflows
3	Utilize the closed loop referral system (NowPow) to connect members to community resources
4	Perform analytics to assess the prevalence of social risk factors and to identify health disparities
5	Develop and implement a Health Equity Plan
6	Identify members who are high-risk and develop electronic registry; Demonstrate use of identification criteria and document members in registry
7	Develop communication protocols with physical health and behavioral health providers for referring members
8	Utilize care managers for members in high-risk registry; Demonstrate that care manager(s) are trained in integrated care
9	Screen all members for behavioral health disorders
10	Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment
11	Develop protocols for Trauma Informed Care
12	Develop protocols to provide patient-centered, culturally competent services.
13	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

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[1] Milestone details for this cohort are anticipated to be completed in the Fall of 2021 as AHCCCS works with subject matter experts and stakeholders to solidify proposal details.

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

1.

Screen members using Social Determinants of Health (SDOH) assessments

Screen all members at least annually, or more frequently as determined by the provider, to assess the status of common social determinants of health (SDOH), develop procedures for intervention or referral based on screening results, document the intervention/referral in the member's care plan, upload the results to NowPow[2] as specified by AHCCCS, and submit Z codes on claims for all social risk factors identified by the tool. The screening tool must at least identify social risk factors in the following domains:
- Food insecurity
- Homelessness/Housing Instability
- Transportation Assistance
- Social Isolation

Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

2.

Develop and implement SDOH screening protocols and associated workflows

Develop and implement SDOH workflows that:
- Determine if SDOH screening needs to occur, including review of historical SDOH assessments in the EHR or NowPow[3];
- Govern how the SDOH screen is performed, including the screening instrument, available languages, modality, and timing;
- Identify staff responsible for reviewing and discussing the results of the SDOH screen with the member, family or guardian (as appropriate), including confirmation of member's desire for a social service referral;
- Identify local CBO partners that can provide resources to address social risk factors in each of the required domains;
- Develop and maintain referral & follow up procedures with CBO partners, including through NowPow;
- Ensure the practice incorporates results of the SDOH screen into clinical care;
- Record the results of the SDOH screen within NowPow and submit Z codes.

3.

Utilize the closed loop referral system (NowPow) to connect members to community resources

Connect and demonstrate effective use of NowPow[4] to connect members to community resources by:
- Completing a NowPow Scope of Work;
- Demonstrating workflow systems that effectively use NowPow, including EHR system interface, as determined by AHCCCS;
- Entering SDOH screening results and generating referrals, if desired by the member, to community based organizations;
- Demonstrating effective follow up on SDOH referrals consistent with CBO communication protocols as noted in Core Component 2, utilizing NowPow.

4.

Perform analytics to assess the prevalence of social risk factors and to identify health disparities

For qualifying participants as identified by AHCCCS, develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols by:
- Aggregating and analyzing SDOH screening results to assess the prevalence of SDOH within the organization's member population
- Stratifying screening results by race, ethnicity, and language to identify and intervene upon health disparities. Participants may use their EHR, NowPow and/ or collaborate with their MCOs to obtain this data.

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[2] Core components including usage of the Closed Loop Referral System platform NowPow are contingent upon the NowPow platform's anticipated capabilities/capacity. AHCCCS is currently engaging with Health Current and NowPow to gain more clarity on the platform's timeline.
[3] Id.
[4] Id.

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

5.	**Develop and implement a Health Equity Plan**

Using analysis from Core Components #4 and 12, develop a Health Equity Plan that, at a minimum:
- Identifies health disparities prevalent within the population of AHCCCS members served, and describes actions to address the disparities
- Assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a culture of equity[5].
- Implement a quality improvement initiative to address identified health disparities.

6.	**Identify members who are high-risk and develop electronic registry;** **Demonstrate use of identification criteria and document members in registry**

Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Organizations should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors, electronic health record (EHR)-based analysis of members with distinguishing characteristics to identify health disparities, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Organizations should prioritize members within the registry whose status may be improved or favorably affected through point-of-care care management.

The registry may be maintained inside or outside of the electronic health record.

Adult members at high risk are determined by the organization, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization, b) decline in physical and/or behavioral health status, c) significant social needs, and population groups with identified health disparities.

7.	**Develop communication protocols with physical health and behavioral health providers for referring members**

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

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 whole person care plan, to communicate relevant clinical data, social service needs, and to identify whether the member has organizational-level care management services provided by another provider.
- Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

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

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[5] Adapted from "A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity" developed for the Department of Health and Human Services by the National Quality Foundation in 2017: https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx .AHCCCS continues to work with stakeholder to identify validated health equity assessment toolkits for participants.

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

8.	**Utilize care managers for members in high-risk registry;** **Demonstrate that care manager(s) are trained in integrated care**

Utilize practice care manager*s* for members included in the high-risk registry, with a caseload not to exceed a ratio of 1:100. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system), or contracted by the practice from external sources. Practice-level care management functions should include:
1) Assessing and periodically reassessing member needs.
2) Playing an active role in developing and implementing integrated care plans.
3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).
4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
5) Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors..

9.	**Screen all members for behavioral health disorders**

Routinely screen all members for at least one of the following or as clinically indicated based on an affirmative response to triggers or general questions for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, and suicide risk using age-appropriate and standardized tools such as, but not limited to:
1) Depression: member Health Questionnaire (PRIME-MD PHQ 2 and PHQ-9).
2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST, DAST 10 or DAST 20), SBIRT.
3) Anxiety: Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS) .
4) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (Adults), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ).
5) Trauma and Adverse Childhood Experiences (ACEs): PC-PTSD-5, Trauma Screening Questionnaire (TSQ), Adverse Childhood Experience Screener for Adults
6) Other MCO provided screening tools.

The organization must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendations. The organization must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

10.	**Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment**

Demonstrate utilization of the American Society of Addiction Medicine (ASAM) Continuum Assessment for conducting substance use disorder and co-occurring disorder (substance use and mental health) assessments, and incorporate level of care recommendations and referrals.

11.	**Develop protocols for Trauma Informed Care**

Develop protocols for utilizing member-centered, culturally sensitive, evidence-based practices in trauma-informed care as identified by AHCCCS, including:
- Identifying and utilizing the developmentally appropriate evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care
- Training all appropriate staff members in AHCCCS-identified Trauma-Informed Care training

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

12.	**Develop protocols to provide patient-centered, culturally competent services**

- Develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.
  - Complete an Implementation Checklist for the National CLAS Standards
  - Create, implement and routinely update a CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
  - Document that CLAS standards are being used in the organization, including, at a minimum:
    1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
    2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
    3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
- Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS.

13.	**Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)**

Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

Project: Ambulatory

Area of Concentration: Adults Transitioning from the Criminal Justice System

Provider Type: Outpatient clinics that provide physical and behavioral health services (eg. ICs, FQHCs, RHCs, 05-Clinics)

Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs transitioning from the Criminal Justice System.

Participation: Participation in the Justice area of concentration- extension cohort is limited to sites that participated in the original TI Justice program. Qualified clinics must 1) contract with all Arizona Complete Care (ACC) plans and the RBHA service the site's GSA, and 2) submit a renewed commitment letter from a justice partner(s) including at least one county probation department(s) and/or ADCRR for co-location, and, when feasible, with diversion-related court programs. The commitment letter(s) must include:

1. A mission/goal statement;
2. An implementation plan including:
   a. Anticipated setting of community supervision requirements in next three-five years (eg. field vs. traditional);
   b. Timeline to achieve or maintain co-location with probation or parole:
      i. Fully integrated health care services (both physical and mental health services) provided in a probation/parole office; OR
      ii. Probation/Parole officers co-located within a fully integrated health care setting(s) at least 2 full days per week, who meet with probationers and refer to healthcare services within the same building complex; OR
      iii. Alternative co-location/coordination arrangements may be presented to AHCCCS for consideration (eg. field vs. traditional).
      iv. AHCCCS encourages original TI justice sites to propose innovative, collaborative approaches to enhance the ability to effectively engage justice-involved members in order to deliver integrated health services.
   c. Collaboration expectations, including but not limited to:
      i. Staff cross-training between healthcare and probation/parole (eg. orientation to processes, assessing criminogenic risk, trauma-informed care),
      ii. Shared case management of members when appropriate (eg. probation officer shares with the healthcare provider the member's progress/challenges towards achieving criminogenic goals and the healthcare provider shares with probation officer the member's progress/challenges toward achieving improved health outcomes),
      iii. Obtaining appropriate releases of information to support data-sharing processes.
3. And data-sharing expectations from both parties.

AHCCCS will review and approve applications that best satisfy this criteria in each region. Selected clinics are also required to participate in the Adult Behavioral Health Area of Concentration or Adult Primary Care Provider Area of Concentration at the organizational level. Additional milestones applicable to the TIP Justice site are delineated below.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

Justice Ambulatory Project	
Core Components[1]	
1	Screen members using Social Determinants of Health (SDOH) assessments for enhanced domains
2	Develop and implement SDOH screening protocols and associated workflows
3	Utilize the closed loop referral system (NowPow) to connect members to community resources
4	Perform analytics to assess the prevalence of social risk factors and to identify health disparities
5	Establish integrated care coordination with justice partner(s)
6	Create peer/family support plan with the member's chosen peer support/ PFRO
7	Develop a high-risk registry and develop criteria used to identify high-risk members, including criminogenic risk factors identified by justice partner(s)
8	Use practice care manager(s) to coordinate care with justice partner(s) for members included in the high-risk registry and demonstrate care manager(s) are trained in integrated care
9	Implement integrated care plan with care manager(s) and probation/parole officer
10	Develop communication protocols with MCOs and providers
11	Screen all members for behavioral health disorders
12	Utilize the ASAM Continuum and ensure access to MAT
13	Screen and provide Tobacco Cessation resources and support for justice-involved individuals
14	Prioritize access to appointments for justice-involved individuals in the high-risk registry
15	Obtain medical information related to referred member's medical treatment while they were incarcerated
16	Develop outreach plan to engage referred adults transitioning from the criminal justice system
17	Participate in the Justice Targeted Investments Program Quality Improvement Collaborative (QIC)

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[1] Milestone details for this cohort are anticipated to be completed in the Fall of 2021 as AHCCCS works with subject matter experts and stakeholders to solidify proposal details.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

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1.

Screen members using Social Determinants of Health (SDOH) assessments for enhanced domains

Screen all members at least annually, or more frequently as determined by the provider, to assess the status of common social determinants of health (SDOH), develop procedures for intervention or referral based on screening results, document the intervention/referral in the member's care plan, upload the results to NowPow[2] as specified by AHCCCS, and submit Z codes on claims for all social risk factors identified by the tool, as available. The screening tool must at least identify social risk factors in the following domains:
1. Food insecurity
2. Homelessness/Housing insecurity
3. Transportation Assistance
4. Social Isolation
5. Employment Instability

Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

2.

Develop and implement SDOH screening protocols and associated workflows

Develop and implement SDOH workflows that:
- Review prior SDOH and criminogenic risk assessments to determine baseline for the member;
- Govern how the SDOH screen is performed, including the screening instrument, available languages, modality, and timing;
- Identify staff responsible for reviewing and discussing the results of the SDOH screen with the member, family or guardian (as appropriate), including confirmation of member's desire for a social service referral;
- Identify local CBO partners that can provide resources to address social risk factors in each of the required domains;
- Develop and maintain referral & follow up procedures with CBO partners, including through NowPow[3];
- Ensure the practice incorporates results of the SDOH screen into clinical care;
- Ensure the practice discusses screening and referral information with justice partner(s);
- Record the results of the SDOH screen within NowPow and submit Z codes.

3.

Utilize the closed loop referral system (NowPow) to connect members to community resources

Connect and demonstrate effective use of NowPow[4] to connect members to community resources by:
- Completing a NowPow Scope of Work;
- Demonstrating workflow systems that effectively use NowPow, including EHR system interface, as determined by AHCCCS;
- Entering SDOH screening results and generating referrals to community based organizations, if desired by the member, including workforce development and reentry programs;
- Demonstrating effective follow up on SDOH referrals consistent with CBO communication protocols as noted in Core Component 2, utilizing NowPow.

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[2] Core components including usage of the Closed Loop Referral System platform NowPow are contingent upon the NowPow platform's anticipated capabilities/capacity. AHCCCS is currently engaging with Health Current and NowPow to gain more clarity on the platform's timeline.
[3] Id.
[4] Id.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

4.	**Perform analytics to assess the prevalence of social risk factors and to identify health disparities**

Develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols by:
- Aggregating and analyzing SDOH screening results to assess the prevalence of SDOH within the organization's member population.
- Stratifying screening results by race, ethnicity, and language to identify and intervene upon health disparities. Participants may use their EHR, NowPow and/ or collaborate with their MCOs to obtain this data.
- Share and evaluate results with justice partner(s).

5.	**Establish integrated care coordination with justice partner(s)**

Provide a progress report on the co-location/coordination implementation plan and identify specific action items to increase collaboration between justice partner(s) and the clinic in the next year. Demonstrate co-location/coordination with justice partner(s), by at least one of the following:
1) Fully integrated health care services (both physical and mental health services) provided in a probation/parole office; and/or
2) Probation/Parole officers co-located within a fully integrated health care setting(s) at least 2 full days per week, who meet with individuals under community supervision and refer to healthcare services within the same building complex; and/or
3) Other AHCCCS-approved co-location/coordination strategies that effectively engage justice-involved members in order to deliver integrated health services.

6.	**Create peer/family support plan with the member's chosen peer support/ PFRO**

Develop communication protocols with at least two AHCCCS-identified Peer and Family Run Organizations to provide Peer and Family Support services for justice-involved members. Create a peer and family support plan using evidence-based approaches that incorporates AHCCCS identified & approved training & credentialing for peer and family support specialists. Peer and family support specialists will have lived experience in the public behavioral health system and Criminal Justice System and be available to the co-located staff to assist formerly incarcerated individuals and their families with, including but not limited to:
1) Eligibility and enrollment applications;
2) Health care education/system navigation;
3) Finding transportation; and
4) Information on other support resources, including health literacy and financial literacy training.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

7.	**Develop a high-risk registry and develop criteria used to identify high-risk members, including criminogenic risk factors identified by justice partner(s)**

Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors as determined in accordance with core component 5, electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.

The registry may be maintained inside or outside of the EHR.

Adult members at high risk are determined by the practice, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status and c) are at medium to high criminogenic risk as determined by probation/parole and the appropriate criminogenic screening tools, such as those listed below:

1) Offender Screening Tool (OST);
2) Field Reassessment Offender Screening Tool (FROST);
3) Criminal Thinking Scales;
4) Arizona Community Assessment Tool (ACAT);
5) Risk, Need, and Responsivity(RNR);
6) Women's Risk Need Assessment (WRNA); and
7) Sex Offender Treatment Intervention and Progress Scale (SOTIPS).

8.	**Use practice care manager(s) to coordinate care with justice partner(s) for members included in the high-risk registry and demonstrate care manager(s) are trained in integrated care**

Utilize practice care managers for members included in the high-risk registry, with a caseload not to exceed a ratio of 1:100 for members listed on the high risk registry. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system) or contracted by the practice from external sources. Practice-level care management functions should include:

1) Assessing and periodically reassessing member needs.
2) Playing an active role in developing and implementing integrated care plans.
3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).
4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
5) Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors and/or AHCCCS-recognized Peer and Family Run Organizations (PFROs).
6) Collaborating with justice partners to optimize permissible data sharing that could inform risk assessment, care plan development and implementation, and compliance with community supervision or other court-ordered requirements.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

9.	**Implement integrated care plan with care manager(s) and probation/parole officer**

Implement the use of an integrated care plan for justice involved members who are listed in the high-risk registry using established data elements. These elements include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history.

An integrated care plan is one that prioritizes both physical and behavioral health needs, and reflects the patient and provider's shared goals for improved health. It includes actionable items and linkages to other services and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, and when appropriate, the family.

TI Justice practice care managers must include in the integrated care plan: a) health care services recommended as part of the probation/parole-specific community supervision plan, and when applicable, b) the critical elements from the care plan developed as a result of "reach-in" activities conducted by the MCOs and/or c) mandated health care services as outlined in the member's Comprehensive Mental Health Court agreement.

The practice care manager must also collaborate with parole/probation officer to align, to the extent possible, follow-up appointments with probation/parole office visits.

10.	**Develop communication protocols with MCOs and providers**

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

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 whole person care plan, to communicate relevant clinical data, social service needs, and to identify whether the member has practice-level care management services provided by another provider.
   ● Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

C. Develop protocols for communicating with managed care organization (MCO)-level care managers and justice liaisons to coordinate with practice-level care management activities, including addressing social risk factors.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

11.	**Screen all members for behavioral health disorders**

Routinely screen all members for at least one of the following or as clinically indicated based on criminogenic risk screening results (e.g. ACAT, FROST, OST), an affirmative response to triggers, or general questions for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, and suicide risk, using age-appropriate and standardized tools, such as, but not limited to:
1) Depression: Patient Health Questionnaire (PRIME-MD PHQ 2 and PHQ-9).
2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST, DAST 10 or DAST 20), SBIRT.
3) Anxiety: Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS) .
4) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (Adults), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ).
5) Trauma and Adverse Childhood Experiences (ACEs): PC-PTSD-5, Trauma Screening Questionnaire (TSQ), Adverse Childhood Experience Screener for Adults
6) Other MCO provided screening tools.

The practice must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendation. The practice must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

12.	**Utilize the ASAM Continuum and ensure access to MAT**

Demonstrate utilization of the American Society of Addiction Medicine (ASAM) Continuum Assessment and level of care recommendations and referrals, ensure reliable and consistent access within the practice setting or, if necessary, transportation to another provider that can deliver medication-assisted treatment (MAT), and develop or adopt protocols to provide MAT of opioids using evidence-based guidelines. Such guidelines can be found at: Medication Assisted Treatment of Opioid Use Disorder Pocket Guide.

13.	**Screen and provide Tobacco Cessation resources and support for justice-involved individuals**

Develop tobacco cessation policies and procedures consistent with the 5 A's of the CDC Best Practices for Comprehensive Tobacco Control Programs for all justice-involved individuals served by the clinic. Procedures must address:
1. Screening all justice-involved individuals for tobacco use and documenting the current and past tobacco use status in the EHR;
2. Advising the member to quit tobacco;
3. Assessing the member's willingness to make a quit attempt;
4. Assisting in the quit attempt, including prescribing tobacco cessation drugs and nicotine replacement therapy (as appropriate);
5. Arranging follow-up by connecting the member with the Arizona Smokers' Helpline (ASHLine).

14.	**Prioritize access to appointments for justice-involved individuals in the high-risk registry**

Prioritize access to appointments for justice-involved individuals listed in the high-risk registry. As applicable to the colocated practices, protocols must focus on ensuring adults transitioning from the Criminal Justice System have same-day access to appointments on the day of release and during visits to a probation or parole office.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

15.	**Obtain medical information related to referred member's medical treatment while they were incarcerated**

Develop BAA with justice partner(s) to obtain medical information related to referred member's medical treatment while they were incarcerated and develop practice procedures for:
1. Requesting, receiving, and securely storing the data;
2. Discussing past medical treatment with the member;
3. Updating the member's integrated care plan accordingly.

16.	**Develop outreach plan to engage referred adults transitioning from the criminal justice system**

Develop an outreach plan that is updated regularly, in cooperation with justice partner(s) to encourage individuals pre- and post-release to utilize the established integrated clinic. This plan should include:
1) Targeted efforts to provide pre-release care coordination and schedule appointments in the integrated clinic for individuals with medium to high criminogenic risk screening.
2) Targeted efforts to provide eligibility and enrollment support to individuals transitioning to community supervision who are not already identified as Medicaid enrolled and to schedule appointments in the integrated clinic upon release.

17.	**Participate in the Justice Targeted Investments Program Quality Improvement Collaborative (QIC)**

Participate in the Justice-specific Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The Justice QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

EXTENSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

Project: Ambulatory
Area of Concentration: Children/Youth with Behavioral Health Needs
Provider Type: Pediatric Behavioral Health Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for children/youth with behavioral health needs and children/youth in the foster care system.

Pediatric BH Ambulatory Project	
Core Components[1]	
1	Screen members using Social Determinants of Health (SDOH) assessments
2	Develop and implement SDOH screening protocols and associated workflows
3	Utilize the closed loop referral system (NowPow) to connect members to community resources
4	Perform analytics to assess the prevalence of social risk factors and to identify health disparities
5	Develop and implement a Health Equity Plan
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII) and ages 6-18 using the Children and Adolescent Level of Care Utilization System (CALOCUS)
8	Develop communication protocols in agreement with ASD
9	Develop protocols for Trauma Informed Care
10	Develop protocols to provide patient-centered, culturally competent services
11	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

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[1] Milestone details for this cohort are anticipated to be completed in the Fall of 2021 as AHCCCS works with subject matter experts and stakeholders to solidify proposal details.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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1.

Screen members using Social Determinants of Health (SDOH) assessments

Screen all members at least annually, or more frequently as determined by the provider, to assess the status of common social determinants of health (SDOH), develop procedures for intervention or referral based on screening results, document the intervention/referral in the member's care plan, upload the results to NowPow[2] as specified by AHCCCS, and submit Z codes on claims for all social risk factors identified by the tool. The screening tool must at least identify social risk factors in the following domains:
- Food insecurity
- Homelessness/Housing Instability

Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

2.

Develop and implement SDOH screening protocols and associated workflows

Develop and implement SDOH workflows that:
- Determine if SDOH screening needs to occur, including review of historical SDOH assessments in the EHR or NowPow[3];
- Govern how the SDOH screen is performed, including the screening instrument, available languages, modality, and timing;
- Identify staff responsible for reviewing and discussing the results of the SDOH screen with the member, family or guardian (as appropriate), including confirmation of member's desire for a social service referral;
- Identify local CBO partners that can provide resources to address social risk factors in each of the required domains;
- Develop and maintain referral & follow up procedures with CBO partners, including through NowPow;
- Ensure the practice incorporates results of the SDOH screen into clinical care;
- Record the results of the SDOH screen within NowPow and submit Z codes.

3.

Utilize the closed loop referral system (NowPow) to connect members to community resources

Connect and demonstrate effective use of NowPow[4] to connect members to community resources by:
- Completing a NowPow Scope of Work;
- Demonstrating workflow systems that effectively use NowPow, including EHR system interface, as determined by AHCCCS;
- Entering SDOH screening results and generating referrals, if desired by the member, to community based organizations;
- Demonstrating effective follow up on SDOH referrals consistent with CBO communication protocols as noted in Core Component 2, utilizing NowPow.

4.

Perform analytics to assess the prevalence of social risk factors and to identify health disparities

For qualifying participants as identified by AHCCCS, develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols by:
- Aggregating and analyzing SDOH screening results to assess the prevalence of SDOH within the organization's member population
- Stratifying screening results by race, ethnicity, and language to identify and intervene upon health disparities. Participants may use their EHR, NowPow and/ or collaborate with their MCOs to obtain this data.

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[2] Core components including usage of the Closed Loop Referral System platform NowPow are contingent upon the NowPow platform's anticipated capabilities/capacity. AHCCCS is currently engaging with Health Current and NowPow to gain more clarity on the platform's timeline.
[3] Id.
[4] Id.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

5. Develop and implement a Health Equity Plan

Using analysis from Core Components #4 and 10, develop a Health Equity Plan that, at a minimum:
- Identifies health disparities prevalent within the population of AHCCCS members served, and describes actions to address the disparities
- Assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a culture of equity[5].
- Implement a quality improvement initiative to address identified health disparities.

6. Develop communication protocols with physical health and behavioral health providers for referring members

A. Develop communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.
  - 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 meaningful hand-off if possible.
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 whole person care plan, to communicate relevant clinical data, social service needs and to identify whether the member has organizational-level care management services provided by another provider.
  - Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)
C. Develop protocols for communicating with managed care organization(MCO)-level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

7. Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII) and ages 6-18 using the Children and Adolescent Level of Care Utilization System (CALOCUS)

Routinely screen children and adolescents 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, using the Early Childhood Service Intensity Instrument (ECSII) for children ages 0-5 and the Child and Adolescent Level of Care Utilization System (CALOCUS) for children and adolescents ages 6-18.

The organization must develop procedures for interventions and treatment, including periodic reassessment.

8. Develop communication protocols in agreement with ASD

A. Follow AHCCCS-identified 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[6].
B. Develop communication protocols 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.

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[5] Adapted from "A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity" developed for the Department of Health and Human Services by the National Quality Foundation in 2017:
https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx .AHCCCS continues to work with stakeholder to identify validated health equity assessment toolkits for participants.
[6] Members whose EPDST assessments or other applicable assessment indicate any developmental milestones that are not met should be screened on the M-CHAT, ASQ, or PEDS tools.

1115 WAIVER DEMONSTRATION PROPOSAL: T.I. PROGRAM RENEWAL

AHCCCS
Arizona Health Care Cost Containment System

EXTENSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

9.	**Develop protocols for Trauma Informed Care**

Develop protocols for utilizing member-centered, culturally sensitive evidence-based practices in trauma-informed care as identified by AHCCCS, including:
- Identifying and utilizing the developmentally appropriate evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care
- Training all appropriate staff members in AHCCCS-identified Trauma-Informed Care training

10.	**Develop protocols to provide patient-centered, culturally competent services**

- Develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.
  - Complete an Implementation Checklist for the National CLAS Standards
  - Create, implement and routinely update a CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
  - Document that CLAS standards are being used in the organization, including, at a minimum:
    1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
    2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
    3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
- Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS.

11.	**Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)**

Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

Project: Ambulatory
Area of Concentration: Children/Youth with Behavioral Health Needs
Provider Type: Pediatric Primary Care Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for children/youth with behavioral health needs and children/youth in the foster care system.

Pediatric PCP Ambulatory Project	
Core Components[1]	
1	Screen members using Social Determinants of Health (SDOH) assessments
2	Develop and implement SDOH screening protocols and associated workflows
3	Utilize the closed loop referral system (NowPow) to connect members to community resources
4	Perform analytics to assess the prevalence of social risk factors and to identify health disparities
5	Develop and implement a Health Equity Plan
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Identify high-risk members and develop an electronic registry; Identify criteria is being used and recorded
8	Utilize practice care manager(s)for members included in the high-risk registry Demonstrate the care manager(s)have been trained to use integrated care plans
9	Screen all members for behavioral health disorders
10	Develop protocols for using Trauma-Informed Care
11	Develop communication protocols in agreement with ASD
12	Ensure medical staff complete ASD training program
13	Develop protocols to provide patient-centered, culturally competent services
14	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

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[1] Milestone details for this cohort are anticipated to be completed in the Fall of 2021 as AHCCCS works with subject matter experts and stakeholders to solidify proposal details.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

1.

Screen members using Social Determinants of Health (SDOH) assessments

Screen all members at least annually, or more frequently as determined by the provider, to assess the status of common social determinants of health (SDOH), develop procedures for intervention or referral based on screening results, document the intervention/referral in the member's care plan, upload the results to NowPow[2] as specified by AHCCCS, and submit Z codes on claims for all social risk factors identified by the tool. The screening tool must at least identify social risk factors in the following domains:

- Food insecurity
- Homelessness/Housing Instability

Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

2.

Develop and implement SDOH screening protocols and associated workflows

Develop and implement SDOH workflows that:
- Determine if SDOH screening needs to occur, including review of historical SDOH assessments in the EHR or NowPow[3];
- Govern how the SDOH screen is performed, including the screening instrument, available languages, modality, and timing;
- Identify staff responsible for reviewing and discussing the results of the SDOH screen with the member, family or guardian (as appropriate), including confirmation of member's desire for a social service referral;
- Identify local CBO partners that can provide resources to address social risk factors in each of the required domains;
- Develop and maintain referral & follow up procedures with CBO partners, including through NowPow;
- Ensure the practice incorporates results of the SDOH screen into clinical care;
- Record the results of the SDOH screen within NowPow and submit Z codes.

3.

Utilize the closed loop referral system (NowPow) to connect members to community resources

Connect and demonstrate effective use of NowPow[4] to connect members to community resources by:
- Completing a NowPow Scope of Work;
- Demonstrating workflow systems that effectively use NowPow, including EHR system interface, as determined by AHCCCS;
- Entering SDOH screening results and generating referrals, if desired by the member, to community based organizations;
- Demonstrating effective follow up on SDOH referrals consistent with CBO communication protocols as noted in Core Component 2, utilizing NowPow.

4.

Perform analytics to assess the prevalence of social risk factors and to identify health disparities

For qualifying participants as identified by AHCCCS, develop and utilize analytic systems to inform the effectiveness of health related social risk factors identification and intervention protocols by:
- Aggregating and analyzing SDOH screening results to assess the prevalence of SDOH within the organization's member population
- Stratifying screening results by race, ethnicity, and language to identify and intervene upon health disparities. Participants may use their EHR, NowPow and/ or collaborate with their MCOs to obtain this data.

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[2] Core components including usage of the Closed Loop Referral System platform NowPow are contingent upon the NowPow platform's anticipated capabilities/capacity. AHCCCS is currently engaging with Health Current and NowPow to gain more clarity on the platform's timeline.
[3] Id.
[4] Id.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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5. **Develop and implement a Health Equity Plan**

Using analysis from Core Components #4 and 13, develop a Health Equity Plan that, at a minimum:
- Identifies health disparities prevalent within the population of AHCCCS members served, and describes actions to address the disparities
- Assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a culture of equity[5].
- Implement a quality improvement initiative to address identified health disparities.

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6. **Develop communication protocols with physical health and behavioral health providers for referring members**

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

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 whole person care plan, to communicate relevant clinical data, social service needs, and to identify whether the member has organizational-level care management services provided by another provider.
- Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

C. Develop protocols for communicating with managed care organization (MCO)-level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

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7. **Identify high-risk members and develop an electronic registry; Identify criteria is being used and recorded**

Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Organizations should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors, electronic health record (EHR)-based analysis of members with distinguishing characteristics to identify health disparities, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Organizations should prioritize members within the registry whose status may be improved or favorably affected through point-of-care care management.

The registry may be maintained inside or outside of the electronic health record.

Pediatric members at high risk are determined by the organization, but must include children/youth who a) have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and b) also require health and related services of a type or amount beyond that required by children/youth generally. This registry must also include all children/youth who have or are at risk for autism spectrum disorder (ASD) and all children/youth engaged in the foster care system

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[5] Adapted from "A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity" developed for the Department of Health and Human Services by the National Quality Foundation in 2017: https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx .AHCCCS continues to work with stakeholder to identify validated health equity assessment toolkits for participants.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

8.	**Utilize practice care manager(s)for members included in the high-risk registry; Demonstrate the care manager(s)have been trained to use integrated care plans**

Utilize organization care managers for members included in the high-risk registry with a caseload not to exceed a ratio of 1:100 for members listed in the high risk registry. Care managers may be employed directly or contracted by the practice from external sources. Practice level care management functions should include:
- Conducting a comprehensive assessment with the child/youth that includes family status and home environment assessment.
- Playing an active role in developing and implementing integrated whole person care plans. These plans should build on family strengths, plan for the transition of youth from pediatric to adult systems of care, as appropriate, and (if applicable) be developed with input from behavioral health Child and Family Teams.
- Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
- Ensuring the provision of member/family education to help build self-management skills and equipping families with the skills needed to navigate a complex health care system.
- Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors.

9.	**Screen all members for behavioral health disorders**

Routinely screen all members for at least one of the following or as clinically indicated based on an affirmative response to triggers or general questions at the age-appropriate time for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, developmental delays in infancy and early childhood, and suicide risk using age-appropriate and standardized tools such as, but not limited to:
1) Depression: member Health Questionnaire (PRIME-MD PHQ and PHQ-A).
2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST), SBIRT.
3) Anxiety: Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS).
4) Developmental delays in infancy and early childhood: Parents' Evaluation of Development Status (PEDS), Ages and Stages Questionnaires (ASQ) or Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R).
5) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ).
6) Trauma and Adverse Childhood Experiences (ACES): Pediatric ACEs and Related Life-events Screener (PEARLS), UCLA Brief Screen for Trauma and PTSD
7) Other MCO provided screening tools.

The organization must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendations. The organization must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

10.	**Develop protocols for using Trauma-Informed Care**

Develop protocols for utilizing member-centered, culturally sensitive evidence-based practices in trauma-informed care as identified by AHCCCS, including:
- Identifying and utilizing the developmentally appropriate evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care
- Training all appropriate staff members in AHCCCS-identified Trauma-Informed Care training

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

11. **Develop communication protocols in agreement with ASD**

Routinely screen children and adolescents 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, using the Early Childhood Service Intensity Instrument (ECSII) for children ages 0-5 and the Child and Adolescent Level of Care Utilization System (CALOCUS) for children and adolescents ages 6-18.

The organization must develop procedures for interventions and treatment, including periodic reassessment.

12. **Ensure medical staff complete ASD training program**

Ensure that all pediatricians, family physicians, advanced practice clinicians and care managers complete a training program in ASD that offers continuing education credits, unless having done so within the past three years. This training should include:
1) Recognizing and treating common coexisting conditions, and
2) Use of commonly accepted toolkits, such as "Caring for Children with ASD: A Resource Toolkit for Clinicians" from the American Academy of Pediatrics.

13. **Develop protocols to provide patient-centered, culturally competent services**

- Develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.
  - Complete an Implementation Checklist for the National CLAS Standards
  - Create, implement and routinely update a CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
  - Document that CLAS standards are being used in the organization, including, at a minimum:
    1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
    2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
    3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
- Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS.

14. **Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)**

Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

AHCCCS
Arizona Health Care Cost Containment System

APPENDIX B
Expansion Cohort
Core Components & Milestones

AHCCCS
Arizona Health Care Cost Containment System

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

Project: Ambulatory
Area of Concentration: Adults with Behavioral Health Needs
Provider Type: Adult Behavioral Health Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Adult BH Ambulatory Project	
Core Component	**Milestone**
1	Utilize a behavioral health integration toolkit and action plan and determine level of integration
2	Implement the use of an integrated care plan
3	Screen members using SDOH and develop procedures for intervention
4	Develop communication protocols with MCOs and providers
5	Participate in the health information exchange with Health Current
6	Identify community based resources
7	Screen members using the LOCUS (Level of Care Utilization System)
8	Develop protocols for Trauma Informed Care
9	Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment
10	Develop protocols to provide patient-centered, culturally competent services
11	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

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

1.

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

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

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

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

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023)	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024)
Practice Reporting Requirement to State	**Practice Reporting Requirement to State**
By May 31, 2023: A. Identify the name of the integration toolkit the organization has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines for each participating practice, **AND** B. Report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practices organizations must complete the IPAT for each participating location.	By December 31, 2023, demonstrate substantive progress has been made on the practice/organization action plan and identify barriers to, and strategies for, achieving additional progress by updating the practice action plan, **AND** By July 31, 2024, report on the progress that has been made since January 1, 2024 and internally identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit updated IPAT scores between August 1, 2024 and Sept 30, 2024 and report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practice organizations must complete the IPAT for each participating location.

AHCCCS
Arizona Health Care Cost Containment System

EXPANSION: ADULT BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

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

2.	Implement the use of an integrated care plan using established data elements. These elements may include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history.

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 community based organizations (if appropriate) and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, and, when appropriate, the family.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, demonstrate that the practice has begun providing input to communicate relevant clinical data into integrated care plans initiated by physical health providers with whom communication protocols have been established per Core Component #4.	By September 30, 2024, based on a record review of a random sample of at least 20 members who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% of the time.

3.	Screen all members to assess the status of common social determinants of health (SDOH), at least annually, or more frequently as determined by the provider[1], and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool. The tool must screen for, at a minimum, the following domains:

1) Food insecurity
2) Homelessness/Housing insecurity
3) Transportation Assistance
4) Social Isolation

Tool examples include but are not limited to: the Patient–Centered Assessment Method (PCAM) , the Health Leads Screening Toolkit , and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Identify which SDOH screening tool is being used by the organization, **AND** B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 6, based on information obtained through the screening.	By September 30, 2024, based on a record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool.

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[1] Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

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

4.

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

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, social service needs, and to identify whether the member has organizational-level care management services provided by another provider.
   - Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

C. Develop protocols for communicating with managed care organization-(MCO) level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State

By September 30, 2023:
A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND**
B. Document that the protocols cover how to:
   1) Refer members,
   2) Conduct meaningful hand-offs,
   3) Handle crises,
   4) Share information,
   5) Obtain consent, and
   6) Engage in provider-to-provider consultation.
	By September 30, 2024, based on a record review of a random sample of at least 20 members whom the organization has newly identified as having received or referred to behavioral health services: attest that 85% of the time referrals are made in a way consistent with AHCCCS-identified best practices regarding telehealth service delivery[2], communication protocols and referral processes for both integrated and non-integrated clinics.

5. Participate in <u>bidirectional exchange of data</u> with Health Current, the health information exchange (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, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Attest that all participating practices are receiving Admission-Discharge-Transfer (ADT) alerts from Health Current. **AND** B. Develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the organization's management of high-risk members.	By September 30, 2024: A. Attest that all participating practices are transmitting data on a core data set (which includes a patient care summary with defined data elements) for all members to Health Current. **AND** B. Implement policies and procedures that describe how longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members.

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[2]In May 2021, the Arizona Legislature enacted HB 2454, the Telehealth Omnibus Bill. One of its provisions contains a telehealth advisory committee, which will inform best telehealth practices in the state by June 1, 2022. AHCCCS is awaiting this committee's guidance and will align this core component with the best practices identified by the committee.

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

6.	Identify community-based resources, at a minimum, through use of lists maintained by 211 and the MCOs. Utilize the community-based resource list(s) and regional knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources to effectively meet social needs.

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. **Peer and family support services (including AHCCCS recognized Peer and Family Run Organizations).**

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023)	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024)
Practice Reporting Requirement to State	Practice Reporting Requirement to State
By September 30, 2023: A. Identify the sources for the organization's list of community-based resources, **AND** B. Identify the agencies and community-based organizations to which the organization has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the organization and the community-based resource. **AND** C. Determine if the community based resources on the organization's list are participating, or plan to participate in NowPow[3].	By September 30, 2024, attest that the organization has implemented the procedures for referring members to community based resources, based on AHCCCS-identified measures.

7.	Screen members to assess what intensity of services are needed to assist them with their emotional, behavioral, and/or medical needs and to inform service recommendations into the integrated care plan, using the <u>LOCUS (Level of Care Utilization System)</u>.

The practice must develop procedures for interventions and treatment, including periodic reassessment.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023)	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024)
Practice Reporting Requirement to State	Practice Reporting Requirement to State
By September 30, 2023: A. Document the practice's policies and procedures for use of the LOCUS, **AND** B. Attest that the results of the LOCUS are in the electronic medical record.	By September 30, 2024, based on a practice record review of a random sample of at least 20 members, attest that the practice performed the LOCUS 85% of the time and incorporated service intensity recommendations into the integrated treatment plan.

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[3] NowPow is the vendor for Arizona's Closed Loop Referral System implemented through Health Current. Heath Current teamed with AHCCCS and the referral system 2-1-1 Arizona to implement a single, statewide closed loop referral system to address social determinants of health (SDOH) needs in Arizona. Earlier in 2021, NowPow was chosen as the vendor for this electronic system. AHCCCS, Health Current and NowPow continue to engage in stakeholder discussion on how the program will be rolled out in the upcoming months and years.

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

8.	Develop protocols for utilizing patient-centered, evidence-based practices in trauma-informed care as identified by AHCCCS.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the appropriate culturally sensitive, evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care, **AND** B. Demonstrate that all staff AHCCCS specified to be trained have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date.	By September 30, 2024, attest to utilizing the evidence based practices and coinciding case management that have been established in Year 2 for trauma-informed care that encompass the SAMHSA 6 Guiding Principles for trauma-informed care.

9.	Demonstrate utilization of the American Society of Addiction Medicine (ASAM) Continuum Assessment and level of care recommendations and referrals.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, attest that the organization utilizes the ASAM Continuum Assessment for conducting substance use disorder and co-occurring disorder (substance use and mental health) assessments.	By September 30, 2024, based on a record review of a random sample of at least 20 members who receive substance use and co-occurring substance use/mental health assessments, attest that the provider has complied with the AHCCCS identified guidelines of completing the ASAM Continuum Assessment to determine the level of care for the member/individual.

AHCCCS
Arizona Health Care Cost Containment System

EXPANSION: ADULT BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

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

10.	A) Complete an organization evaluation, develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.

- ○ Complete an Implementation Checklist for the National CLAS Standards
- ○ Create, implement and routinely update a formal CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
- ○ Document that CLAS standards are being used in the organization, including, at a minimum:
  1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
  2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
  3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations

B) Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: C. Document the organization's policies and procedures to implement a CLAS implementation plan, **AND** D. Attest that CLAS standards are being used in the organization, **AND** E. Attest all staff have completed AHCCCS identified training.	By September 30, 2024: A. Implement the organization's policies and procedures to implement a CLAS implementation plan, **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.

11.	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. AND B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 2 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.	By September 30, 2024, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. AND B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 3 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.

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

Project: Ambulatory
Area of Concentration: Adults with Behavioral Health Needs
Provider Type: Adult Primary Care Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Adult PCP Ambulatory Project	
Core Component	**Milestone**
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare
2	Identify members who are high-risk and develop electronic registry; Demonstrate use of identification criteria and document members in registry
3	Utilize care managers for members in high-risk registry; Demonstrate that care manager(s) are trained in integrated care
4	Implement integrated care plan
5	Screen all members to assess SDOH
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Screen all members for behavioral health disorders
8	Utilize the American Society of Addiction Medicine (ASAM) Continuum Assessment
9	Participate in the health information exchange with Health Current
10	Identify community-based resources
11	Prioritize access to appointments for all individuals listed in high-risk registry
12	Develop protocols for Trauma Informed Care
13	Develop protocols to provide patient-centered, culturally competent services
14	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

EXPANSION: ADULT PRIMARY CARE PROVIDERS
AHCCCS Targeted Investments Program
Core Components and Milestones

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

1.

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

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

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

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

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023)	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024)
Practice Reporting Requirement to State	**Practice Reporting Requirement to State**
By May 31, 2023: A. Internally identify the name of the integration toolkit the organization has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines for each participating practice, **AND** B. Report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practices organizations must complete the IPAT for each participating location.	By December 31, 2023, demonstrate substantive progress has been made on the practice/organization action plan and identify barriers to, and strategies for, achieving additional progress by updating the practice action plan, **AND** By July 31, 2024, report on the progress that has been made since January 1, 2024 and internally identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit updated IPAT scores between August 1, 2024 and Sept 30, 2024 and report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practice organizations must complete the IPAT for each participating location.

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

2.	Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Organizations should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors as determined in accordance with Core Component 5, electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Organizations should prioritize members within the registry whose status may be improved or favorably affected through point-of-care care management.

The registry may be maintained inside or outside of the electronic health record.

Adult members at high risk are determined by the organization, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By August 31, 2023, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members, **AND** By September 30, 2023, demonstrate that the high-risk identification criteria are routinely used, and that the names and associated clinical information for members meeting the criteria are recorded in the registry.	By September 30, 2024, attest that the care manager is utilizing the high-risk registry to track integrated care management activity and member progress, consistent with Core Component 3.

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

3.	Utilize practice care manager*s* for members included in the high-risk registry, with a caseload not to exceed a ratio of 1:100 for members listed in the high risk registry. Care managers are responsible for high-risk patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams. Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means. A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable.

Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system), or contracted by the practice from external sources. Practice-level care management functions should include:
  1) Assessing and periodically reassessing member needs.
  2) Playing an active role in developing and implementing integrated care plans.
  3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).
  4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
  5) Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
A. Identify at least one care manager assigned to provide integrated care management services for members listed in the practice high risk registry. Indicate the caseload per care manager full time equivalent (FTE), **AND**
B. Document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management, consistent with Core Component 2, **AND**
C. Demonstrate that the care manager(s) has been trained in:
    • Comprehensive assessment of member needs and goals;
    • Use of integrated care plans;
    • Member and family education; and
    • Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10;
    • All other appropriate training as identified by AHCCCS
	A. By May 31, 2024, document that care managers have been trained in motivational[1] interviewing, are conducting motivational interviewing with high risk members and including member activation and self-management support, and have completed all other appropriate training as identified by AHCCCS **AND**
	B. By September 30, 2024, based on a practice record review of a random sample of at least 20 members listed in the high-risk registry during the past 12 months, attest that the care manager has completed all required documentation including: a) completing a comprehensive assessment, b) educating members, c) appropriately facilitating linkages to community-based organizations, and d) whether the member already received integrated care/case management from other practices and/or MCOs, at least 85% of the time.

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[1] CM motivational interviewing training requirement: 6 CEUs by May 31, 2024; or 6 CEUs within the past 24 months; or motivational interviewing certificate within the past 24 months.

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

4.	Implement the use of an integrated care plan using established data elements. These elements may include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history. 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 community based organizations (if appropriate) and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, and, when appropriate, the family.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, demonstrate that the practice has begun using an integrated care plan.	By September 30, 2024, based on a record review of a random sample of at least 20 members who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% of the time.

5.	Screen all members to assess the status of common social determinants of health (SDOH) at least annually, or more frequently as determined by the provider[2], and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool. The tool must screen for, at a minimum, the following domains: 1) Food insecurity 2) Homelessness/Housing insecurity 3) Transportation Assistance 4) Social Isolation Tool examples include but are not limited to: the Patient–Centered Assessment Method (PCAM) , the Health Leads Screening Toolkit , and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).	
	Milestone Measurement Period 1 (October 1, 2022-September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023-September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify which SDOH screening tool is being used by the organization, **AND** B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	By September 30, 2024, based on a record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool.

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[2] Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

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

6.

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

- 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 meaningful hand-off if possible.

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, social service needs, and to identify whether the member has organizational-level care management services provided by another provider.

- Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

C. Develop protocols for communicating with managed care organization-(MCO) level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND**
B. Document that the protocols cover how to:
   1) Refer members,
   2) Conduct meaningful hand-offs,
   3) Handle crises,
   4) Share information,
   5) Obtain consent, and
   6) Engage in provider-to-provider consultation.
	By September 30, 202, based on a record review of a random sample of at least 20 members whom the organization has newly identified as having received or referred to behavioral health services, attest that 85% of the time referrals are made in a way consistent with AHCCCS-identified best practices regarding telehealth service delivery[3], communication protocols and referral processes for both integrated and non-integrated clinics.

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[3] In May 2021, the Arizona Legislature enacted HB 2454, the Telehealth Omnibus Bill. One of its provisions contains a telehealth advisory committee, which will inform best telehealth practices in the state by June 1, 2022. AHCCCS is awaiting this committee's guidance and will align this core component with the best practices identified by the committee.

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

7.	Routinely screen all members for at least one of the following or as clinically indicated based on an affirmative response to triggers or general questions for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, and suicide risk using age-appropriate and standardized tools such as, but not limited to:

1) Depression: Patient Health Questionnaire (PRIME-MD PHQ 2 and PHQ-9).
2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST, DAST 10 or DAST 20), SBIRT.
3) Anxiety: Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS) .
4) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (Adults), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ).
5) Trauma and Adverse Childhood Experiences (ACEs): PC-PTSD-5, Trauma Screening Questionnaire (TSQ), Adverse Childhood Experience Screener for Adults
6) Other MCO provided screening tools.

The organization must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendations. The organization must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State

By September 30, 2023:
  A. Identify the organization's policies and procedures for use of standardized screening tools to identify:
     1. Depression,
     2. Drug and alcohol misuse,
     3. Anxiety,
     4. Trauma and ACEs
     5. Suicide risk.
  The policies must include which standardized tools will be used, **AND**
  B. Identify the organization's procedures for interventions or referrals, as the result of a positive screening, **AND**
  C. Attest that the results of all specified screening tool assessments are documented in the patients" electronic health record.
	By September 30, 2024:
	  A. Based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that a reassessment if clinically necessary occurred for within the evidence-based timeframe recommended 85% of the time. **AND**
	  B. By September 30, 2024, based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that the appropriate interventions and referrals occurred for members who screened positive 85% of the time.

8.	Demonstrate utilization of the <u>American Society of Addiction Medicine (ASAM) Continuum Assessment</u> and level of care recommendations and referrals.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, attest that the organization utilizes the ASAM Continuum Assessment for conducting substance use disorder and co-occurring disorder (substance use and mental health) assessments.	By September 30, 2024, based on a record review of a random sample of at least 20 members who receive substance use and co-occurring substance use/mental health assessments, attest that the provider has complied with the AHCCCS identified guidelines of completing the ASAM Continuum Assessment to determine the level of care for the member/individual.

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

9.	Participate in bidirectional exchange of data with Health Current, the health information exchange (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, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Attest that all participating practices are receiving Admission-Discharge-Transfer (ADT) alerts from Health Current. **AND** B. Develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the organization's management of high-risk members.	**By September 30, 2024:** A. Attest that all participating practices are transmitting data on a core data set (which includes a patient care summary with defined data elements) for all members to Health Current. **AND** B. Implement policies and procedures that describe how longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members.

10.	Identify community-based resources, at a minimum, through use of lists maintained by 211 and the MCOs. Utilize the community-based resource list(s) and regional knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources to effectively meet social needs. 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) Peer and family support services (including AHCCCS recognized Peer and Family Run Organizations).

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Identify the sources for the organization's list of community-based resources, **AND** B. Identify the agencies and community-based organizations to which the organization has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the organization and the community-based resource. **AND** C. Determine if the community based resources on the organization's list are participating, or plan to participate in NowPow[4].	By September 30, 2024, attest that the organization has implemented the procedures for referring members to community based resources, based on AHCCCS-identified measures.

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[4] NowPow is the vendor for Arizona's Closed Loop Referral System implemented through Health Current. Heath Current teamed with AHCCCS and the referral system 2-1-1 Arizona to implement a single, statewide closed loop referral system to address social determinants of health (SDOH) needs in Arizona. Earlier in 2021, NowPow was chosen as the vendor for this electronic system. AHCCCS, Health Current and NowPow continue to engage in stakeholder discussion on how the program will be rolled out in the upcoming months and years.

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

11.	**Prioritize access to appointments for all individuals listed in the high-risk registry.**	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, document the protocols used to prioritize access to members listed in the high-risk registry.	By September 30, 2024, attest to the implementation of the protocols used to prioritize access to members listed in the high-risk registry.

12.	**Develop protocols for utilizing patient-centered, culturally sensitive evidence-based practices in trauma-informed care as identified by AHCCCS.**	
	Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the appropriate culturally sensitive, evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMHSA 6 Guiding Principles for trauma-informed care, **AND** B. Demonstrate that all staff AHCCCS specified to be trained have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date.	By September 30, 2024, attest to utilizing the evidence based practices and coinciding case management that have been established in Year 2 for trauma-informed care that encompass the SAMHSA 6 Guiding Principles for trauma-informed care.

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

13.	A) Complete an organization evaluation, develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.

- Complete an Implementation Checklist for the National CLAS Standards
- Create, implement and routinely update a formal CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)
- Document that CLAS standards are being used in the organization, including, at a minimum:
  1) Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient
  2) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services
  3) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations

B) Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Document the organization's policies and procedures to implement a CLAS implementation plan, **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.	By September 30, 2024: A. Implement the organization's policies and procedures to implement a CLAS implementation plan, **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.

14.	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 2 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.	By September 30, 2024, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 3 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

Project: Ambulatory
Area of Concentration: Adults Transitioning from the Criminal Justice System
Provider Type: Outpatient clinics that provide physical and behavioral health services (eg. ICs, FQHCs, RHCs, 05-Clinics)
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs transitioning from the Criminal Justice System.
Participation: Participation in the Justice area of concentration is at the site/clinic level. Qualified clinics must 1) contract with all Arizona Complete Care (ACC) plans and the RBHA service the site's GSA, and 2) submit a commitment letter from a justice partner(s) including at least one county probation department(s) and/or ADCRR for co-location, and, when feasible, with diversion-related court programs. The commitment letter(s) must include:

1. A mission/goal statement;
2. An implementation plan including:
   a. Anticipated setting of community supervision requirements in next three-five years (eg. field vs. traditional);
   b. Timeline to achieve co-location with probation or parole:
      i. Fully integrated health care services (both physical and mental health services) provided in a probation/parole office; OR
      ii. Probation/Parole officers co-located within a fully integrated health care setting(s) at least 2 full days per week, who meet with probationers and refer to healthcare services within the same building complex; OR
      iii. Alternative co-location arrangements may be presented to AHCCCS for consideration (eg. field vs. traditional).
   c. Collaboration expectations, including but not limited to:
      i. Staff cross-training between healthcare and probation/parole (eg. orientation to processes, assessing criminogenic risk, trauma-informed care),
      ii. Shared case management of members when appropriate (eg. probation officer shares with the healthcare provider the member's progress/challenges towards achieving criminogenic goals and the healthcare provider shares with probation officer the member's progress/challenges toward achieving improved health outcomes),
      iii. Obtaining appropriate releases of information to support data-sharing processes.
3. And data-sharing expectations from both parties.

AHCCCS will review and approve applications that best satisfy this criteria in each region. Selected clinics are also required to participate in the Adult Behavioral Health Area of Concentration or Adult Primary Care Provider Area of Concentration at the organizational level. Additional milestones applicable to the TIP Justice site are delineated below.

Justice Ambulatory Project	
Core Component	**Milestone**
1	Create peer/family support plan with the member's chosen peer support/PFRO
2	Develop a high-risk registry and develop criteria used to identify high-risk members, including criminogenic risk factors identified by justice partner(s)
3	Use practice care manager(s) to coordinate care with justice partner(s) for members included in the high-risk registry and demonstrate care manager(s) are trained in integrated care.
4	Implement integrated care plan with care manager(s) and probation/parole officer
5	Screen members to assess SDOH for enhanced domains
6	Develop communication protocols with MCOs and providers
7	Screen all members for behavioral health disorders
8	Utilize the ASAM Continuum and ensure access to MAT
9	Screen and provide Tobacco Cessation resources and support for justice-involved individuals
10	Identify community-based resources and reentry programs
11	Prioritize access to appointments for justice-involved individuals in the high-risk registry
12	Establish integrated care in probation/parole office
13	Develop outreach plan to engage referred individuals transitioning from the criminal justice system
14	Participate in the Justice Targeted Investments Program Quality Improvement Collaborative (QIC)

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

1.	Develop communication protocols with, if available, at least two AHCCCS-identified Peer and Family Run Organizations, including in-house peer support staff as available, to provide Peer and Family Support services for justice-involved members. Create a peer and family support plan using evidence-based approaches that incorporates AHCCCS identified & approved training & credentialing **for** peer and family support specialists. Peer and family support specialists will have lived experience in the public behavioral health system and Criminal Justice System and be available to the co-located staff to assist formerly incarcerated individuals and their families with, including but not limited to: 1) Eligibility and enrollment applications; 2) Health care education/system navigation; 3) Finding transportation; and 4) Information on other support resources, including health literacy and financial literacy training.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023−September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Identify the names of the PFROs with which the site has developed communication and protocols and verify specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 1 **AND** B. Demonstrate all members are provided comprehensive information that enables their choice of services from any of the offered PFROs, **AND** C. Document communication policies and procedures for communicating and referring members to their preferred PFRO, **AND** D. Document that the practice has created a peer and family support plan, which incorporates peer and family specialists as part of the co-located staff and specifically articulates their role.	By June 30, 2024, document peer and family support specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 2 & 3. **AND** **By September 30, 2024,** A. Attest that all members are provided comprehensive information that enables their choice of services from any of the offered PFROs. **AND** B. Based on a practice record review of at least 20 members whom the organization has newly identified as having received or referred to peer/family support services, attest that the communication protocol and peer and family support plan was implemented at least 85% of the time.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

| 2. | Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors as determined in accordance with core component 5, electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.

The registry may be maintained inside or outside of the EHR.

Adult members at high risk are determined by the practice, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status and c) are at medium to high criminogenic risk as determined by probation/parole and the appropriate criminogenic screening tools, such as those listed below:

1) Offender Screening Tool (OST);
2) Field Reassessment Offender Screening Tool (FROST);
3) Criminal Thinking Scales;
4) Arizona Community Assessment Tool (ACAT);
5) Risk, Need, and Responsivity(RNR);
6) Women's Risk Need Assessment (WRNA); and
7) Sex Offender Treatment Intervention and Progress Scale (SOTIPS). |
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Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Document policies and procedures to request/receive criminogenic risk assessment information from justice partner(s) to inform a decision to include referred individuals on the high risk registry, **AND**
  B. Demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members.
	By September 30, 2024:
	  A. Attest that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B, **AND**
	  B. Attest that the high-risk identification criteria are routinely used and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

3.	Utilize practice care manager*s* for members included in the high-risk registry, with a caseload not to exceed a ratio of 1:100 for members listed in the high risk registry. Care managers are responsible for high-risk patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams. Care managers can be located within the practice site, nearby or remotely and available through telephone or in person through telepresence means. A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a bachelor's bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable.

Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system) or contracted by the practice from external sources. Practice-level care management functions should include:
1) Assessing and periodically reassessing member needs.
2) Playing an active role in developing and implementing integrated care plans.
3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).
4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
5) Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors and/or AHCCCS-recognized Peer and Family Run Organizations (PFROs).
6) Collaborating with justice partners to optimize permissible data sharing that could inform risk assessment, care plan development and implementation, and compliance with community supervision or other court-ordered requirements.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Identify at least one care manager assigned to provide integrated care management services for members listed in the practice high-risk registry. Indicate the caseload per care manager full time equivalent (FTE), **AND** B. Document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management consistent with Core Component 2, **AND** C. Demonstrate that the care manager(s) has been trained in: • Comprehensive assessment of member needs and goals; • Use of integrated care plans; • Member and family education; and • Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10; • All other appropriate training as identified by AHCCCS	By May 31, 2024, document that care managers have been trained in motivational interviewing[1], are conducting motivational interviewing with high risk members including member activation and self-management support, and have completed all other appropriate training as identified by AHCCCS **AND** By September 30, 2024, based on a practice record review of a random sample of at least 20 members listed in the high-risk registry during the past 12 months, attest that the care manager has completed all required documentation including: a) completing a comprehensive assessment, b) educating members, c) appropriately facilitating linkages to community-based organizations, and d) whether the member already received integrated care/case management from other practices and/or MCOs, at least 85% of the time.

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[1] CM motivational interviewing training requirement: 6 CEUs by May 31, 2024; or 6 CEUs within the past 24 months; or motivational interviewing certificate within the past 24 months.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

4.	Implement the use of an integrated care plan for justice involved members who are listed in the high-risk registry using established data elements. These elements include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history. 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 community based organizations (if appropriate) and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, the family, and when appropriate, the Child and Family Team. TI Justice practice care managers must include in the integrated care plan: a) health care services recommended as part of the probation/parole-specific community supervision plan, and when applicable, b) the critical elements from the care plan developed as a result of "reach-in" activities conducted by the MCOs and/or c) mandated health care services as outlined in the member's Comprehensive Mental Health Court agreement. The practice care manager must also collaborate with parole/probation officer to align, to the extent possible, follow-up appointments with probation/parole office visits.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023, document protocols to implement integrated care plans considering "reach-in" activities, the Comprehensive Mental Health Court Contract and the community supervision case plan.	**By September 30, 2024:** A. Attest that the practice has implemented protocols to incorporate information into the integrated care plan to include the community supervision case plan and when applicable, the "reach-in" activities and the the Comprehensive Mental Health Court Contract, **AND** B. Based on a practice record review of a random sample of at least 20 members whom the practice has identified as receiving behavioral health services and were justice-involved during the past 12 months, attest that the care manager has incorporated the community supervision case plan into the integrated care plan, and as applicable, the reach-in care plan and the Comprehensive Mental Health Court Contract at least 85% of the time..

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

5.	Screen all members to assess the status of common social determinants of health (SDOH), at least annually, or more frequently as determined by the provider[2], and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool. The tool must screen for, at a minimum, the following domains:
	   1) **Food insecurity**
	   2) **Homelessness/Housing insecurity**
	   3) **Transportation Assistance**
	   4) **Social Isolation**
	   5) **Employment instability**
	
	Tool examples include but are not limited to: the <u>Patient–Centered Assessment Method (PCAM)</u> , <u>the Health Leads Screening Toolkit</u> , and <u>the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)</u>.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	Milestone Measurement Period 2 (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Identify which SDOH screening tool is being used by the practice, **AND**
  B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.
	By September 30, 2024, based on a practice record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool.

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[2] Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

6.	A. Develop communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent and provider-to-provider consultation. • 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 meaningful hand-off if possible. 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, social service needs and to identify whether the member has practice-level care management services provided by another provider. • Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.) C. Develop protocols for communicating with managed care organization (MCO)-level care managers and justice liaisons to coordinate with practice-level care management activities, including addressing social risk factors.	

Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND**
B. Document that the protocols cover how to:
  1) Refer members,
  2) Conduct meaningful hand-offs,
  3) Handle crises,
  4) Share information,
  5) Obtain consent, and
  6) Engage in provider-to-provider consultation.
	By September 30, 2024, based on a practice record review of a random sample of at least 20 members whom the practice has newly identified as having received or to referred behavioral health or primary care services, attest that 85% of the time referrals are made in a way consistent with AHCCCS-identified best practices regarding telehealth service delivery[3], communication protocols and referral processes for both integrated and non-integrated clinics.

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[3]In May 2021, the Arizona Legislature enacted HB 2454, the Telehealth Omnibus Bill. One of its provisions contains a telehealth advisory committee, which will inform best telehealth practices in the state by June 1, 2022. AHCCCS is awaiting this committee's guidance and will align this core component with the best practices identified by the committee.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

7.	Routinely screen all members for at least one of the following or as clinically indicated based on criminogenic risk screening results (e.g. ACAT, FROST, OST), an affirmative response to triggers, or general questions for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, and suicide risk, using age-appropriate and standardized tools, such as, but not limited to: 1) Depression: Patient Health Questionnaire (PRIME-MD PHQ 2 and PHQ-9). 2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST, DAST 10 or DAST 20), SBIRT. 3) Anxiety: Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS) . 4) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (Adults), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ). 5) Trauma and Adverse Childhood Experiences (ACEs): PC-PTSD-5, Trauma Screening Questionnaire (TSQ), Adverse Childhood Experience Screener for Adults 6) Other MCO provided screening tools. The practice must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendation. The practice must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
A. Identify the organization's policies and procedures for use of standardized screening tools to identify:
    1. Depression,
    2. Drug and alcohol misuse,
    3. Anxiety,
    4. Trauma and ACEs
    5. Suicide risk.
    The policies must include which standardized tools will be used, **AND**
B. Identify the organization's procedures for interventions or referrals, as the result of a positive screening, **AND**
C. Attest that the results of all specified screening tool assessments are documented in the patients" electronic health record.
	By September 30, 2024:
	A. Based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that a reassessment, if clinically necessary, occurred within the recommended evidence-based timeframe 85% of the time. **AND**
	B. Based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that the appropriate interventions and referrals occurred for members who screened positive 85% of the time.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

8.	Demonstrate utilization of the <u>American Society of Addiction Medicine (ASAM) Continuum Assessment</u> and level of care recommendations and referrals, ensure reliable and consistent access within the practice setting or, if necessary, transportation to another provider that can deliver medication-assisted treatment (MAT), and develop or adopt protocols to provide MAT of opioids using evidence-based guidelines. Such guidelines can be found at: <u>Medication Assisted Treatment of Opioid Use Disorder Pocket Guide.</u>	
	Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Attest that the organization utilizes the ASAM Continuum Assessment for conducting substance use disorder and co-occurring disorder (substance use and mental health) assessments. **AND** B. Document reliable access to at least one physician who can prescribe buprenorphine.	**By September 30, 2024:** A. Based on a record review of a random sample of at least 20 members who receive substance use and co-occurring substance use/mental health assessments, attest that the provider has complied with the AHCCCS identified guidelines of completing the ASAM Continuum Assessment to determine the level of care for the member/individual. **AND** B. Attest to the adoption of protocols that are consistent with SAMHSA's MAT of opioids evidence-based guidelines, **AND** C. Provide three examples of meeting the MAT guidelines for members with opioid use disorder.

9.	Develop tobacco cessation policies and procedures consistent with the 5 A's of the <u>CDC Best Practices for Comprehensive Tobacco Control Programs</u> for all justice-involved individuals served by the clinic. Procedures must address: 1. Screening all justice-involved individuals for tobacco use and documenting the current and past tobacco use status in the EHR; 2. Advising the member to quit tobacco; 3. Assessing the member's willingness to make a quit attempt; 4. Assisting in the quit attempt, including prescribing tobacco cessation drugs and nicotine replacement therapy (as appropriate); 5. Arranging follow-up by connecting the member with the Arizona Smokers' Helpline (<u>ASHLine</u>).	
	Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Document policies and procedures for screening all adults transitioning from the criminal justice system for current and past tobacco use, **AND** B. Document policies and procedures, consistent with CDC best practices, to help the member quit tobacco.	By September 30, 2024, based on a record review of a random sample of at least 20 members screened positive for current tobacco use in the last 12 months, attest that the practice implemented the tobacco cessation procedures consistent with the CDC best practices 85% of the time.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

10	Identify community-based resources and reentry programs, at a minimum, through use of lists maintained by 211 and the MCOs. Utilize the community-based resource list(s) and regional knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources to effectively meet social needs.
	
	At a minimum, if available, practices should establish relationships with:
	  1) Community-based social service agencies,
	  2) Reentry programs and services that assist individuals with transition from the criminal justice system,
	  3) Self-help referral connections,
	  4) Substance misuse treatment support services,
	  5) AHCCCS-recognized Peer and Family Support Organizations (PFROs).	

Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Identify the sources for the practice's list of community-based resources, **AND**
  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. **AND**
  C. Determine if the community based resources on the organization's list are participating, or plan to participate in NowPow[4].
	By September 30, 2024, attest that the organization has implemented the procedures for referring members to community based resources, based on AHCCCS-identified measures.

11.	Prioritize access to appointments for justice-involved individuals listed in the high-risk registry. As applicable to the colocated practices, protocols must focus on ensuring adults transitioning from the Criminal Justice System have same-day access to appointments on the day of release and during visits to a probation or parole office.	

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023, document the protocols used to prioritize access to justice-involved members listed in the high-risk registry.	By September 30, 2024, attest to the implementation of the protocols used to prioritize access to members listed in the high-risk registry.

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[4] NowPow is the vendor for Arizona's Closed Loop Referral System implemented through Health Current. Heath Current teamed with AHCCCS and the referral system 2-1-1 Arizona to implement a single, statewide closed loop referral system to address social determinants of health (SDOH) needs in Arizona. Earlier in 2021, NowPow was chosen as the vendor for this electronic system. AHCCCS, Health Current and NowPow continue to engage in stakeholder discussion on how the program will be rolled out in the upcoming months and years.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

12.	Provide a progress report on the colocation implementation plan and identify specific action items to increase collaboration between justice partner(s) and the clinic in the next year. Demonstrate co-location with justice partner(s), by either:

1) Fully integrated health care services (both physical and mental health services) provided in a probation/parole office; or
2) Probation/Parole officers co-located within a fully integrated health care setting(s) at least 2 full days per week, who meet with individuals under community supervision and refer to healthcare services within the same building complex. Alternative arrangements may be presented to AHCCCS for consideration.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	Milestone Measurement Period 2 (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Demonstrate that co-located service delivery and community supervision services are delivered consistent with the original AHCCCS-approved commitment letter as of September 30, 2023. B. Provide a progress report on the colocation implementation plan and identify specific action items to increase collaboration between justice partner(s) and the clinic in the next year.	**By September 30, 2024:** A. Demonstrate that co-located service delivery and community supervision services are delivered consistent with the original AHCCCS-approved commitment letter as of September 30, 2024. B. Provide a progress report on the colocation implementation plan and identify specific action items to increase collaboration between justice partner(s) and the clinic in the next year.

13.	Develop an outreach plan that is updated regularly, in cooperation with the justice partner(s) to encourage individuals pre- and post-release to utilize the established integrated clinic. This plan should include:

1) Targeted efforts to provide pre-release care coordination and schedule appointments in the integrated clinic for individuals with medium to high criminogenic risk screening.
2) Targeted efforts to provide eligibility and enrollment support to individuals transitioning to community supervision who are not already identified as Medicaid enrolled and to schedule appointments in the integrated clinic upon release.

Milestone Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	Milestone Measurement Period 2 (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Document the practice procedures for obtaining criminogenic risk information and implementing an outreach plan in cooperation with the probation and/or ADCRR parole office(s) that specifically targets individuals with medium to high criminogenic risk, **AND** B. Document the practice procedures for identifying and providing eligibility and enrollment support to individuals transitioning to probation and/or ADCRR parole offices. Procedures must include an outreach tracking mechanism and a systematic review process to identify ways to improve.	**By September 30, 2024:** A. Attest that the practice has implemented procedures for obtaining criminogenic risk information and implementing an outreach plan in cooperation with the probation and/or ADCRR parole office(s) that specifically targets individuals with medium to high criminogenic risk **AND** B. Attest the practice has implemented procedures for identifying and providing eligibility and enrollment support to individuals transitioning to probation and/or ADCRR parole offices.

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

14.	Participate in the Justice-specific Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The Justice QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.	
	Milestone Period Measurement Period 1 (October 1, 2022−September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023−September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the Justice TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical Justice QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 2 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.	**By September 30, 2024,** attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the Justice TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical Justice QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 3 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

Project: Ambulatory
Area of Concentration: Children/Youth with Behavioral Health Needs
Provider Type: Pediatric Behavioral Health Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for children/youth with behavioral health needs and children/youth in the foster care system.

Pediatric BH Ambulatory Project	
Core Component	**Milestone**
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare
2	Implement the use of an integrated care plan
3	Screen members using SDOH and develop procedures for intervention
4	Develop communication protocols with MCO's and providers
5	Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII) and ages 6-18 using the Children and Adolescent Level of Care Utilization System (CALOCUS)
6	Participate in the health information exchange with Health Current
7	Identify community-based resources
8	Develop protocols for Trauma-Informed Care
9	Develop communication protocols in agreement with ASD
10	Develop procedures to provide information to families with children/youth with ASD
11	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers
12	Develop a protocol for obtaining records for those in the foster care system and medication needs.
13	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy
14	Develop protocols to provide patient-centered, culturally competent services
15	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

1.

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

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

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

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

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By May 31, 2023: A. Identify the name of the integration toolkit the organization has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines for each participating practice, **AND** B. Report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practices organizations must complete the IPAT for each participating location.	By December 31, 2023, demonstrate substantive progress has been made on the practice/organization action plan and identify barriers to, and strategies for, achieving additional progress by updating the practice action plan, **AND** By July 31, 2024, report on the progress that has been made since January 1, 2024 and internally identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit updated IPAT scores between August 1, 2024 and Sept 30, 2024 and report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practice organizations must complete the IPAT for each participating location.

EXPANSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

2.	Implement the use of an integrated care plan using established data elements. These elements may include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history. 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 community based organizations (if appropriate) and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, the family, and when appropriate, the Child and Family Team[1].

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, demonstrate that the practice has begun providing input to communicate relevant clinical data into integrated care plans initiated by physical health providers with whom communication protocols have been established per Core Component 4.	By September 30, 2024, based on a record review of a random sample of at least 20 members who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% of the time.

3.	Screen all members to assess the status of common social determinants of health (SDOH), at least annually, or more frequently as determined by the provider[2], and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool. The tool must be pediatric-specific, and must screen for, at a minimum, the following domains: 1) Food insecurity 2) Homelessness/Housing insecurity Common pediatric screening tools that screen for housing and food insecurity include (but are not limited to) the <u>Income, Housing, Education/Employment, Legal Status, and Personal and Family Stability and Safety (I-HELP) Social History Tool</u> and the <u>Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)</u>.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Identify which pediatric-specific SDOH screening tool is being used by the practice, **AND** B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 7, based on information obtained through the screening.	By September 30, 2024, based on a practice record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool.

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[1] The Child and Family Team is used in the behavioral health setting and consists of individuals important to the child and family (for example, friends, neighbors, member of church, relatives) and may also include representatives of child-serving agencies (for example, Department of Child Safety, Department of Economic Security/Division of Developmental Disabilities).
[2] Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

EXPANSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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

- 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 meaningful hand-off if possible.

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, social service needs and to identify whether the member has organizational-level care management services provided by another provider.

- Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations, etc.)

C. Develop protocols for communicating with managed care organization-(MCO) level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

Milestone Period Measurement Period 1 (October 1,–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State

By September 30, 2023:
A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND**
B. Document that the protocols cover how to:
  1) Refer members,
  2) Conduct meaningful hand-offs,
  3) Handle crises,
  4) Share information,
  5) Obtain consent, and
  6) Engage in provider-to-provider consultation.
	By September 30, 2024, based on a record review of a random sample of at least 20 members whom the organization has newly identified as having received or referred to behavioral health services, attest that 85% of the time referrals are made in a way consistent with AHCCCS-identified best practices regarding telehealth[3] service delivery, communication protocols and referral processes for both integrated and non-integrated clinics.

5.	Routinely screen children and adolescents 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, using the Early Childhood Service Intensity Instrument (ECSII) for children ages 0-5 and the Child and Adolescent Level of Care Utilization System (CALOCUS) for children and adolescents ages 6-18.

The organization must develop procedures for interventions and treatment, including periodic reassessment.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State

By September 30, 2023:
  A. Document the practice's policies and procedures for use of the ECSII and CALOCUS, **AND**
  B. Attest that the results of the ECSII and CALOCUS are in the electronic medical record.
	By September 30, 2024, based on a practice record review of a random sample of at least 20 members' ages 0–18, attest that the practice performed the ECSII or CALOCUS 85% of the time and incorporated service intensity recommendations into the integrated treatment plan.

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[3] In May 2021, the Arizona Legislature enacted HB 2454, the Telehealth Omnibus Bill. One of its provisions contains a telehealth advisory committee, which will inform best telehealth practices in the state by June 1, 2022. AHCCCS is awaiting this committee's guidance and will align this core component with the best practices identified by the committee.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

6.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (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, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Attest that all participating practices are receiving Admission-Discharge-Transfer (ADT) alerts from Health Current. **AND** B. Develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the organization's management of high-risk members.	**By September 30, 2024:** A. Attest that all participating practices are transmitting data on a core data set (which includes a patient care summary with defined data elements) for all members to Health Current. **AND** B. Implement policies and procedures that describe how longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members

7.	**Identify community-based resources, at a minimum, through use of lists maintained by 211 and the MCOs. Utilize the community-based resource list(s) and regional knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources to effectively meet social needs.** **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 AHCCCS recognized Peer and Family Run Organizations).**

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Identify the sources for the organization's list of community-based resources, **AND** B. Identify the agencies and community-based organizations to which the organization has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the organization and the community-based resource. **AND** C. Determine if the community based resources on the organization's list are participating, or plan to participate in NowPow[4].	By September 30, 2024, attest that the organization has implemented the procedures for referring members to community based resources, based on AHCCCS-identified measures.

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[4] NowPow is the vendor for Arizona's Closed Loop Referral System implemented through Health Current. Heath Current teamed with AHCCCS and the referral system 2-1-1 Arizona to implement a single, statewide closed loop referral system to address social determinants of health (SDOH) needs in Arizona. Earlier in 2021, NowPow was chosen as the vendor for this electronic system. AHCCCS, Health Current and NowPow continue to engage in stakeholder discussion on how the program will be rolled out in the upcoming months and years.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

8.	Develop protocols for utilizing patient-centered, evidence-based practices in trauma-informed care as identified by AHCCCS.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the developmentally appropriate, culturally sensitive evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the SAMSHA 6 Guiding Principles for trauma-informed care, **AND** B. Demonstrate that all staff AHCCCS specified to be trained and have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date.	By September 30, 2024, attest to utilizing the evidence based practices and coinciding case management that have been established in Year 2 for trauma-informed care that encompass the SAMSHA 6 Guiding Principles for trauma-informed care.

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[5]. B. Develop communication protocols 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, 2022-September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023-September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the name(s) of the ASD Specialized Diagnosing Providers[6] with which the organization has developed a communication protocol and referral agreement. **AND** B. Document the agreed-upon policies and procedures, consistent with AHCCCS-identified diagnostic and referral pathways, that guide the organization to respond to these referrals and follow-up with the referring provider once a diagnosis determination has been made.	By September 30, 2024, based on a record review of a random sample of at least 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 AHCCCS-identified diagnostic and referral pathways.

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[5] Members whose EPDST assessments or other applicable assessment indicate any developmental milestones that are not met should be screened on the M-CHAT, ASQ, or PEDS tools.
[6] Providers able to assess children/individuals and may provide a diagnosis on the autism spectrum pedisorder, as applicable.

EXPANSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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 and may include referrals to AHCCCS recognized Peer and Family Run-Organizations, if appropriate.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, document policies and procedures that guide the organization in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD.	By September 30, 2024, attest to the implementation of the policies and procedures that guide the organization 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, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, document policies and procedures that guide the organization 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 and/or behavioral health providers. Protocol elements should include: a) Continuum of services dependent on individual needs b) Degree of preparation for living independently and c) Hand-off process to specified adult providers including specialists d) Identified social needs	By September 30, 2024, attest to the implementation of the policies and procedures that guide the organization 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 and/or behavioral health providers.Protocol elements should include: a) Continuum of services dependent on individual needs b) Degree of preparation for living independently and c) Hand-off process to specified adult providers including specialists. d) Referral to appropriate community based organizations.

EXPANSION: PEDIATRIC BEHAVIORAL HEALTH
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

12.	A. Develop a protocol for obtaining records for children/youth in the foster care 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 Department of Child Safety Comprehensive Health Plan (CHP).
	B. Develop a protocol for addressing medication needs of children/youth in the foster care 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 best practices for the use of psychotropic medications for children and adolescents involved in the foster care system as identified by AHCCCS

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Attest to the development of policies and protocols used for obtaining records for children/youth engaged in the foster care system, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** B. Attest to the development of policies and protocols for addressing any medication needs of children/youth engaged in the foster care system, consistent with this Core Component.	**By September 30 2024:** A. Attest to the implementation of policies and protocols used for obtaining records for children/youth engaged in the foster care system, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** B. Attest to the implementation of policies and protocols for addressing any medication needs of children/youth engaged in the foster care system, consistent with this Core Component.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

13.	**A.** Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the foster care 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. **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 foster care system

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Attest to the development of policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations, **AND** B. Attest to the development of protocols for assessing risk and educating foster parents/guardians on the child's needs, **AND** C. Attest to the development of protocols that ensure confidentiality between the member and provider.	By September 30, 2024: A. Attest to the implementation of policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations, AND B. Attest to the implementation of protocols for assessing risk and educating foster parents/guardians on the child's needs, AND C. Attest to the implementation of protocols that ensure confidentiality between the member and provider.

Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

14.	A) Complete an organization evaluation, develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.

- ○ **Complete an Implementation Checklist for the National CLAS Standards**
- ○ **Create, implement and routinely update a formal CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)**
- ○ **Document that CLAS standards are being used in the organization, including, at a minimum:**
    1) **Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient**
    2) **Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services**
    3) **Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations**

B) Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Document the organization's policies and procedures to implement a CLAS implementation plan, AND B. Attest that CLAS standards are being used in the organization, AND C. Attest all staff have completed AHCCCS identified training.	By September 30, 2024: A. Implement the organization's policies and procedures to implement a CLAS implementation plan, **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.

15.	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 2 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.	By September 30, 2024, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 3 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.

AHCCCS
Arizona Health Care Cost Containment System

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

Project: Ambulatory
Area of Concentration: Children/Youth with Behavioral Health Needs
Provider Type: Pediatric Primary Care Provider
Objective: To provide integrated whole person primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for children/youth with behavioral health needs and children/youth in the foster care system.

Pediatric PCP Ambulatory Project	
Core Component	**Milestone**
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare
2	Identify high-risk members and develop an electronic registry;; Identify criteria is being used and recorded
3	Utilize practice care manager(s)for members included in the high-risk registry; Demonstrate the care manager(s)have been trained to use integrated care plans
4	Implement the use of an integrated care plan and develop communication protocols with MCOs and providers
5	Screen all members to assess SDOH
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Screen all members for behavioral health disorders
8	Screen all new mothers for postpartum depression
9	Participate in the health information exchange with Health Current
10	Identify community-based resources, at a minimum through use lists managed by MCO's
11	Prioritize access to appointments for all individuals listed in the high-risk registry
12	Develop protocols for using Trauma-Informed Care
13	Develop communication protocols in agreement with ASD
14	Ensure medical staff complete ASD training program
15	Develop procedures to provide parent support
16	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers
17	Develop a protocol for obtaining records for those in the foster care system and their medication needs
18	Schedule office visits for children/youth in foster care
19	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy
20	Develop protocols to provide patient-centered, culturally competent services
21	Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC)

EXPANSION: PEDIATRIC PRIMARY CARE PROVIDERS
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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

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

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

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

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By May 31, 2023: A. Identify the name of the integration toolkit the organization has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines for each participating practice, **AND** B. Report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practices organizations must complete the IPAT for each participating location.	By December 31, 2023, demonstrate substantive progress has been made on the practice/organization action plan and identify barriers to, and strategies for, achieving additional progress by updating the practice action plan, **AND** By July 31, 2024, report on the progress that has been made since January 1, 2024 and internally identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit updated IPAT scores between August 1, 2024 and Sept 30, 2024 and report each participating practice's level of integration using the results of the IPAT level of integration tool to AHCCCS. Multi-practice organizations must complete the IPAT for each participating location.

![AHCCCS - Arizona Health Care Cost Containment System]

EXPANSION: PEDIATRIC PRIMARY CARE PROVIDERS
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

2.	Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated whole person care management. Organizations should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), social risk factors as determined in accordance with Core Component 5, electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current. Organizations should prioritize members within the registry whose status may be improved or favorably affected through point-of-care care management The registry may be maintained inside or outside of the electronic health record.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
A. By August 31, 2023, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk member members, **AND** B. By September 30, 2023, demonstrate that the high-risk identification criteria are routinely used and that the names and associated clinical information for members meeting the criteria are recorded in the registry.	By September 30, 2024, attest that the care manager is utilizing the high-risk registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

3. Utilize organization care managers for members included in the high-risk registry with a caseload not to exceed a ratio of 1:100 for members listed in the high risk registry. Pediatric care management is a patient and family-centered, assessment-driven, team-based function designed to meet the needs of pediatric patients while enhancing the caregiving capabilities of families and promoting self-care skills and independence. Care management should be proactive and family-centered and address medical, social, developmental, behavioral, educational and social/financial needs while creating strong community relationships across the continuum of care. Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means. A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable. Care managers may be employed directly or contracted by the practice from external sources.

   Practice level care management functions should include:
   1) Conducting a comprehensive assessment with the child/youth that includes family status and home environment assessment.
   2) Playing an active role in developing and implementing integrated care plans. These plans should build on family strengths, plan for the transition of youth from pediatric to adult systems of care, as appropriate, and (if applicable) be developed with input from behavioral health Child and Family Teams[1].
   3) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
   4) Ensuring the provision of member/family education to help build self-management skills and equipping families with the skills needed to navigate a complex health care system.
   5) Working with members and their families to facilitate linkages to community organizations, including social service agencies to address social risk factors.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Identify at least one care manager who has been assigned to provide integrated care management for members listed in the organization's high-risk registry. Indicate the caseload per care manager full-time employee equivalent (FTE), **AND** B. Document that the duties of the care manager include the elements of care management listed in this Core Component, and the process for prioritizing members to receive organization care management, consistent with Core Component 2, **AND** C. Demonstrate that the care manager(s) has been trained in: 　○ Comprehensive assessments of children/youth's needs, including family status, home environment assessments,	By May 31, 2024, document that care managers have been trained in motivational interviewing based on AHCCCS specified training criteria[2], are conducting motivational interviewing with high risk members to facilitate family engagement and self-management support, and when appropriate, child/youth engagement and self-management support, and have completed all other appropriate training as identified by AHCCCS **AND** By September 30, 2024, based on a record review of a random sample of at least 20 members, whom the organization has identified as having received behavioral health services during the past 12 months, attest that the care manager has completed all required documentation including: a) completing a comprehensive assessment, b) educating families, c) appropriately facilitating linkages to community organizations, and d) planning for the

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[1] The Child and Family Team is used in the behavioral health setting and consists of individuals important to the child and family (for example, friends, neighbors, member of church, relatives) and may also include representatives of child-serving agencies (for example, Department of Child Safety, Department of Economic Security/Division of Developmental Disabilities).
[2] CM motivational interviewing training requirement: 6 CEUs by May 31, 2024; or 6 CEUs within the past 24 months; or motivational interviewing certificate within the past 24 months.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

	○ Using integrated care plans, ○ Member and family education, including managing chronic conditions and self-management (as appropriate), and ○ Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10. ○ All other appropriate training as identified by AHCCCS	transition of youth from pediatric to adult systems, (as appropriate), at least 85% of the time.

4.	**Implement the use of an integrated care plan using established data elements. These elements may include, but are not limited to: problem identification, risk drivers, barriers to care, medical history, social risk factors and medication history.** **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 community based organizations (if appropriate), and should be updated continually in the care plan in consultation with all members of the clinical team, the patient, the family, and when appropriate, the Child and Family Team.**

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023, demonstrate that the practice has begun using an integrated care plan.	By September 30, 2024, based on a record review of a random sample of at least 20 members who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% of the time.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

5.	Screen all members to assess the status of common social determinants of health (SDOH), at least annually, or more frequently as determined by the provider[3], and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool. The tool must be pediatric-specific, and must screen for, at a minimum, the following domains:

1) **Food insecurity**
2) **Homelessness/Housing insecurity**

Common pediatric screening tools that screen for housing and food insecurity include (but are not limited to) the <u>Income, Housing, Education/Employment, Legal Status, and Personal and Family Stability and Safety (I-HELP) Social History Tool</u> and the <u>Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)</u>.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
By September 30, 2023: A. Identify which pediatric-specific SDOH screening tool is being used by the organization, **AND** B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	By September 30, 2024, based on a record review of a random sample of at least 20 members, attest that 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool.

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[3] Providers are encouraged, but not required, to utilize NowPow to review if members have recently received an SDOH screening from other providers.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

6.	

	A. Develop communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.
	    ● 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 meaningful hand-off if possible.
	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, social service needs, and to identify whether the member has organizational-level care management services provided by another provider.
	    ● Protocols must identify the collaborating providers and specify their approach to integrated care management (e.g. integrated clinic, external referrals, Collaborative Care Model, e-consult, community based organizations,etc.)
	C. Develop protocols for communicating with managed care organization-(MCO) level care managers to coordinate with organizational-level care management activities, including addressing social risk factors.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND**
  B. Document that the protocols cover how to:
    1) Refer members,
    2) Conduct meaningful hand-offs,
    3) Handle crises,
    4) Share information,
    5) Obtain consent, and
    6) Engage in provider-to-provider consultation.
	By September 30, 2024, based on a record review of a random sample of at least 20 members whom the organization has newly identified as having received or referred to behavioral health services, attest that 85% of the time referrals are made in a way consistent with AHCCCS-identified best practices regarding telehealth service delivery[4], communication protocols and referral processes for both integrated and non-integrated clinics.

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[4]In May 2021, the Arizona Legislature enacted HB 2454, the Telehealth Omnibus Bill. One of its provisions contains a telehealth advisory committee, which will inform best telehealth practices in the state by June 1, 2022. AHCCCS is awaiting this committee's guidance and will align this core component with the best practices identified by the committee.

![AHCCCS - Arizona Health Care Cost Containment System]

EXPANSION: PEDIATRIC PRIMARY CARE PROVIDERS
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

7.	Routinely screen all members for at least one of the following or as clinically indicated based on an affirmative response to triggers or general questions at the age-appropriate time for depression, drug and alcohol misuse, anxiety, trauma and adverse childhood experiences, developmental delays in infancy and early childhood, and suicide risk using age-appropriate and standardized tools such as, but not limited to:

    1) **Depression:** Patient Health Questionnaire (PRIME-MD PHQ and PHQ-A).
    2) **Drug and alcohol misuse:** CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST), SBIRT.
    3) **Anxiety:** Generalized Anxiety Disorder (GAD 7), Duke Anxiety-Depression Scale (DADS).
    4) **Developmental delays in infancy and early childhood:** Parents' Evaluation of Development Status (PEDS), Ages and Stages Questionnaires (ASQ) or Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R).
    5) **Suicide Risk:** Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Beck Depression Inventory, Beck Hopelessness Scale, Ask Suicide-Screening Questions (ASQ).
    6) **Trauma and Adverse Childhood Experiences (ACES):** Pediatric ACEs and Related Life-events Screener (PEARLS), UCLA Brief Screen for Trauma and PTSD
    7) **Other MCO provided screening tools.**

The organization must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendations. The organization must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Identify the organization's policies and procedures for use of standardized screening tools to identify:
    1. Depression,
    2. Drug and alcohol misuse,
    3. Anxiety,
    4. Developmental delays in infancy
    5. Early childhood, cognitive, emotional and behavioral problems, including ACEs, and
    6. Suicide risk.
  The policies must include which standardized tools will be used, **AND**
  B. Identify the policies and procedures for routinely screening members, in accordance with the AHCCCS EPSDT Periodicity Schedule for screening of children, **AND**
  C. Identify the practice's procedures for interventions or referrals, as the result of a positive screening; **AND**
  D. Attest that the results of all practice's specified screening tool assessments are documented in the patients' electronic health record.
	By September 30, 2024:
	  A. Based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that a reassessment if clinically necessary within the evidence-based timeframe recommended 85% of the time. **AND**
	  B. Based on a record review of a random sample of at least 20 members listed in the high-risk registry in the last 12 months, attest that the appropriate interventions and referrals occurred for members who screened positive 85% of the time.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

8.	Routinely screen all mothers of children in attendance at each of the 1, 2, 4, and 6 month well visits for postpartum depression using the <u>Edinburgh Perinatal/Postnatal Depression Scale (EPDS)</u>. The practice must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendations. The practice must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Document policies and procedures to perform the Edinburgh Perinatal/Postnatal Depression Scale for all mothers of children in attendance at each of the 1, 2, 4, and 6 month well visit. **AND** B. Identify the practice's procedures for interventions or referrals, as the result of a positive screening, **AND** C. Attest that the result of all practice's specified screening tool assessments are documented in the patients" electronic health record.	**By September 30, 2024:** A. Based on an organization record review of a random sample of at least 20 children under 6 months old in the past 12 months whose mother was in attendance at each of the 1, 2, 4, and 6 month well visits, attest that an assessment occurred within the evidence-based timeframe recommended 85% of the time. **AND** B. Based on an organization practice record review of a random sample of at least 20 children under 6 months old in the last 12 months whose mother was in attendance at each of the 1, 2, 4, and 6 month well visits, attest that the appropriate interventions and referrals occurred for mothers who screened positive 85% of the time.

9.	Participate in bidirectional exchange of data with Health Current, the health information exchange (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, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Attest that all participating practices are receiving Admission-Discharge-Transfer (ADT) alerts from Health Current. **AND** B. Develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the organization's management of high-risk members.	**By September 30, 2024:** A. Attest that all participating practices are transmitting data on a core data set (which includes a patient care summary with defined data elements) for all members to Health Current. **AND** B. Implement policies and procedures that describe how longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

10.	Identify community-based resources, at a minimum through use of lists maintained by the managed care organizations. 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 to effectively meet social needs.

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, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Identify the sources for the organization's list of community-based resources, **AND** B. Identify the agencies and community-based organizations to which the organization has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the organization and the community-based resource. **AND** C. Determine if the community based resources on the organization's list are participating, or plan to participate in NowPow[5].	By September 30, 2024, attest that the organization has implemented the procedures for referring members to community based resources, based on AHCCCS-identified measures.

11.	Prioritize access to appointments for all individuals listed in the high-risk registry. As applicable to the organization, specialized focus must be on: 1) Ensuring that children/youth in the foster care system have prioritized access to initial visits, and subsequent follow-up appointments.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, document the protocols used to prioritize access to members listed in the high-risk registry.	By September 30, 2024, attest to the implementation of the protocols used to prioritize access to members listed in the high-risk registry.

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[5]NowPow is the vendor for Arizona's Closed Loop Referral System implemented through Health Current. Heath Current teamed with AHCCCS and the referral system 2-1-1 Arizona to implement a single, statewide closed loop referral system to address social determinants of health (SDOH) needs in Arizona. Earlier in 2021, NowPow was chosen as the vendor for this electronic system. AHCCCS, Health Current and NowPow continue to engage in stakeholder discussion on how the program will be rolled out in the upcoming months and years.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

12.	Develop protocols for utilizing patient-centered, evidence-based practices in trauma-informed care as identified by AHCCCS.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the developmentally appropriate, culturally sensitive evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the **SAMHSA 6 Guiding Principles for trauma-informed care, AND** B. Demonstrate that all staff AHCCCS specified to be trained have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date	By September 30, 2024, attest to utilizing the evidence based practices and coinciding case management that have been established in Year 2 for trauma-informed care that encompass the **SAMHSA 6 Guiding Principles for trauma-informed care.**

13.	A. Follow AHCCCS-identified 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[6]. B. Develop communication protocols 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, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: A. Identify the name(s) of the ASD Specialized Diagnosing Providers[7] with which the organization has developed a communication protocol and referral agreement. **AND** B. Document the agreed-upon policies and procedures, consistent with AHCCCS-identified diagnostic and referral pathways, that guide the organization to respond to these referrals and follow-up with the referring provider once a diagnosis determination has been made.	By September 30, 2024, based on a record review of a random sample of at least 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 AHCCCS-identified diagnostic and referral pathways.

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[6] Members whose EPDST assessments or other applicable assessment indicate any developmental milestones that are not met should be screened on the M-CHAT, ASQ, or PEDS tools.
[7] Providers able to assess children/individuals and who may provide a diagnosis on the autism spectrum disorder, as applicable.

EXPANSION: PEDIATRIC PRIMARY CARE PROVIDERS
AHCCCS Targeted Investments Program
Core Components and Milestones

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

14.	Ensure that all pediatricians, family physicians, advanced practice clinicians and care managers complete a training program in ASD that offers continuing education credits, unless having done so within the past three years. This training should include:
	1) Recognizing and treating common coexisting conditions, and
	2) Use of commonly accepted toolkits, such as "Caring for Children with ASD: A Resource Toolkit for Clinicians" from the American Academy of Pediatrics.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, identify the percentage (and names) of pediatricians, family physicians, advanced practice clinicians and care managers, who have been with the practice at least 12 months and who have completed an ASD training program for at least 3 continuing education units (CEUs) in the last three years, and provide a PDF of the CEU received.	By September 30, 2024, document that 85% of pediatricians, family physicians, advanced practice clinicians and care managers, who have been with the practice for at least 12 months, have completed an ASD training program for at least 3 CEUs in the last three years.

15.	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 and may include referrals to an AHCCCS recognized Peer and Family Run-Organization, if appropriate.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, document policies and procedures that guide the organization in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD	By September 30, 2024, attest to the implementation of policies and procedures that guide the organization in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD.

16.	Develop protocols for teenagers / young adults with ASD to facilitate smooth care transitions from pediatric to adult providers.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, document policies and procedures that guide the organization 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 and/or behavioral health providers. Protocol elements should include: a) Continuum of services dependent on individual needs b) Degree of preparation for living independently and c) Hand-off process to specified adult providers including specialists. d) Identified social needs	By September 30, 2024, attest to the implementation of policies and procedures that guide the organization 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 and/or behavioral health providers. Protocol elements should include: a) Continuum of services dependent on individual needs b) Degree of preparation for living independently and c) Hand-off process to specified adult providers including specialists. d) Referral to appropriate community based organizations.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

17.	A. Develop a protocol for obtaining records for children/youth in the foster care 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 Department of Child Safety Comprehensive Health Plan (CHP). B. Develop a protocol for addressing medication needs of children/youth in the foster care 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 best practices for the use of psychotropic medications for children and adolescents involved in the foster care system as identified by AHCCCS	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023: 　A. Attest to the development of policies and protocols used for obtaining records for children/youth engaged in the foster care system, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** 　B. Attest to the development of policies and protocols for addressing any medication needs of children/youth engaged in the foster care system, consistent with this Core Component.	**By September 30 2024:** 　A. Attest to the implementation of policies and protocols used for obtaining records for children/youth engaged in the foster care system, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** 　B. Attest to the implementation of policies and protocols for addressing any medication needs of children/youth engaged in the foster care system, consistent with this Core Component.

18.	Practices that provide primary care must schedule office visits for children/youth in the foster care system on the following *enhanced* EPSDT schedule: 　1) Monthly for infants birth to 6 months, 　2) Every three months for children between 6–24 months, 　3) Once for children at 30 months, 　4) Bi-annually for children/youth 24 months up to 21 years of age.	
	Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**
	By September 30, 2023, document policies and procedures to schedule and perform additional EPSDT visits consistent with the enhanced periodicity schedule for children/youth in the foster care system.	By September 30, 2024, attest that the organization implements the policy and measures gaps in well-care visits for children/youth in the foster care system based on the enhanced EPSDT periodicity schedule.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

19.	**A.** Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the foster care 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. **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 foster care system.

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2023–September 30, 2024) **Practice Reporting Requirement to State**

By September 30, 2023:
  A. Attest to the development of policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations, **AND**
  B. Attest to the development of protocols for assessing risk and educating foster parents/guardians on the child's needs, **AND**
  C. Attest to the development of protocols that ensure confidentiality between the member and provider.
	By September 30, 2024:
	  A. Attest to the implementation of policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations, **AND**
	  B. Attest to the implementation of protocols for assessing risk and educating foster parents/guardians on the child's needs, **AND**
	  C. Attest to the implementation of protocols that ensure confidentiality between the member and provider.

Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

20.

A) Complete an organization evaluation, develop protocols and implement practices in line with the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as identified by the U.S. Department of Health and Human Services Office of Minority Health.

- ○ **Complete an Implementation Checklist for the National CLAS Standards**
- ○ **Create, implement and routinely update a formal CLAS implementation plan (organizations are not required, but encouraged to complete the CLAS Action Worksheet for this process)**
- ○ **Document that CLAS standards are being used in the organization, including, at a minimum:**
  1) **Completing an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient**
  2) **Offer language assistance to individuals who have limited English proficiency and/or other communication needs, including translation services offered by MCOs, at no cost to them, to facilitate timely access to all health care and services**
  3) **Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations**

B) Attest that all AHCCCS-identified staff members are trained in cultural competency as identified by AHCCCS

Milestone Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023: A. Document the organization's policies and procedures to implement a CLAS implementation plan **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.	**By September 30, 2024:** A. Implement the organization's policies and procedures to implement a CLAS implementation plan **AND** B. Attest that CLAS standards are being used in the organization, **AND** C. Attest all staff have completed AHCCCS identified training.

21.

Participate in the Targeted Investments Program Quality Improvement Collaborative (QIC) offered by AHCCCS and community partners. The QIC will support TI Program participants by providing assistance with meeting core components and milestones, with quality improvement guidance, and will facilitate peer learning.

Milestone Period Measurement Period 1 (October 1, 2022–September 30, 2023) Practice Reporting Requirement to State	Milestone Measurement Period 2 (October 1, 2023–September 30, 2024) Practice Reporting Requirement to State
By September 30, 2023, attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 2 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.	**By September 30, 2024,** attest that: A. The participating organization has registered both an administrative representative and licensed clinical representative to participate in the TI Program Quality Improvement Collaborative (QIC). Organizations with only one site in the TI Program may elect to have one representative if that person has both clinical and administrative Program responsibilities. **AND** B. The organization's administrative and clinical QIC representatives (excepting one site participants as noted above) or their designees have met AHCCCS-identified attendance requirements for the Year 3 Quality Improvement Collaborative virtual group meetings offered for the Area of Concentration.