CARF Behavioral Health Crosswalk

Summary: The Commission on Accreditation of Rehabilitation Facilities (CARF) Behavioral Health standards establish an accreditation framework for behavioral health organizations that provide programs and services for integrated behavioral health, mental health, substance use disorders/addictions, psychosocial rehabilitation, and family services. Areas where CARF Behavioral Health standards would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. All behavioral health organizations seeking CARF BH accreditation must meet a general set of standards. In addition, organizations must meet "core program standards" based on their core program operations; therefore, it is possible that an organization reporting to have CARF Behavioral Health accreditation may not necessarily have met each of the CARF BH standards highlighted below.

AHCCCS TI 2.0 Milestones	CARF BH
1. Quality Improvement Collaborative (QIC) **[All Areas of Concentration]**	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identify a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice.	*Note from Bailit Health: Of the CLAS standards specifically required by AHCCCS for programs years 2 and 3, CARF BH accreditation appears to reasonably cover standards 3, 4, 9 and 12.* The organization implements a cultural competency, diversity, and inclusion plan that: a. Addresses: (1) Persons served. (2) Personnel. (3) Other stakeholders.

• Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	b. Is based on consideration of the diversity of its stakeholders in the following areas: (1) Culture. (2) Age. (3) Gender. (4) Sexual orientation. (5) Spiritual beliefs. (6) Socioeconomic status. (7) Language. (8) Race. (9) Other factors, as relevant. c. Includes actions to be taken. d. Is reviewed at least annually for relevance. e. Is updated as needed. Intent Statements • The organization demonstrates an awareness of, respect for, and attention to the diversity of the people with whom it interacts (persons served, personnel, families/support systems, and other stakeholders) that are reflected in attitudes, organizational structures, policies, procedures, and services. • The organization's cultural competency, diversity, and inclusion plan addresses how it will respond to the diversity of its stakeholders as well as how the self-awareness, knowledge, skills, and behaviors will allow personnel to work effectively cross culturally by understanding, appreciating, respecting, and responding to differences and similarities in beliefs, values, and practices within and between cultures. • Knowledge of and response to aspects of diversity are critical components in providing quality services to the persons served. This includes the design and delivery of

	services in a manner that will be most effective given the cultures of the persons served and the local community and that promote comfort, trust, and familiarity. • Cultural competency is a broad concept that encompasses more than facts about various cultures. It is an ongoing learning process that fosters acceptance, inclusion, and respect for diversity in all forms. Team members, in response to the needs of the persons served…are culturally and linguistically competent. Ongoing supervision of clinical or direct service personnel…addresses cultural competency. A community needs assessment addresses the following elements: • Culture and languages of the populations residing in the service area. • Input regarding…cultural linguistic, physical health, and behavioral health treatment needs. A training plan for all CCBHC employed and contract staff who have direct contact with persons served or their families… aligns with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) 3 to advance health equity, improve quality of services, and eliminate disparities. The CCBHC demonstrates efforts to provide meaningful access to services for individuals with limited English proficiency or language-based disabilities.

	The CCBHC has in place interpretation/translation services that: are readily available (and) meet the language needs of the population served. Documents and information vital to services: a. Meet the needs of persons served in terms of: (1) Languages commonly spoken in the community served. (2) Literacy levels. (3) The need for alternative formats. b. Are available online and in hard copy. c. Are provided in a timely manner at intake and throughout services The CCBHC's services, including those supplied by its Designated Collaborating Organizations (DCOs), demonstrate person-centered and family-centered recovery-oriented care that…recognizes the cultural ethnic needs of the person served, including American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups for whom access to traditional approaches or medicines may be part of CCBHC services. Training on cultural competency includes…issues of race, ethnicity, age, sexual orientation, and gender identity for all staff.

3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establishing processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	The ongoing strategic planning of the organization considers…social determinants of health. The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's: • Employment history • Living situation • Legal involvement • Social determinants of health • History of trauma (experienced or witnessed, including abuse, neglect, violence, sexual assault) • Need for, and availability of, social supports The program conducts a written, crisis-focused assessment of each person served that includes at a minimum…social determinants of health contributing to the current crisis. A community needs assessment addresses the following elements…economic factors and social determinants of health affecting the population's access to health services.
4. Use of Community Cares [All Areas of Concentration]	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares.	N/A

• Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization.	The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's: • Gender • Sexual orientation • Gender identity

• At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	The CCBHC uses technology for the following clinical practice and care delivery activities: • Capturing health information including demographic information (e.g., race, ethnicity, preferred language, sexual and gender identity, and disability status).
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's: • Use of nicotine, and/or related products, including: (1) Current use (2) Historical use When assessment identifies that the person served currently uses nicotine products, the program offers one or more of the following: a. Education on the health risks of nicotine, the potential impact on the person's recovery, and long-term health.

	b. Counseling and support. c. Medications to support reduction or elimination of use. d. Smoking cessation services Based on need, an organized education and training program…addresses, as age- and developmentally appropriate…prevention/intervention, including, but not limited to…nicotine use.
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic.	*Organizations can seek a "Specific Population Designation" for Criminal Justice. When the program provides behavioral health services in a prison or jail setting, the transition plan refers the person served for: a. Reentry services within the other correctional systems when appropriate. b. Identified continuing care in the community in which the person served will reside when released from custody. c. In-prison continuing care or aftercare maintenance services, when available. Predischarge transition plans are: a. Developed: (1) With the active involvement of the person served. (2) Cooperatively by treatment program and correctional institution staff. b. Based on a comprehensive needs and risk assessment.

• Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	c. When applicable, effectively communicated to continuing care providers. The predischarge plan addresses: a. The personal restoration plan of the person served. b. A transition that offers continuity of care. c. Transition for the person served to a level of care congruent with: (1) The current treatment program. (2) Specific needs, including: (a) Level of criminality/threat to the safety of the larger community. (b) Risk of relapse/recidivism. (3) Available resources. d. Continuation of needed treatment upon discharge. e. Expectations regarding ongoing legal requirements
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate.	N/A

• Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	
10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	The program addresses the needs of the persons served in the following areas: Care coordination for each person served, including, but not limited to: (1) Implementation of the person-centered plan. (2) Ongoing monitoring of the person-centered plan, including revisions as needed. (3) Providing or arranging for: (a) Primary care. (b) Behavioral healthcare. (c) Hospital care. (d) Medical specialty care. (e) Community and/or social support services. (f) Other services, as appropriate Sharing information about the person served…with the following providers involved in the care of the person served, as applicable: (i) Primary care. (ii) Behavioral healthcare. (iii) Hospital care.

	(iv) Medical specialty care. (v) Community and/or social support services. (vi) Others, as appropriate. Person-centered planning: a. Addresses, in an integrated manner: (1) Physical health needs. (2) Behavioral health needs. b. Is shared with the person served. c. Is shared with all providers involved in implementing the plan.
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth.	The program addresses the needs of the persons served in the following areas: Care coordination for each person served, including, but not limited to: (1) Implementation of the person-centered plan. (2) Ongoing monitoring of the person-centered plan, including revisions as needed. (3) Providing or arranging for: (a) Primary care. (b) Behavioral healthcare. (c) Hospital care. (d) Medical specialty care. (e) Community and/or social support services. (f) Other services, as appropriate Sharing information about the person served…with the following providers involved in the care of the person served, as applicable: (i) Primary care.

• Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	(ii) Behavioral healthcare. (iii) Hospital care. (iv) Medical specialty care. (v) Community and/or social support services. (vi) Others, as appropriate. Person-centered planning: a. Addresses, in an integrated manner: (1) Physical health needs. (2) Behavioral health needs. b. Is shared with the person served. c. Is shared with all providers involved in implementing the plan.

CARF Opioid Treatment Program Crosswalk

Summary: The CARF Opioid Treatment Program (OTP) standards are tailored to organizations providing opioid treatment services. Areas where CARF OTP standards would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. CARF Opioid Treatment Program accreditation(s) would only appear to meet specific TI 2.0 milestone elements, particularly related to tobacco cessation and care coordination.

AHCCCS TI 2.0 Milestones	CARF OTP
1. Quality Improvement Collaborative (QIC) **[All Areas of Concentration]**	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identify a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members.	The organization implements a cultural competency, diversity, and inclusion plan that: a. Addresses: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Is based on consideration of the diversity of its stakeholders in the following areas: (1) Culture. (2) Age. (3) Gender.

Please note that practices cannot delegate any of these activities to a partner organization.	(4) Sexual orientation. (5) Spiritual beliefs. (6) Socioeconomic status. (7) Language. (8) Race. (9) Other factors, as relevant. c. Includes actions to be taken. d. Is reviewed at least annually for relevance. e. Is updated as needed. Intent Statements • The organization demonstrates an awareness of, respect for, and attention to the diversity of the people with whom it interacts (persons served, personnel, families/support systems, and other stakeholders) that are reflected in attitudes, organizational structures, policies, procedures, and services. • The organization's cultural competency, diversity, and inclusion plan addresses how it will respond to the diversity of its stakeholders as well as how the self-awareness, knowledge, skills, and behaviors will allow personnel to work effectively cross culturally by understanding, appreciating, respecting, and responding to differences and similarities in beliefs, values, and practices within and between cultures. • Knowledge of and response to aspects of diversity are critical components in providing quality services to the persons served. This includes the design and delivery of services in a manner that will be most effective given the

	cultures of the persons served and the local community and that promote comfort, trust, and familiarity. • Cultural competency is a broad concept that encompasses more than facts about various cultures. It is an ongoing learning process that fosters acceptance, inclusion, and respect for diversity in all forms. The organization's leadership: a. Assesses the accessibility needs of the: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Implements an ongoing process for identification of barriers in the following areas: (1) Architecture. (2) Environment. (3) Attitudes. (4) Finances. (5) Employment. (6) Communication. (7) Technology. (8) Transportation. (9) Community integration, when appropriate. (10) Any other barrier identified by the: (a) Persons served. (b) Personnel. (c) Other stakeholders.

3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	The ongoing strategic planning of the organization considers…social determinants of health. The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's: • Employment history • Living situation • Legal involvement • Social determinants of health • History of trauma (experienced or witnessed, including abuse, neglect, violence, sexual assault) • Need for, and availability of, social supports
4. Use of Community Cares [All Areas of Concentration]	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares.	N/A

• Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization.	The organization implements a performance measurement and management plan that addresses...collection of relevant data on the characteristics of the persons served. The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's:

• At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	• Gender • Sexual orientation • Gender identity The organization implements a cultural competency, diversity, and inclusion plan that: a. Addresses: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Is based on consideration of the diversity of its stakeholders in the following areas: (1) Culture. (2) Age. (3) Gender. (4) Sexual orientation. (5) Spiritual beliefs. (6) Socioeconomic status. (7) Language. (8) Race. (9) Other factors, as relevant. c. Includes actions to be taken. d. Is reviewed at least annually for relevance. e. Is updated as needed.

6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's…pertinent current and historical life information, including the person's: • Use of nicotine, and/or related products, including: (1) Current use (2) Historical use When assessment identifies that the person served currently uses nicotine products, the program offers one or more of the following: a. Education on the health risks of nicotine, the potential impact on the person's recovery, and long-term health. b. Counseling and support. c. Medications to support reduction or elimination of use. d. Smoking cessation services Based on need, an organized education and training program…addresses, as age- and developmentally appropriate…prevention/intervention, including, but not limited to…nicotine use.

7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	*Organizations can seek a "Specific Population Designation" for Criminal Justice. When the program provides behavioral health services in a prison or jail setting, the transition plan refers the person served for: a. Reentry services within the other correctional systems when appropriate. b. Identified continuing care in the community in which the person served will reside when released from custody. c. In-prison continuing care or aftercare maintenance services, when available. Predischarge transition plans are: a. Developed: (1) With the active involvement of the person served. (2) Cooperatively by treatment program and correctional institution staff. b. Based on a comprehensive needs and risk assessment. c. When applicable, effectively communicated to continuing care providers. The predischarge plan addresses: a. The personal restoration plan of the person served. b. A transition that offers continuity of care.

	c. Transition for the person served to a level of care congruent with: (1) The current treatment program. (2) Specific needs, including: (a) Level of criminality/threat to the safety of the larger community. (b) Risk of relapse/recidivism. (3) Available resources. d. Continuation of needed treatment upon discharge. e. Expectations regarding ongoing legal requirements
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion.	The program addresses the needs of the persons served in the following areas: • care coordination for each person served, including, but not limited to: providing or arranging for: (a) primary care (b) behavioral healthcare (c) hospital care (d) medical specialty care (e) community and/or social support services. • Sharing information about the person served...with the following providers involved in the care of the person served, as applicable: (i) primary care (ii) behavioral

• Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	healthcare (iii) hospital care (iv) medical specialty care (v) community and/or social support services
10. Adult PCP postpartum depression screening [Adult Primary Care Concentration]	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's...physical health issues, including...current pregnancy and prenatal care. When providing services to pregnant persons, the program...provides access to (1) prenatal care (2) prenatal education (3) postpartum follow-up. The program addresses the needs of the persons served in the following areas: • care coordination for each person served, including, but not limited to: providing or arranging for: (a) primary care (b) behavioral healthcare (c) hospital care (d) medical specialty care (e) community and/or social support services. • Sharing information about the person served...with the following providers involved in the care of the person served, as applicable: (i) primary care (ii) behavioral healthcare (iii) hospital care (iv) medical specialty care (v) community and/or social support services

11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's...physical health issues, including...current pregnancy and prenatal care. The program addresses the needs of the persons served in the following areas: Care coordination for each person served, including, but not limited to: (1) Implementation of the person-centered plan. (2) Ongoing monitoring of the person-centered plan, including revisions as needed. (3) Providing or arranging for: (a) Primary care. (b) Behavioral healthcare. (c) Hospital care. (d) Medical specialty care. (e) Community and/or social support services. (f) Other services, as appropriate Sharing information about the person served…with the following providers involved in the care of the person served, as applicable: (i) Primary care. (ii) Behavioral healthcare. (iii) Hospital care.

	(iv) Medical specialty care. (v) Community and/or social support services. (vi) Others, as appropriate. Person-centered planning: a. Addresses, in an integrated manner: (1) Physical health needs. (2) Behavioral health needs. b. Is shared with the person served. c. Is shared with all providers involved in implementing the plan.

CARF Employment and Community Services Crosswalk

Summary: The CARF Employment and Community Services (ECS) standards provide an accreditation framework for programs and services that provide employment and life skill development and support for persons to live and work as independently as possible. As you can see in the crosswalk below, CARF ECS standards essentially *do not meet any* TI 2.0 milestones (for any area of concentration).

AHCCCS TI 2.0 Milestones	CARF ECS
1. Quality Improvement Collaborative (QIC) **[All Areas of Concentration]**	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members.	The organization implements a cultural competency, diversity, and inclusion plan that: a. Addresses: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Is based on consideration of the diversity of its stakeholders in the following areas: (1) Culture. (2) Age. (3) Gender.

Please note that practices cannot delegate any of these activities to a partner organization.	(4) Sexual orientation. (5) Spiritual beliefs. (6) Socioeconomic status. (7) Language. (8) Race. (9) Other factors, as relevant. c. Includes actions to be taken. d. Is reviewed at least annually for relevance. e. Is updated as needed. Intent Statements • The organization demonstrates an awareness of, respect for, and attention to the diversity of the people with whom it interacts (persons served, personnel, families/support systems, and other stakeholders) that are reflected in attitudes, organizational structures, policies, procedures, and services. • The organization's cultural competency, diversity, and inclusion plan addresses how it will respond to the diversity of its stakeholders as well as how the self-awareness, knowledge, skills, and behaviors will allow personnel to work effectively cross culturally by understanding, appreciating, respecting, and responding to differences and similarities in beliefs, values, and practices within and between cultures. • Knowledge of and response to aspects of diversity are critical components in providing quality services to the persons served. This includes the design and delivery of services in a manner that will be most effective given the

	cultures of the persons served and the local community and that promote comfort, trust, and familiarity. • Cultural competency is a broad concept that encompasses more than facts about various cultures. It is an ongoing learning process that fosters acceptance, inclusion, and respect for diversity in all forms. Team members, in response to the needs of the persons served…are culturally and linguistically competent. The organization's leadership: a. Assesses the accessibility needs of the: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Implements an ongoing process for identification of barriers in the following areas: (1) Architecture. (2) Environment. (3) Attitudes. (4) Finances. (5) Employment. (6) Communication. (7) Technology. (8) Transportation. (9) Community integration, when appropriate. (10) Any other barrier identified by the: (a) Persons served.

	(b) Personnel. (c) Other stakeholders.
3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	The ongoing strategic planning of the organization considers...social determinants of health.

4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	N/A
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide	The organization implements a performance measurement and management plan that addresses...collection of relevant data on the characteristics of the persons served.

data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	The organization implements a cultural competency, diversity, and inclusion plan that: a. Addresses: (1) Persons served. (2) Personnel. (3) Other stakeholders. b. Is based on consideration of the diversity of its stakeholders in the following areas: (1) Culture. (2) Age. (3) Gender. (4) Sexual orientation. (5) Spiritual beliefs. (6) Socioeconomic status. (7) Language. (8) Race. (9) Other factors, as relevant. c. Includes actions to be taken. d. Is reviewed at least annually for relevance. e. Is updated as needed.
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	N/A

7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	N/A

8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	As needed, the employee/person served receives educational resources on...appropriate medical or behavioral health resources/options.
10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan.	As needed, the employee/person served receives educational resources on...appropriate medical or behavioral health resources/options.

• Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider.	N/A

• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	

NCQA PCMH Crosswalk

Summary: The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) standards evaluate primary care practices in the United States.

To meet the NCQA PCMH standards, primary care medical practices must meet all core requirements (in blue font). In addition, they must gain 25 points by meeting a combination of elective requirements, which are assigned a specific number of points (in red font). Therefore, whether a practice fulfills the elective requirements must be determined on a case-by-case basis.

Areas where NCQA PCMH standards would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. Those highlighted in orange are met by elective standards.

Only one component of the TI 2.0 milestones is achieved via a core NCQA PCMH standard, which is to screen members for health-related social needs. Several other criteria pertaining to HRSNs, team-based care, behavioral health screenings, and establishing partnerships with/making referrals to CBOs *could* be satisfied for all areas of concentration and adult and pediatric concentrations with NCQA PCMH *elective* credits. However, the assessment of whether the practice has met the milestones would need to be determined on a practice-specific (i.e., case-by-case) basis given that the standards are elective, and an organization may or may not opt to fulfill those specific elective standards.

Key:

AC	Patient-Centered Access and Continuity
CC	Care Coordination and Care Transitions
KM	Knowing and Managing Your Patients
QI	Performance Measurement and Quality Improvement
TC	Team-Based Care and Practice Organization

AHCCCS TI 2.0 Milestones	NCQA PCMH
1. Quality Improvement Collaborative (QIC) [All Areas of Concentration]	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing	N/A

interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	*Note from Bailit Health: NCQA PCMH standards meet CLAS Standards 8, 10, 11, 12, 13, according to this crosswalk by ThinkCulturalHealth.hhs.gov* QI 04 (Core) Patient Experience Feedback: Monitors patient experience through: A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions, as: Access. Communication. Coordination. Whole-person care, self-management support and comprehensiveness. B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means. KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two): A. Targets population health management on disparities in care. B. Educates practice staff on health literacy. C. Educates practice staff in cultural competence. a. GUIDANCE: Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures, and be

	respectful and responsive to the health beliefs and cultural and linguistic needs of patients. KM 10 (Core) Language: Assesses the language needs of its population. KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.
3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population.	KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required): A. Medical history of patient and family. B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health: conditions in a patient's environment where people live, learn, work and play that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental risk factors; exposure to crime,

• Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices.) KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data. TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system. KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources. KM 25 (1 Credit) School/Intervention Agency Engagement: Engages with schools or intervention agencies in the community. KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21. KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources. CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.

	CC 04 (Core) Referral Management: The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical question, the required timing and the type of referral. B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.
4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates	N/A

capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required): A. Medical history of patient and family. B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health: conditions in a patient's environment where people live, learn, work and play that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental risk factors; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices.)

	KM 09 (Core) Diversity: Assesses the diversity of its population (all items required): A. Race. B. Ethnicity. C. Gender identity. D. Sexual orientation. E. One other aspect of diversity. KM 10 (Core) Language: Assesses the language needs of its population. TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system. QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. Clinical quality. B. Patient experience. KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data. KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two): A. Targets population health management on disparities in care. B. Educates practice staff on health literacy.

	C. Educates practice staff in cultural competence. AC 09 (1 Credit) Equity of Access: Uses information about the population served by the practice to assess equity of access that considers health disparities.
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	N/A
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety.	N/A

• Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit, based on evidence-based guidelines, or coordinates with oral health partners. KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.

9. Pediatric PCP Postpartum depression screening [Pediatric Primary Care Concentration]	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression. CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care. TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.
10. Adult PCP postpartum depression screening [Adult Primary Care Concentration]	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan.	KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder.

• Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression. CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care. TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • 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	CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care. CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response. TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.

relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record. CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments. KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression.

Joint Commission Ambulatory Care Crosswalk

Summary: The Joint Commission Ambulatory Care standards evaluate ambulatory care organizations in the United States. Areas where Joint Commission Ambulatory Care standards would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. There are some Ambulatory Care standards that align with aspects of milestone 2, specifically CLAS, and milestones 3 and 5 pertaining to HRSNs, which apply to All Areas of Concentration. Otherwise, the TI 2.0 criteria are not met by the Joint Commission Ambulatory Care standards.

Key:

LD	Leadership
NPSG	National Patient Safety Goals
PC	Provision of Care, Treatment, and Services
RI	Rights and Responsibilities of the Individual

AHCCCS TI 2.0 Milestones	Joint Commission Ambulatory Care
1. Quality Improvement Collaborative (QIC) **[All Areas of Concentration]**	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place.	RI.01.01.03: The organization respects the patient's right to receive information in a manner the patient understands. • The organization provides information in a manner tailored to the patient's age, language, and ability to understand.

• Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	• The organization provides interpreting and translation services, as necessary. • The organization communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.
3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population.	NPSG.16.01.01: Improving health care equity for the organization's patients is a quality and safety priority. • The organization assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services. • The organization identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the organization's patients. • The organization develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population. • The organization acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.

• Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	• At least annually, the organization informs key stakeholders, including leaders, and staff, about its progress to improve health care equity.
4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as	N/A

the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	LD.03.02.01: The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality. NPSG.16.01.01: Improving health care equity for the organization's patients is a quality and safety priority. • The organization assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services. • The organization identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the organization's patients. • The organization develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population. • The organization acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity. • At least annually, the organization informs key stakeholders, including leaders, and staff, about its progress to improve health care equity.
6. Promote tobacco cessation	

[Justice Concentration]	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	N/A
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate.	N/A

Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	N/A

10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	N/A
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information,	PC.02.01.05: The organization provides interdisciplinary, collaborative care, treatment, or services. PC.02.02.01: The organization coordinates the patient's care, treatment, or services based on the patient's needs.

obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	

Joint Commission Behavioral Health Care and Human Services Crosswalk

Summary: The Joint Commission Behavioral Health Care and Human Services standards evaluate behavioral health care or human services organizations in the United States. Areas where Joint Commission Behavioral Health Care and Human Services standards would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. Those highlighted in orange are satisfied depending on the organization's scope. Some of the Joint Commission standards only apply to specific types of organizations depending on what services they provide – these are in a red font. There are some Behavioral Health Care and Human Services standards that align with aspects of milestone 2, specifically CLAS, and milestones 3 and 5 pertaining to HRSNs, which apply to All Areas of Concentration. Otherwise, the TI 2.0 criteria are not met by the Joint Commission Behavioral Health Care and Human Services standards.

Key:

CTS	Care, Treatment, and Services
LD	Leadership
NPSG	National Patient Safety Goals
RI	Rights and Responsibilities of the Individual

AHCCCS TI 2.0 Milestones	Joint Commission Behavioral Health Care and Human Services
1. Quality Improvement Collaborative (QIC) [All Areas of Concentration]	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A

2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	CTS.02.02.01: The organization collects assessment data on each individual served. • Cultural preferences • Language preference and language(s) spoken RI.01.01.03: The organization respects the right of the individual served to receive information in a manner the individual understands. • The organization provides information to the individual served in a manner tailored to the individual's language and ability to understand. • The organization provides interpreting and translation services, as necessary. • The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual.
3. Health-Related Social Needs (HRSN) Screening **[All Areas of Concentration]**	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data.	NPSG.16.01.01: Improving health care equity for the individuals served by the organization is a quality and safety priority. • The organization assesses the health-related social needs (HRSNs) of the individual served and provides information about community resources and support services. • The organization identifies health care disparities in the population it serves by stratifying quality and safety

• Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	data using the sociodemographic characteristics of the individuals served by the organization. • The organization develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in the individuals it serves. • The organization acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity. At least annually, the organization informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity. CTS.02.02.01: The organization collects assessment data on each individual served. • Environment and living situation(s) • Leisure and recreational interests • Religion or spiritual orientation • Cultural preferences • Childhood history • Military service history, if applicable • Financial issues • Usual social, peer-group, and environmental setting(s) • Language preference and language(s) spoken • Ability to self-care • Family circumstances, including but not limited to bereavement, divorce, or incarceration of a family member • Current and past trauma • Community resources accessed by the individual served

	CTS.03.01.07: When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. CTS.06.01.01: For organizations providing case management/care coordination services: Case management/care coordination services are based on the individual's needs, preferences, goals, and community resources available to the individual. • For organizations providing case management/care coordination services: With the assistance of staff, the individual served and, as appropriate, the individual's family, identify needs, preferences, and goals for the following: ○ Housing ○ Employment ○ Education ○ Transportation ○ Crisis support ○ Health care and behavioral health services (for example, medication, therapy) ○ Financial services and benefits ○ Assistance with housekeeping ○ Assistance with personal hygiene ○ Assistance with the retention and improvement of other skills related to activities of daily living ○ Social support and adaptive skills ○ Support of spirituality ○ Schools ○ Leisure and recreational activities for children, youth, and adults ○ Parental support for children and youth

	○ Interaction with the criminal or juvenile justice system, if applicable • For organizations providing case management/care coordination services: Staff coordinating case management/care coordination services assist the individual served in identifying, using, and accessing family, neighborhood, and community supports and services. • For organizations providing case management/care coordination services: The individual served and staff coordinating case management/care coordination services evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.
4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR.	N/A

• Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data;	LD.03.02.01: The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality. NPSG.16.01.01: Improving health care equity for the individuals served by the organization is a quality and safety priority. • The organization assesses the health-related social needs (HRSNs) of the individual served and provides information about community resources and support services. • The organization identifies health care disparities in the population it serves by stratifying quality and safety data using the sociodemographic characteristics of the individuals served by the organization. • The organization develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in the individuals it serves.

Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	• The organization acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity. • At least annually, the organization informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	N/A
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization.	N/A

• Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion.	N/A

• Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	
10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	N/A
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International	CTS.03.01.07: When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record.

certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	CTS.03.01.01: The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. • Care, treatment, or service decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.

SAMHSA CCBHC Crosswalk

Summary: The Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) certification criteria define uniform standards that providers must meet to be a CCBHC. Areas where SAMHSA certification would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. SAMHSA CCBHC criteria overlap with *some*, but not all TI 2.0 Milestones (for all five areas of concentration). In particular, SAMHSA CCBHC criteria overlap with TI 2.0 milestones related to culturally and linguistically appropriate services, health-related social needs screening, postpartum depression screening, and care coordination.

AHCCCS TI 2.0 Milestones	SAMHSA CCBHC
1. Quality Improvement Collaborative (QIC) [All Areas of Concentration]	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A

2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	*Note from Bailit Health: Of the CLAS standards specifically required by AHCCCS for programs years 2 and 3, CARF BH accreditation appears to reasonably cover standards 3, 4, and 12.* • A community needs assessment and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. • The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families… Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. • The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities. • Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting. • Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive,

	and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines). • Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed. • The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. • The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing	• The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement. • A comprehensive evaluation is required for all people receiving CCBHC services… The evaluation shall include: ○ An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.

relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to community service providers to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	○ Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. • The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan. • Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare. • The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: schools. child welfare agencies, juvenile and criminal justice agencies

	and facilities (including drug, mental health, veterans, and other specialty courts), Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic, foster care service, and other social and human services. • CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following: specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders, suicide and crisis hotlines and warmlines, Indian Health Service or other tribal programs, homeless shelters, housing agencies, employment services systems, peer-operated programs, services for older adults such as Area Agencies on Aging, Aging and Disability Resource Centers, State and local health departments and behavioral health and developmental disabilities agencies, substance use prevention and harm reduction programs, criminal and juvenile justice (including law enforcement, courts, jails, prisons and detention centers), legal aid, immigrant and refugee services, SUD Recovery/Transitional housing, programs and services for families with young children (including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs), Coordinated Specialty Care programs for first episode psychosis, other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs).

	• Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports. • The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
4. Use of Community Cares [All Areas of Concentration]	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR.	N/A

• Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data;	• The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. • The CCBHC uses technology that has been certified to current criteria under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs: o Capture health information, including demographic information such as race, ethnicity,

Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	preferred language, sexual and gender identity, and disability status (as feasible). o At a minimum, support care coordination by sending and receiving summary of care records. o Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice. o Provide evidence-based clinical decision support. o Conduct electronic prescribing. Note: Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	• CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders.

	• The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders.
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic.	N/A

• Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	A comprehensive evaluation is required for all people receiving CCBHC services. The evaluation shall include: • Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. • Pregnancy and/or parenting status. • Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.

	• Relevant medical history and major health conditions that impact current psychological status. • A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. • An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs). • Basic cognitive screening for cognitive impairment. • Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. • The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. • Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services). Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs

	must provide evidenced-based services that are developmentally appropriate, youth-guided, and family/caregiver-driven. Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.
10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	A comprehensive evaluation is required for all people receiving CCBHC services. The evaluation shall include: • Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. • Pregnancy and/or parenting status. • Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments. • Relevant medical history and major health conditions that impact current psychological status. • A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. • An examination that includes current mental status, mental health (including depression screening, and

	other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs). • Basic cognitive screening for cognitive impairment. • Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. • The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. • Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-	• The CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week. • The CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs. • Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health

level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. • The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services… Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible. • Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care. • The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural

	Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. • The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type. • The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient

	and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk. • The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. • The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified

	in these criteria. PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO: o Emergency crisis intervention services o 24-hour mobile crisis teams o Crisis receiving/stabilization • A comprehensive evaluation is required for all people receiving CCBHC services. The evaluation shall include:… o An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. o Pregnancy and/or parenting status. o Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments. o Relevant medical history and major health conditions that impact current psychological status. o An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs). • The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across

	the lifespan… The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols. • The CCBHC will provide ongoing primary care monitoring of health conditions as identified…and as clinically indicated for the individual. Monitoring includes the following: o ensuring individuals have access to primary care services; o ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; o coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and o promoting a healthy behavior lifestyle.

Social Current Private Organization Crosswalk

Summary: The Social Current Private Organization standards apply to organizations that offer social or human services, are in the United States, and are either non-profit or for-profit. The standards are split into three categories. The first two, the Administration and Management Standards and Service Delivery Administration Standards, apply to all types of organizations that offer social or human services. The third category of standards, Service Standards, applies to organizations based on their scope and populations served. The standards that apply to all organizations are in blue font, whereas the Service standards are in red font. Areas where Social Current Private Organizations standards (applicable to all organizations) would appear to reasonably satisfy the TI 2.0 criteria are highlighted in green. Those highlighted in orange are satisfied by the Service Standards.

A couple of the requirements regarding CLAS standards and partnerships with CBOs (which apply to all concentrations) are satisfied by the Social Current standards. Some of the TI 2.0 criteria pertaining to HRSNs and behavioral health for the Adult and Pediatric Primary Care Concentrations and Adult Behavioral Heath Concentration *could* be fulfilled by the Service Standards. Whether an organization fulfills some of the TI 2.0 criteria would need to be determined on a case-by-case basis, given that the Service Standards depend on the organization scope and populations served.

Key:

AFM	For-Profit Administration and Financial Management
ASE	Administrative and Service Environment
NET	Network Administration
TS	Training and Supervision
ICHH	Integrated Care; Health Homes[+]
JJCM	Juvenile Justice Case Management Services*
MHSU	Mental Health and/or Substance Use Services
PS	Pregnancy Support Services

[+] Please note that Integrated Care; Health Homes standards apply to behavioral health organizations.

* Please note that the Juvenile Justice Case Management Services only applies to organizations that offer services to **youth** involved with the juvenile justice system.

AHCCCS TI 2.0 Milestones	Social Current Private Organizations
1. Quality Improvement Collaborative (QIC) **[All Areas of Concentration]**	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A
2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	NET 3.03: In developing and maintaining the network, the network management entity's leaders consider, and annually review as part of their annual planning: 1. the full range of services within the network's scope and the network's capacity to meet its responsibilities and goals; 2. geographic access to network services, including travel times to locations and proximity to public transportation; 3. the demographic makeup of network service providers compared to the demographic makeup of service recipients; 4. access to specialty service providers, including culturally relevant service providers; and 5. flexible hours of operation that meet the needs and preferences of service recipients. TS 2.04: Training for direct service personnel addresses differences within the organization's service population, as appropriate to the type of service being provided, including: 1. interventions that address cultural and socioeconomic factors in service delivery;

	2. the role cultural identity plays in motivating human behavior; 3. procedures for working with non-English speaking persons or individuals with communication impairments; 4. understanding explicit and implicit bias and discrimination; 5. recognizing individuals and families with special needs; 6. the needs of individuals and families in crisis, including recognizing and responding to a mental health crisis; 7. the needs of victims of violence, abuse, or neglect and their family members; and 8. basic health and medical needs of the service population. ASE 3.02: The organization designs and adapts its programs and services, as appropriate, to accommodate the visual, auditory, linguistic, and motor abilities of persons served. ASE 3.03: The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level.

3. Health-Related Social Needs (HRSN) Screening [All Areas of Concentration]	
• Screen members served by the practice annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establish processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	ICHH 4.02: Assessments are conducted using a standardized assessment tool to identify: 1. basic needs including food, clothing and shelter; 2. the person's behavioral health, physical health, and community and social support service needs and goals; 3. history of trauma; 4. relevant systems involvement; 5. individual and family strengths, risks, and protective factors; 6. natural supports and helping networks; and 7. the impact of the individual's health care needs on the family unit. AFM 3.02: The organization conducts ongoing community outreach and education to: A. communicate its purpose, role, functions, capacities, and scope of services; B. provide information about the strengths, needs, and challenges of the individuals, families, and groups it serves; and C. build community support and presence and maintain effective partnerships. NET 9.01: The network management entity recruits or contracts with members and community partners based on anticipated and identified needs of the service population, including needs related to geographic location, and cultural and linguistic diversity.

	TS 2.06: Direct service personnel demonstrate competence in, or receive training on how to: 1. identify and access needed community resources; 2. collaborate with other service providers; 3. access financial assistance, including public assistance and government subsidies; and 4. empower service recipients and their families to advocate on their own behalf. PS 8.03: Expectant parents are helped to access other community services needed to support positive life course development, including, as appropriate: 1. child care; 2. transportation services; 3. financial assistance; 4. legal services; and 5. domestic violence, sexual abuse, or sexual assault services. JJCM 5.02: The organization maintains a comprehensive, up-to-date list of community programs and services, and information on how to access them.
4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans).	N/A

• Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its	NET 3.02: Once every long-term planning cycle, the network management entity reviews the demographics of the persons and families it serves and compares it to the demographics of its defined service population. ICHH 7.01: Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities.

EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	
6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	JJCM 3.0: Assessments are conducted in a standardized manner and address: 1. youths' strengths and assets; 2. youths' problems and needs; and 3. risks youth pose to the community. JJCM 5.03: Youth are linked to programs and services needed to achieve goals and objectives identified in their service plans, including, as appropriate: 1. health services; 2. mental health and counseling services; 3. services for substance use conditions; 4. social and life skills development services; and 5. educational and vocational services
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility	JJCM 3.02: Youth participate in an individualized, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. updated as needed based on youths' risks and needs; 3. focused on information pertinent for meeting service objectives; and

assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic. • Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	4. supplemented with information provided by the referral source and/or collaborating providers, when appropriate JJCM 3.0: Assessments are conducted in a standardized manner and address: 1. youths' strengths and assets; 2. youths' problems and needs; and 3. risks youth pose to the community. JJCM 5.03: Youth are linked to programs and services needed to achieve goals and objectives identified in their service plans, including, as appropriate: 1. health services; 2. mental health and counseling services; 3. services for substance use conditions; 4. social and life skills development services; and 5. educational and vocational services JJCM 7.02: A written summary of the supervision period is provided to the court and the public agency with jurisdiction over the youth, and includes an assessment of: 1. any unmet needs; 2. the degree to which goals were or were not achieved; and 3. reasons for success or failure.
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	N/A

9. Pediatric PCP Postpartum depression screening [Pediatric Primary Care Concentration]	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	ICHH 7.03: The organization offers individuals and their families health education on topics relevant to their needs that will empower them to manage their chronic conditions and promote wellness. ICHH 6.03: The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation. ICHH 6.07: Care coordination activities are documented in the case record, including: 1. linkages to community providers as well as completed follow-up; 2. communication with partnering providers both internally and externally; and 3. communication with the person.
10. Adult PCP postpartum depression screening [Adult Primary Care Concentration]	
• Identify when an attributed member becomes pregnant or gives birth.	ICHH 7.03: The organization offers individuals and their families health education on topics relevant to their needs that

• Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	will empower them to manage their chronic conditions and promote wellness. PS 6.01: Expectant parents are linked to the following healthcare services, as appropriate to their needs: 1. prenatal health care; 2. genetic risk identification and counseling services; 3. labor and delivery services; 4. diagnosis and treatment of health problems, including sexually transmitted diseases; 5. dental care; 6. mental health care, including information, screening, and treatment for postpartum depression; 7. postpartum care; 8. ongoing health care, including routine medical checkups; and 9. pediatric care, including well-baby visits and immunizations. ICHH 6.03: The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation.

	ICHH 6.07: Care coordination activities are documented in the case record, including: 1. linkages to community providers as well as completed follow-up; 2. communication with partnering providers both internally and externally; and 3. communication with the person.
11. Perinatal Mental Health **[Adult Behavioral Health Concentration]**	
Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation. • Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan.	ICHH 3.03: The organization uses health information technologies to: 1. link services including shared access to the person's health information; 2. organize, track, and analyze critical program information including referrals and needed follow-up; and 3. satisfy applicable reporting requirements. ICHH 6.03: The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation. MHSU 10.05: Care coordination activities include:

• Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served. ICHH 6.07: Care coordination activities are documented in the case record, including: 1. linkages to community providers as well as completed follow-up; 2. communication with partnering providers both internally and externally; and 3. communication with the person. ICHH 7.03: The organization offers individuals and their families health education on topics relevant to their needs that will empower them to manage their chronic conditions and promote wellness. PS 6.01: Expectant parents are linked to the following healthcare services, as appropriate to their needs: 1. prenatal health care; 2. genetic risk identification and counseling services; 3. labor and delivery services; 4. diagnosis and treatment of health problems, including sexually transmitted diseases; 5. dental care; 6. mental health care, including information, screening, and treatment for postpartum depression; 7. postpartum care; 8. ongoing health care, including routine medical checkups; and 9. pediatric care, including well-baby visits and immunizations.

HRSA Health Disparities Reducer Badge Crosswalk

Summary: The Health Disparities Reducer Badge is part of HRSA's Community Health Quality Recognition (CHQR) program for Health Centers or look-alikes. The Health Disparities Reducer Badge primarily focuses on clinical quality measure (CQM) performance for measures for which there might be some broad overlap with TI 2.0 milestones but not to a degree that there is direct alignment. Since much of what the Health Disparities Reducer Badge involves will therefore not be captured in the crosswalk, we briefly summarize the badge requirements below:

- Earn at least one Health Center Quality Leader (HCQL) Badge or National Quality Leader (NQL) Badge
  - HCQL Badge: Top 30% in overall CQM performance
  - NQL Badges include Behavioral Health, Cancer Screening, Diabetes Health, Heart Health, HIV Prevention and Care, Maternal and Child Health based on performance on between two and five CQMs within each category
- Improve by at least 15% in one or more CQMs in back-to-back reporting years
- Increase total patients by at least 5% in back-to-back reporting years
- Meet targets for low birth weight, hypertension control, and uncontrolled diabetes for all racial or ethnic groups served in the latest reporting year

As a result, HRSA's Health Disparities Reducer Badge essentially *does not satisfy any criteria* for AHCCCS TI 2.0 Milestones (for any area of concentration).

AHCCCS TI 2.0 Milestones	HRSA Health Disparities Reducer Badge
1. Quality Improvement Collaborative (QIC) [All Areas of Concentration]	
• Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University. The QIC will support TI Program participants by providing interim updates on their milestones, assist with quality improvement, offer HEDIS technical assistance, and facilitate peer learning.	N/A

2. Culturally and Linguistically Appropriate Services (CLAS) **[All Areas of Concentration]**	
• Complete an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place. • Build and support a culturally and linguistically diverse practice team. • Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of the population served by the practice. • Design, implement and improve programs that provide culturally appropriate services that meet the needs of the attributed members. Please note that practices cannot delegate any of these activities to a partner organization.	N/A
3. Health-Related Social Needs (HRSN) Screening **[All Areas of Concentration]**	
• Screen members annually using an evidence based, standardized HRSN screening tool that includes (at least) the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document screening results in the practice EHR and claims (i.e. G codes and Z codes) and establishing processes to maintain confidentiality of patient data. • Identify, select and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize establishing	N/A

relationships with CBOs that address social needs that are prevalent within the practice population. • Develop referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (Community Cares) or other mediums as preferred by the CBO. • Make referrals to and track the status of member referrals to CBOs to ensure receipt of services and/or interventions. • Ensure practice team members are effectively sharing and receiving referral data from CBOs, through Community Cares or other means.	
4. Use of Community Cares **[All Areas of Concentration]**	
• Complete a Community Cares scope of work. • Ensure practice team members can access and generate reports in Community Cares. • Document screening data in Community Cares or another Managed Care Organization (MCO), Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) sponsored closed loop referral system (as available for members enrolled in applicable health plans). • Effectively document relevant data from Community Cares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR. • Make referrals for services that address HRSNs (internal and external) and demonstrate effective follow-up on referrals through Community Cares or another	N/A

ACO/CIN sponsored closed loop referral system (as applicable). Internal referrals are permitted so long as the practice demonstrates capabilities to provide/ fulfill the identified needed support and service at the clinic and within the specified period by submitting a detailed screening and referral report to AHCCCS.	
5. Identify prevalent HRSNs **[All Areas of Concentration]**	
• Collect member-reported demographic data (i.e., race/ethnicity, primary language, disability status, geography of member's residence, sex assigned at birth, gender identity, and sexual orientation) using statewide data standards where specified by AHCCCS, documenting the data in the practice EHR and developing policies for updating data and maintaining data. Practices cannot delegate these activities to a partner organization. • At least annually stratify AHCCCS TI 2.0 quality incentive measures using clinical data, member-reported demographic data and/or HRSN data in the practice EHR to identify health inequities using the practice EHR, Community Cares and/or other tools. • Develop and implement a community-informed health equity plan to reduce at least one identified inequity at least annually. The practice supplements data from its EHR, as outlined above, with other sources, including but not limited to: stratified HEDIS measure performance provided by ASU; Community Cares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.	N/A

6. Promote tobacco cessation **[Justice Concentration]**	
• Train staff on how to discuss tobacco cessation with and offer tobacco cessation support services for justice-involved individuals. • Identify effective tobacco cessation support services that align with the needs of the individuals referred to the justice clinic and workflow of the justice clinic.	One of the badges that can be (but is not required to be) attained to subsequently earn the Health Disparities Reducer Badge is the Heart Health Badge, which requires 80% performance on *Tobacco Use Screening and Cessation Intervention* (along with 80% performance on three other, non-tobacco related CQMs).
7. Engage incarcerated individuals prior to MCO reach-in activities **[Justice Concentration]**	
Justice clinics can independently conduct, or partner with a managed care organization (MCO) justice liaison and/or medical personnel within the penitentiary to conduct, the following activities: • Screen the individual for social needs using a standardized HRSN screening tool containing the following domains: housing instability, utility assistance, food insecurity, transportation needs and interpersonal safety. • Document whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. • Review and update the individual's contact information, as needed. • Identify any health needs, as defined by the member, that were not previously identified during the individual's intake assessment or referral to the justice clinic.	N/A

• Submit a pre-release application for AHCCCS benefits via HEAplus, when appropriate. Justice clinics that partner with state parole (ADCRR) must conduct these activities between 30 and 45 days prior to release from prison. Justice clinics that partner with counties must conduct these activities between the 10th and 20th day of incarceration in jail.	
8. Pediatric oral health **[Pediatric Primary Care Concentration]**	
• Train staff and create processes to place dental varnish in the PCP office. • Educate the member on the importance of oral health. • Refer the member to their dentist or a dentist in their network and follow-up with the dentist to ensure the service was provided.	• Increase patients receiving mental health, substance use disorder, vision, dental, or enabling services by at least 5% in back-to-back reporting years.
9. Pediatric PCP Postpartum depression screening **[Pediatric Primary Care Concentration]**	
• Educate the present caregiver(s) and guardian(s) about depression, including postpartum depression, as appropriate. • Screen present caregiver(s) and guardian(s) for anxiety and depression, including postpartum depression, using appropriate evidence-based tools, and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	N/A

10. Adult PCP postpartum depression screening **[Adult Primary Care Concentration]**	
• Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion. • Maintain a registry of behavioral health providers that can be given to the caregiver(s) and guardian(s) at time of appointment. • Coordinate with behavioral health provider(s), care managers and/or case managers for follow-up.	N/A
11. Adult Behavioral Health **[Adult Behavioral Health Concentration]**	
• Train behavioral health providers and/or prescribers in Perinatal Mental Health via Postpartum Support International certification in either the Mental Health/ Psychotherapy specialty or Pharmacotherapy specialty. • Establish referral and communication protocols with physical health and behavioral health providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.	• Increase patients receiving mental health, substance use disorder, vision, dental, or enabling services by at least 5% in back-to-back reporting years. • One of the badges that can be (<u>but is not required to be</u>) attained to subsequently earn the Health Disparities Reducer Badge is the Behavioral Health Badge, which requires: ○ 18.2% performance for *Depression Remission at 12 Months*

• Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider. • Identify when an attributed member becomes pregnant or gives birth. • Notify the members' health plan when the notification of pregnancy or birth was not generated by the health plan. • Engage caregiver(s) and guardian(s) for a follow-up appointment within 84 days. • Educate the present caregiver(s) and guardian(s) about postpartum depression and anxiety. • Screen present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and document the results and discussion.	○ 80.5% performance on *Depression Screening and Follow-Up Plan* ○ At least 5% of patients receive Screening, Brief Intervention and Referral to Treatment ○ At least 10% increase in patients receiving medication-assisted treatment between consecutive UDS reporting years