Provider Type: Primary Care
Project: Adult

Key Dates

9/15/2023: Submit provider interest form to request application assistance and document review prior to submitting official application through the AHCCCS Online portal.

10/20/2023: Confirm that clinics under your organization's TIN will meet application requirements and submit an application through AHCCCS Online portal with all required Supporting Documentation by 5p.m. (MST/AZ Time).

10/20/2024: Implement required processes.

Application Requirements

By 5 p.m. (MST/AZ Time) **10/20/2023**, adult primary care organizations must submit the Targeted Investments 2.0 application through the AHCCCS Online portal and:

1. Attest by 10/20/2023 that at least **three** of the **five** Process Requirements:
   a. Will be implemented by all participating AHCCCS enrolled, non-specialty clinics under the Tax ID by **10/20/2024**. Attestation language and the ability to choose service addresses enrolled with AHCCCS will be provided in the portal, and
   b. Will continue to be implemented by all participating AHCCCS enrolled, non-specialty clinics under the Tax ID through **10/20/2025**.

2. Confirm that clinics under your organization's TIN have an EHR system capable of bi-directional data exchange with the HIE (Contexture). Participants can choose from one of the following to meet this requirement:
   a. **Option 1:** Organization already has an EHR system capable of bi-directional exchange of a core data set with Contexture:

      Applicants must upload a signed scope of work, dated no later than 10/20/2023, to connect the system to Contexture's new HIE platform once available.

      OR

   b. **Option 2:** Organization does not have an EHR system capable of bi-directional exchange of a core data set with Contexture:

      Applicants must upload a commitment letter, signed by the organization's Chief Executive Officer or individual in an equivalent position as of 10/20/2023, that identifies the EHR system and the intent to connect to Contexture's new HIE platform once available.

3. Upload required **Supporting Documentation** that include all mandatory **Supporting Documentation Elements** for each of the implemented Process Requirements with the application by **10/20/2023**.

** Important**

Individuals must access the AHCCCS Online portal to submit an application. The link to the TI 2.0 Application portal will only be visible to the organization's Master Account Holder or another AHCCCS Online User who is granted access by the Master Account Holder. Please note that Master Accounts are locked after 90 days of inactivity; Individual Accounts are deleted after 120 days of inactivity. If there are no active Master Accounts or User Accounts to promote, applicants must register for a new AHCCCS Online account at least a month prior to the application deadline to receive the authentication code via postal mail.

Application Assistance

Applicants are strongly encouraged to submit a TI 2.0 Provider Interest Form before 9/15/2023 to request a pre-application document review to confirm draft policies, protocols, and procedures contain the minimum elements prior to submitting the application. The application and documentation submitted through the portal is considered final- there will not be an opportunity to revise documentation to qualify for the program after the application deadline.

Process Requirements

Targeted Investments 2.0 builds upon the whole-person care initiative championed by the original Targeted Investments program. In addition to coordinating BH and PCP services, participants will: 1) build communication and referral protocols with community partners to address each individual's health-related social needs, and 2) conduct population-health analyses to identify and address inequities in health outcomes. In attempt to reduce barriers to participation while setting up the program participants for success, PCP and BH participants must demonstrate readiness and commitment to these initiatives by establishing foundational processes and procedures (i.e., Process Requirements) by the application deadline (10/20/2023). These processes do not need to be implemented until the end of TI 2.0 Year 2 (10/20/2024), as it is expected that these policies and workflows will be refined through milestone guidance and lessons learned throughout the year. Participants must continue these processes throughout Year 3 (10/20/2025) to remain eligible for the program.

Supporting Documentation

TI 2.0 applicants must upload their organization's policies and procedures that govern the required processes with the application. Uploaded documents must contain all Supporting Document Elements, defined in the following checklist, to meaningfully implement that required process. Supporting Documentation varies between organizations, so AHCCCS will be flexible in reviewing uploaded documents to confirm the supporting document elements are included regardless of the document name. Applicants are strongly encouraged to circle or highlight the areas that address these elements prior to uploading the document.

4. Each uploaded document must be a PDF, less than 10MB, and include an excerpt of the final policy, protocol, or procedure with the provider organization's name in the header.
5. Documents that contain the following will be rejected from the system and **will not count** as credit for that requirement:
    a. PHI—no examples are requested
    b. Tracked Changes or comments—must be final policies, protocols, and procedures as a PDF
    c. Photographs of documents—must be scanned, legible, PDF

Targeted Investments 2.0 participants must keep all information related to the TI 2.0 program for a period of seven years after the program ends due to the potential for post-pay audit. If you have questions, please email us at TargetedInvestments@azahcccs.gov.

Adult Primary Care Process Requirements & Supporting Document Elements

1.	**PROCESS REQUIREMENT: Procedures for screening all members for health-related social needs (HRSN) and other conditions affecting whole person health, and coordinating referrals and engagement with other providers serving that member or available to provide needed services to members, including communication protocols with accessible resources to ensure effective care coordination to meet members' comprehensive health needs.**

1.1 Uploaded HRSN screening procedures must:

- ☐ A) Include a blank copy of the screening tool or clinical assessment that includes all 8 domains: housing instability, food insecurity, unreliable transportation, interpersonal safety, utility assistance, employment instability, justice/legal involvement, and social isolation/support.
- ☐ B) Identify when (during the appointment, how often) HRSN screening occurs.
- ☐ C) Identify who administers the HRSN screening.
- ☐ D) Specify where screening results and the member's desire to be referred are documented
- ☐ E) Explain how the appropriate community service providers are, or will be, identified (e.g., using CommunityCares, maintaining an Excel sheet).
- ☐ F) Explain how community service referrals are sent.
- ☐ G) Explain how the community service provider registry is kept up to date for housing instability, food insecurity, transportation (e.g., maintaining an Excel sheet). Use of CommunityCares automatically satisfies this criterion.

1.2 Uploaded care coordination protocols must:

- ☐ A) Explain how members acute (primary care) and behavioral healthcare needs are identified.
- ☐ B) Explain how the organization coordinates referrals and treatment with internal and/or external healthcare providers.
- ☐ C) Explain how the organization coordinates follow-up with the member after discharge from hospital (e.g. use of HIE ADT alerts).

2.	**PROCESS REQUIREMENT: Identification of accountable position(s) to pursue whole person care and population health initiatives.**

2.1 Job description of accountable position(s) to manage whole person care and population health initiatives that:

- ☐ A) Identify the job title and describe the duties of the individual that is held accountable for ensuring the organization's staff are screening and referring, as appropriate, all members to resources that meet the individual's HRSN and BH needs. As long as this one person is ultimately responsible for the organization's related efforts, this one person may delegate related duties and/or have additional duties and responsibilities.
- ☐ B) Identify the job title and describe the duties of the manager that is held accountable for identifying health inequities amongst the organization's patient population and creating plans to address them. As long as this one person is ultimately responsible for the organization's related efforts, this one person may delegate related duties and/or have additional duties and responsibilities.

2.2 Uploaded initiative coordination protocols that:

- ☐ A) Describe how the responsible individual interfaces with the organization's leadership or executive management team to ensure initiatives related to health equity and whole-person care are aligned with, and prioritized within, the organization's strategic plan.
- ☐ B) Explain how the organization's activities and outcomes associated with health equity and whole-person care initiatives are communicated to staff that are screening members for health-related social needs.

3.	**PROCESS REQUIREMENT: Protocols for utilizing member-centered, culturally sensitive, evidence-based practices in trauma-informed care.**

3.1 Uploaded trauma-informed care protocols must:

- ☐ A) Identify the staff/positions responsible for screening patients for trauma.
- ☐ B) Describe the process of documenting screening results and the patient's desire to be referred-to follow up care.
- ☐ C) Identify external referral resources that provide (and/or explain how internal resources provide) culturally sensitive trauma-informed care once trauma has been identified.
- ☐ D) Describe the referral (external) and/or hand-off (internal) process to appropriately intervene when a positive screen is identified, and the member agrees to a referral.

3.2 Uploaded training documentation must:

- ☐ A) Describe annual TIC training requirements for staff responsible for TIC screening that include, at minimum, 3 hours of evidence-based training program per year.

4.	**PROCESS REQUIREMENT: Policies for identifying, tracking, and coordinating care for high-risk members, particularly those with identified social risk factors, to best allocate resources, reduce redundancies, and improve member experience.**
	4.1 Uploaded procedures that describe identification of high-risk members and tracking must: ☐ A) Describe the specific criteria considered to identify a high-risk member. ☐ B) Explain which sources are used to make data-informed decisions about member's high-risk status. ☐ C) Explain the format of the registry identifying high-risk members. ☐ D) Explain how and when the patient's risk level is re-evaluated. ☐ E) Identify staff/positions responsible for maintaining the high-risk registry. **4.2 Uploaded policy(s) to efficiently and effectively coordinate care for high-risk members must:** ☐ A) Identify and describe the minimum qualifications of the organization's internal care manager or external care management entity. ☐ B) Describe the duties and responsibilities of the care manager or care management entity. ☐ C) Describe the maximum number of high-risk members a care manager is responsible for (must be below 100 per FTE).

5.	**PROCESS REQUIREMENT: Policies that demonstrate how a psychiatric provider is readily available for consultation and processes that explain how the clinics collaborate with the consultant and other providers to manage the member's care.**
	5.1 Uploaded consultation policies must: ☐ A) Explain the organization's evidence-based approach for the PCP to connect with a behavioral health consultant (external) or internal behavioral health provider, similar to the Collaborative Care Model. **5.2 Uploaded referral and collaboration protocols must:** ☐ A) Describe procedures to document the psychiatric consultation in the member's chart or electronic health record. ☐ B) Describe referral and communication procedures for behavioral health and physical health providers to effectively share information that informs treatment. ☐ C) Explain processes for reliably transferring a member to an effective, higher level of behavioral health care as needed.