| Core Component | Review Criteria |
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| 1 - Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) | **A. Attest,** through the TI 2.0 Application Portal once available in Fall 2024, that the organization has attended 100% of the QICs in the program year. AHCCCS will track and review Year 2 QIC group meeting attendance records for demonstration of 100% attendance. **Participants do not need to upload or provide documentation to validate QIC attendance unless there is a discrepancy**. |
| | **B. Submit name(s),** through the TI 2.0 Application Portal once available in Fall 2024, of the individual(s) who have registered for the online learning platform and completed registration documentation (e.g., confirmation email message). **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**. |
| | **C. Attest,** through the TI 2.0 Application Portal once available in Fall 2024, that the organization has submitted complete, timely projects to the ASU TIPQIC team in the program year. ASU TIPQIC will confirm that the organization has submitted all TI online projects by established due dates and the deliverables meet minimum expectations. **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**. |

| Core Component | Review Criteria |
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| **2 - Plan and implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards** | **A. Upload** a completed National CLAS Standards implementation checklist, including a plan for implementing CLAS standards that are not yet in place. (i.e., standards for which the practice selected Planning to Implement or Not Planning to Implement at this Time). The plan must include:<br>☐ Organization review of standards 2-13 (2.2 through 2.13),<br>☐ The timeframe in which the practice aims to implement each standard,<br>☐ The individual(s) who leading implementation of each standard,<br>☐ A list of actions the practice is taking to implement each standard, and<br>☐ A description of additional resources the practice may need to implement each standard and how the practice plans to obtain such resources. |
| | **B. Upload** documentation that demonstrates how the practice recruits and supports a diverse practice team. The documents must include a description of:<br>☐ How the practice team reflects the diversity of the population the practice serves,<br>☐ How the practice's current recruiting and hiring processes support diversity,<br>☐ How the practice promotes diversity among various staff roles (e.g., clinical staff, practice management, clerical),<br>☐ At least one opportunity to improve diversity throughout the practice (e.g., conducting regular assessments of hiring, retention and workforce demographics) and the practice's plan to act on that opportunity (e.g., promoting mentoring opportunities; building diversity-related performance metrics into management and leadership job descriptions and goals)<br>☐ How the practice includes information on providing culturally and linguistically appropriate care in staff training materials, and<br>☐ How the practice offers and incentivizes completion of training (in person or virtual) to all employees on providing culturally and linguistically appropriate care.<br>Examples for how to improve recruitment of diverse staff include: development of community-based internships; collaboration with local schools, training programs and faith-based organizations; advertisement of job postings through minority job fairs, job boards and newsletters; development of job postings that are in multiple languages, use gender neutral language, and that consider lived experience; and updating the hiring process to blind-review resumes. |
| | **C. Attest,** through the TI 2.0 Application Portal once available in Fall 2024, that the processes described in 2B (Standards 2-4) have been implemented by 9/30/2024. **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**. |

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| | **D. NCQA ONLY - Upload** documentation that the practice expects will satisfy the requirements for:<br>☐ NCQA HE 1.A (Building a Diverse Staff), detailing:<br>☐ activities completed<br>☐ activities to be completed<br>☐ key milestones<br>☐ key dates for completion<br>☐ HE 1.B. (Promoting DEI amongst staff), detailing:<br>☐ activities completed<br>☐ activities to be completed<br>☐ key milestones<br>☐ key dates for completion<br>AHCCCS will confirm it meets other milestone elements (at minimum) and provide suggestions for what additional documentation NCQA may be looking for. |

| Core Component | Review Criteria |
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| **3 - Implement a process for screening addressing health-related social needs (HRSN)** | **A. Upload** documentation that outlines how the practice educates the member, obtains consent, performs HRSN screening and discusses screening results. The documents must include:<br>☐ The name of the screening tool and included domains (containing, at minimum: housing instability, utility assistance, food insecurity, transportation needs, interpersonal safety, employment, and justice involvement, ). If the HRSN screening is combined with other intake or screening tools, provide a copy.<br>☐ The languages in which the screening tool is available;<br>☐ A description of the population from whom data are being collected;<br>☐ When data are being collected (e.g., prior to the visit, during the visit);<br>☐ Where data are being collected (e.g., in the waiting room, in the visit room);<br>☐ How data are being collected (e.g., paper form, electronic survey);<br>☐ Who collects data/conducts the screen (e.g., community health worker, medical assistant);<br>☐ A script (if the screen is administered live) and/or written description (if the screen is administered through a survey) that explains for the member/family/caregiver:<br>☐ why the practice is conducting the screening, |

- ☐ how the information will be used,
- ☐ how the information will be shared,
- ☐ what happens if a need is identified, and
- ☐ how the practice will obtain and document member consent for performing the screening. This must include educating members of the option to opt out of screening;

☐ The practice's process for reducing over screening of members that have recently been screened by a partner organization (e.g., MCO, community service provider) and for which the practice has complete screening data;

☐ How the practice confirms the screening results correctly identify all of the member's HRSN;, and

☐ How the practice obtains member consent to referrals to a resource or intervention.

**B. Upload** documentation on the practice's process to document screening and referral results in the practice EHR. The documents must include:

☐ The practice's policies for appropriately documenting a positive screen in the EHR (e.g., if practice chooses to document the level of severity for an HRSN, it should be able to aggregate data to provide a yes/no assessment as to whether the member has a positive need).

☐ The practice's process for documenting the components from 3A in the EHR.

**C. Attest,** through the TI 2.0 Application Portal once available in Fall 2024, that G and Z codes are utilized to document screening and referral details through claims by 9/30/2024. **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**.

**D. Upload** documentation on the practice's process to protect data sharing and confidentiality. The documents must include:

☐ Information on which practice staff can access which level of data and how the practice periodically updates such access,

☐ Policies for how access to data may vary based on device (e.g., laptop, cell phone, paper records),

☐ Policies for how the practice protects data based on device (e.g., password protection policies for electronic data, locks to limit access to physical data),

☐ Details on permissible and impermissible use of data, and

☐ Information on how the practice communicates with members about its policies and procedures around maintaining the privacy and security of individual data.

**E. NCQA ONLY - Upload** documentation that the practice expects will satisfy the requirements for:

☐ NCQA HE 2.F (Privacy Protections for Data), detailing:

- ☐ activities completed
- ☐ activities to be completed

- ☐ key milestones
- ☐ key dates for completion

☐ NCQA HE 2.G (Notification of Language Services), detailing:

- ☐ activities completed
- ☐ activities to be completed
- ☐ key milestones
- ☐ key dates for completion

AHCCCS will confirm it meets other milestone elements (at minimum) and provide suggestions for what additional documentation NCQA may be looking for.

**F. Upload documentation on the practice's processes to maintain a registry of community service providers. If the organization is using the Arizona CommunityCares system or another CLRS, upload:**

☐ A signed scope of work to use of the Arizona CommunityCares closed loop referral system or attestation that all members are covered under an MCO, ACO, or CIN with a sponsored closed-loop referral system (i.e., the system's resources are maintained by an external entity) automatically satisfies this criteria.

**G. If the organization is not using the Arizona CommunityCares system, upload:**

☐ Signed attestation from a senior practice leader that the practice has developed and is actively maintaining a registry of CBOs in the practice service area. The practice should upload the most recent registry of CBOs with the attestation.

☐ A current copy of the CBO registry.

☐ The practice's process for selecting community service providers with which to establish agreements. The documents must, at a minimum, include a description of how the practice performs assessments of:

- ☐ whether the community service provider delivers services that address social needs that are prevalent within the practice population,
- ☐ whether the community service provider has the capacity and capability to serve the practice's members, and
- ☐ whether the community service provider delivers specialized services for a specific subpopulation that aligns with the provider's member population (note: it may not always be feasible to select such partners).

*Participants are not required to satisfy 3G if using CommunityCares for this milestone.

| Core Component | Review Criteria |
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| **4 - Connect to and demonstrate effective use of the statewide closed loop referral system (CommunityCares), or other closed loop referral system(s) that can report referral-level information** | **A. Upload** the practice's CommunityCares scope of work and onboarding plan. Documentation must include:<br>☐ The plan and timeline for onboarding the practice onto the platform (e.g., establish legal partnerships, create user accounts, develop custom reports and/or screening tools) and<br>☐ The plan and timeline for training providers on how to use the platform and troubleshooting any issues that arise with the platform (e.g., issues making or checking the status of a referral). |
| | **B. Upload** a signed attestation from senior practice leadership (e.g., medical lead, financial lead, lead executive, or other practice leadership) that team members have accounts to log into CommunityCares. Must include:<br>☐ The name(s) and title(s) of practice team member(s) who have accounts to log into CommunityCares,<br>☐ The name and title of the individual who will serve as the administrator responsible for generating reports using CommunityCares data, and<br>☐ The name, role, and signature of the senior practice leader. |
| | **C. Upload** documentation identifying the team member(s) responsible for utilizing the administrative functions of CommunityCares, including:<br>☐ Periodically updating information about practice operations:<br>☐ team member(s) responsible,<br>☐ the frequency of these updates,<br>☐ the specific data the practice updates, e.g., office hours, including weekend and after-hours availability, address, telephone number, service offerings (e.g., primary care, behavioral health care),<br>☐ cultural and linguistic capabilities, including languages (including American Sign Language) offered by the practice, either by providers or skilled medical interpreter (indicate if the interpreter is onsite or offsite), availability to accept referrals),<br>☐ website URL, and<br>☐ whether the practice location has accommodations for individuals with physical disabilities, including in offices, exam room(s), equipment.<br>☐ Generating reports: |

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| | ☐ team member(s) responsible<br>☐ the types of reports that the practice generates (e.g., most common member needs, number of types of referrals made, individuals who are making referrals, referral status), and<br>☐ the frequency each report is generated. |
| | **D. Upload** documentation that describes the practice's policies and procedures for using CommunityCares and/or other MCO, ACO, or CIN HRSN referral programs, as appropriate to make electronic service referrals to CBOs. Documentation must include:<br>☐ How to request and document consent from patient to share information and refer to CBO for services;<br>☐ Description of explanation to member/family/caregiver of steps to expect once a referral is made;<br>☐ Description of practice process for making electronic referrals, including determining the need for referral based on screening results, member/family/caregiver consultation and consent, practice team member responsible for making referral, practice workflows for making and documenting referrals<br>☐ Description of process upon notification of fulfillment from CBO, including how the information will be transmitted to the practice and process for documenting referral into member's EHR.<br>☐ **If using a system other than CommunityCares:** Documentation of processes to send referral data to AHCCCS, including: AHCCCS ID, date screened, screening results, referral to (community service provider), referral date, referral method (e.g., telephone), and current referral status.<br>☐ **If leveraging an MCO, ACO, or CIN referral program reports:** Documentation of an implemented data sharing agreement and processes for the entity to send screening and referral data, as described above, to AHCCCS on a monthly basis by 4/30/2025. |

| Core Component | Review Criteria |
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| **5 - Identify health inequities prevalent within the population attributed to the practice and implement plans to reduce them** | **A. Submit** a completed AHCCCS Health Equity Collaboration Analysis using the template provided by AHCCCS via Google Form or submitting the completed xls to TargetedInvestments@azahcccs.gov. Due 5/31/2024. |
| | **B. NCQA ONLY - Submit** an update on compliance with all required HE Accreditation elements applicable to providers as listed on the formal gap analysis and any relevant information related to the gap analysis, including initial findings, key dates, completed activities, remaining activities, etc. Due 7/31/2024.<br><br>**AHCCCS will provide the template before July, 2024**. Participants can prepare by reviewing the NCQA Gap Analysis tool in the NCQA IRT portal. NCQA will demonstrate how to use the IRT portal in a workgroup this May. |
| | **C. Upload** documentation that demonstrates the practice's process for collecting, documenting and maintaining member-reported demographic data for race/ethnicity, primary language, disability status, geography, sex assigned at birth, gender identity and sexual orientation. The documents must include:<br>☐ Process for collecting these data from members (i.e., when data are being collected, where data are being collected, how data are being collected, who collects the data, the questions and/or script being used to collect the data, which should include an explanation to the member of why the data are being collected, how data will be used, how it will not be used, and with whom it will be shared and for what purpose(s)),<br>☐ Processes for reconciling differences in the member's EMR between the most recent member-reported data vs. data reported by AHCCCS and/or health plans,<br>☐ Procedures for sharing demographic data with members of the care team (i.e., information on which practice staff can access which level of data, how access to data may vary based on device, how the practice protects data based on device, permissible and impermissible use of data and how the practice communicates with members and updates its policies and procedures related to data sharing and confidentiality), and<br>☐ Screenshots of the fields in the practice EHR and intake forms to document each of the demographic variables for which the practice collects data, including the question format as well as the member response options for each variable, confirming:<br>☐ response options align with statewide data standards where specified by AHCCCS and<br>☐ if applicable, the timeframe in which changes will be made to align with these standards. |

**AHCCCS will define these standards consistent with Federal and State guidance in the Summer, 2024**. Participants will have a reasonable timeframe to implement these changes.

**D. NCQA Only - Upload** documentation that the practice expects will satisfy the requirements for:

- ☐ NCQA HE 2.A (Systems for Individual-Level Data), detailing:
  - ☐ activities completed
  - ☐ activities to be completed
  - ☐ key milestones
  - ☐ key dates for completion
- ☐ NCQA HE 2.B (Factor 1) [Collection of Data on Race/Ethnicity - Direct Collection of Data from All Individuals], detailing:
  - ☐ activities completed
  - ☐ activities to be completed
  - ☐ key milestones
  - ☐ key dates for completion
- ☐ NCQA HE 2.C (Factor 1) [Collection of Data on Language - DIrect Collection of Language Needs from All Individuals], detailing:
  - ☐ activities completed
  - ☐ activities to be completed
  - ☐ key milestones
  - ☐ key dates for completion
- ☐ NCQA HE 2.D (Collection of Data on Gender Identity), detailing:
  - ☐ activities completed
  - ☐ activities to be completed
  - ☐ key milestones
  - ☐ key dates for completion
- ☐ NCQA HE 2.E. (Collection of Data on Sexual Orientation), detailing:
  - ☐ activities completed
  - ☐ activities to be completed
  - ☐ key milestones
  - ☐ key dates for completion

AHCCCS will confirm it meets other milestone elements (at minimum) and provide suggestions for what additional documentation NCQA may be looking for.

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| | **E. Upload** documentation that demonstrates the practice's policies and procedures for stratifying performance on quality incentive measures using clinical data stratified by (a) member-reported demographic data (i.e., the variables specified in milestone 5.C) and/or (b) HRSN data collected in milestone 3 in the practice EHR. Practices should report stratified performance for all subpopulations, regardless of the size of the denominator. Documentation must include:<br>☐ Description of the source of referenced data (e.g., EMR, MCO gap-reports), including:<br>☐ frequency of receiving the data<br>☐ processes to pull or otherwise receive the data<br>☐ Description of how, if more than one source is used, the data are matched from one system to another (i.e. "primary index")<br>☐ Description of how stratified metrics are generated (e.g., which EMR report)<br>☐ If an ACO/CIN is assisting the practice with this effort, describe:<br>☐ how each ACO/CIN supports the clinic for mutual members<br>☐ how the practice completes this effort for AHCCCS members not enrolled with the ACO/CIN. |
| | **F. NCQA Only - Upload** documentation that the practice expects will satisfy the requirements for:<br>☐ NCQA HE 6.A (Reporting Stratified Measures), detailing:<br>☐ activities completed<br>☐ activities to be completed<br>☐ key milestones<br>☐ key dates for completion<br>☐ NCQA HE 6.B (Use of Data to Assess Disparities), detailing:<br>☐ activities completed<br>☐ activities to be completed<br>☐ key milestones<br>☐ key dates for completion<br>AHCCCS will confirm it meets other milestone elements (at minimum) and provide suggestions for what additional documentation NCQA may be looking for. |

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| **6 - Tobacco Cessation** | **A. Attest,** through the TI 2.0 Application Portal once available in Fall 2024, that each TIP2.0 Justice clinic has a tobacco cessation champion (including virtual). **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**. |
| | **B. Upload** documentation describing the communications and information-sharing process between staff trained in tobacco cessation counseling and the justice clinic's tobacco cessation champion/relevant leadership. Documentation must describe:<br>☐ Name(s) and position(s) of staff who completed the tobacco cessation training, the name of the training program(s), and the date(s) of the program(s) attended.<br>☐ Processes for how the tobacco cessation champion ensures tobacco cessation programming and counseling are being administered according to the training and established standards (including virtual). |
| | **C. Upload** documentation describing the clinic's processes for offering evidence-based tobacco counseling and treatment to members and informing other reentry coordinators. Documentation must include:<br>☐ The name(s) of the evidence based tobacco counseling program(s) utilized, (e.g., motivational interviewing, the 5 A's, the 5 R's, ASHLine training).<br>☐ How the clinic provides tobacco counseling and treatment virtually or otherwise promotes accessibility to all members, and<br>☐ How the tobacco cessation specialist and/or TIP Justice Clinic Re-entry team (core component 7) educates the MCO justice liaisons, justice transition teams within the detention center, and any other entity involved with coordinating the individual's reentry about the services desired by that individual and availability of the service generally. |

| Core Component | Review Criteria |
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| **7 - Early Reach-In** | **A. Upload** documentation that outlines how the justice clinic will work independently or with MCO justice liaisons and/or with medical personnel within the detention center to coordinate reentry. Documentation must:<br>☐ Describe how the clinic is notified of the incarcerated individuals warranting a reach-in from that clinic.<br>☐ Describe how the clinic interfaces or otherwise coordinates engagement with the individual during incarceration (including virtual).<br>☐ Identify the HRSN screening tool used during reach-in. If different from the HRSN screening tool and methodology specified in milestone 3, include a blank copy of the screening tool. |

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| | ☐ Describe how the staff engaging the individual during incarceration is documenting whether the individual has an existing relationship with a primary care organization and/or a behavioral health organization. If no, identify the process the clinic will take to connect an individual to a primary care provider and/or behavioral health organization.<br>☐ Describe how staff are reviewing and updating the individual's contact information and sharing with entities involved with the individual's reentry as appropriate.<br>☐ Share any identified health needs that were not previously identified during the individual's intake assessment or referral to the justice clinic with entities still involved with the individual's reentry.<br>It is reasonable for justice clinic policies and procedures to vary based on the detention center jail. |
| | **B. Upload** documentation that describes how the justice clinic will coordinate with MCO justice liaisons and Justice Transition Planners in each detention center with which the clinic works to share any relevant health information. The documents must include:<br>☐ The name(s) and position(s) of justice clinic staff who are responsible for sharing the relevant health information and<br>☐ The frequency with which the justice clinic staff will outreach with the MCO justice liaisons and Justice Transition Planners. |