1	**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.** **15% of Annual Payment**	
	Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
	By September 30, 2024, attest that: A. The organization's representative must have attended 100% of the Year 2 QIC group meetings (February 5, 2024; May 9, 2024; August 8, 2024). B. One representative from the participating organization has registered for the online learning platform. C. The organization's representative has submitted a TI online project representing at least one project for each area of concentration by the required due dates that meet minimum scoring rubric requirements. Organizations participating in multiple areas of concentration may satisfy the milestone for two areas of concentration with the same age cohort (e.g., Adult BH and Adult PCP). Online Project instructions are accessible through Canvas.	*By September 30, 2025, attest that:* D. The organization's representative must have attended 100% of the Year 3 QIC group meetings. E. One representative from the participating organization has registered for the online learning platform. F. The organization's representative has submitted a TI online project representing at least two projects for each area of concentration by the required due dates that meet minimum scoring rubric requirements. Organizations participating in multiple areas of concentration may satisfy the milestone for two areas of concentration with the same age cohort (e.g., Adult BH and Adult PCP).

Core Component 1 Specifications	
System Collaboration Opportunities	Health Plans, Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs) (collectively defined henceforth as Networks), participating providers, community service providers, subject matter experts, and other stakeholders are encouraged to join the QIC discussions. Networks may be able to assist participants with projects (e.g., root cause analyses).
Additional Resources	TIPQIC website

2	**Implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards, developed by the U.S. Department of Health and Human Services Office of Minority Health. Implementation shall include:** **1. Completing an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place.** **2. Building and supporting a culturally and linguistically diverse practice team.** **3. Offering language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of attributed members.** **4. Designing, implementing and improving programs that provide culturally appropriate services that meet the needs of the attributed members.** **10% of Annual Payment**	
	Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
	By September 30, 2024: A. Upload the completed National CLAS Standards implementation checklist and a plan for implementing CLAS Standards that are not yet in place. B. Upload documentation demonstrating how the practice recruits and supports a culturally and linguistically diverse practice team. C. Attest that the processes described in milestone 2B (Standards 2-4) have been implemented by 9/30/2024. D. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 1.A and b. NCQA HE 1.B.	*By September 30, 2025:* E. Upload documentation demonstrating how the practice implements CLAS Standards 5-13. F. Attest that the processes described in milestone 2E have been implemented by 9/30/2025. G. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 3.A, b. NCQA HE 3.B, c. NCQA HE 3.C, d. NCQA HE 3.D, e. NCQA HE 5.A (Factors 1-5), f. NCQA HE 5.B, and g. NCQA HE 6.D (Factors 2, 4, and 6).

Core Component 2 Specifications	
System Collaboration Opportunities	Entities are responsible for implementing CLAS standards specific to the patient population they are responsible for. Practices are responsible for their attributed members, Plans are responsible for their enrollees, and AHCCCS is responsible for all members. Although Plans and AHCCCS have the largest responsibility, experience in this work, and resources to efficiently correspond with all members, providers are best equipped to collect patient and provider attributes. Communicating to the member that there is an adequate network of diverse and culturally competent providers increases their comfortability in seeking services.
Additional Resources	AZ CLAS Supplemental Toolkit (ADHS)
Methodology	Provider attribution is consistent with the methodology used for performance measures (currently TI 1.0 Y6 methodologies). Generally: PCP participants are responsible for members seen for primary care services and patients empaneled-to but not seen by the practice when the patient does not seek PCP services from another outpatient facility, BH participants are responsible for members seen by the organization for outpatient services (excluding crisis response and SMI evaluations as identified through claims) in the past 24 months, and Justice participants are responsible for members referred to the clinic from a justice partner or health plan in the previous 24 months. AHCCCS and ASU welcome feedback to improve these attribution methodologies in a standardized format with available data (e.g., "we'll send you a list of members" satisfies neither criteria). AHCCCS requires Health Plans to reconcile PCP assignment with the member's claims history by October, 2024 (and quarterly thereafter).
Examples	**Practices can meet this milestone in many ways, but should roughly approximate the level of effort described in the following example.** **Example:** an organization identifies through analyses of its patient population that its American Indian populations have lower rates of diabetes control compared to the population average. The organization interviews patients and local community organizations and identifies that American Indians experience challenges going to their providers' office and, once they arrive, they do not feel that providers consider their preferences. The organization requires cultural competence training for all practice staff to better understand the patients' concerns and preferences before developing a treatment plan. The organization also partners with local American Indian organizations to hold regular pop-up clinics in the community where patients can go to receive education, routine screening, and treatment for diabetes.

3	**Implement a process for screening for health-related social needs (HRSN) and connecting members seen to CBOs to address individual social needs. Implementation shall include:** **1. Screening 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.** **2. Documenting screening results in the member's Electronic Health Record (EHR) and claims (i.e. G codes and Z codes) and establishing processes to maintain confidentiality of patient data.** **3. Identifying, selecting and establishing partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. Practices should prioritize relationships with CBOs that address social needs that are prevalent within the practice population.** **4. Developing referral and communication processes with each CBO to refer members for community resources and/or interventions using the statewide closed-loop referral system (CommunityCares) or other mediums as preferred by the CBO.** **5. Making referrals to and tracking the status of member referrals to CBOs to ensure receipt of services and/or interventions.** **6. Ensuring practice team members are effectively sharing and receiving referral data from CBOs, through CommunityCares or other means.** **7. If utilizing a network sponsored closed loop referral system, the MCO, ACO, or CIN can demonstrate TI participating providers' compliance with items 3-7 for their contracted MCOs by sending reports of HRSN screening and referral data to AHCCCS. Clinics contracted with any health plans not covered under an ACO or CIN (or under an MCO, ACO, or CIN without a sponsored closed loop referral system) must work directly with CBOs to achieve items 3-7 (e.g., mutually developed referral processes for members not managed by the MCO, ACO, or CIN).** **20% of Annual Payment**

Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
By September 30, 2024: A. Upload documentation that outlines how the practice educates the member, obtains consent, performs HRSN screening and discusses screening results. B. Upload documentation on the practice's process to document screening and referral results in the practice EHR. C. Attest that G and Z codes are utilized to document screening and referral details through claims by 9/30/2024.	*By March 31, 2025:* H. Attest that all the organization's participating practices screened and documented results for at least 85% of the population seen by the practice between October 1, 2024 and March 31, 2025 using the specified HRSN screening tool and processes outlined in milestone 3.A. I. Attest to establishing mutually developed referral and communication protocols with each community service provider satisfying (at least) the domains above and/or referral and communication protocols with each Network with a sponsored closed-loop referral system.

	D. Upload documentation on the practice's process to protect data sharing and confidentiality. E. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 2.F b. NCQA HE 2.G F. Upload documentation on the practice's processes to maintain a registry of community service providers through CommunityCars or another CLRS (N/A if no CLRS are utilized). G. Upload documentation on the practice's processes to maintain a registry of community service providers through methods other than a CLRS (N/A if CLRS are utilized).	J. Attest that the practice is actively referring members to CBOs through their preferred medium, appropriately sharing data, and following up on the status of those referrals- including processes related to an MCO, ACO, or CIN sponsored closed loop referral system. By September 30, 2025: K. Based on an assessment of the practice's full population **or a** practice record review of a random sample of at least 20 members that wanted to receive assistance with an identified HRSN, attest that practice made referrals for at least 85% of the population between April 1, 2025 and September 30, 2025.

Core Component 3 Specifications	
System Collaboration Opportunities	Practices are responsible for HRSN screening and referrals of the members they see unless the member has already been screened in the year and no significant changes have occurred since the last screening (as determined by the provider) and documenting the screening and referral results in the member's electronic medical record. Some Networks have already developed screening and referral systems to reduce administrative burden for participating providers and MCOs. Networks, Community Cares, and the 211 program can help providers identify local community resources. Providers can help AHCCCS and networks assess the impact of HRSN and access to resources to members' overall health by identifying screening results and referral status through claims. These analyses help CBOs demonstrate efficacy of their programs to stakeholders (e.g., donors) and AHCCCS demonstrate efficacy of the Targeted Investments 2.0 program to Centers for Medicare & Medicaid Services (CMS).
Additional Resources	CMS recommended list of Z codes, AHCCCS Community Cares webpage, Contexture Community Cares webpage, Solari 211 program
Methodology (Seen patients who needed screening)	The performance rate should be calculated as follows: (practice patients seen for which a screening was performed and documented between 10/1/2024 and 3/1/2025) / (total patients seen* by the practice between 10/1/2024 and 3/1/2025). Note: The numerator may include patients the practice has seen with a documented screening even if the screening was performed by a health care partner. If the practice has documentation of an individual opting out of a screening, that individual should be included in the calculation of the performance rate. *Members seen is defined as members served at a participating clinic in the program year, unless another time period is specified, for an outpatient service excluding crisis response services and SMI-evaluations as identifiable through claims.
Signed Scope of Work	A signed scope of work to use of the Arizona CommunityCares closed loop referral system (i.e. Core Component 3) 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.
CBO Payment	The TI 2.0 program does not change the way community service providers are paid. Also, community service providers and CBOs are not required to be credentialed by managed care organizations to perform the activities envisioned for TI 2.0.

Methodology (Screened patients who desired a referral)	The performance rate should be calculated as follows: (practice patients seen* for which a screening identified a need and the patient expressed a desire for assistance and for which the practice made a referral) / (all practice patients seen, between 4/1/2025-9/30/2025 whose screening identified a need for which the individual sought assistance.) *Members seen is defined as members served at a participating clinic in the program year, unless another time period is specified, for an outpatient service excluding crisis response services and SMI-evaluations as identifiable through claims.

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 details, to connect members seen to community resources. Implementation shall include:** **1. Completing a CommunityCares scope of work.** **2. Ensuring practice team members can access and generate reports in Community Cares.** **3. Documenting screening data in CommunityCares 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).** **4. Effectively documenting relevant data from CommunityCares and other MCO, ACO, or CIN sponsored closed loop referral system(s) (as applicable) into the practice EHR.** **5. Making referrals for services that address HRSNs (internal and external) and demonstrating effective follow-up on referrals through CommunityCares 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.** **6. If utilizing an MCO, ACO, or CIN sponsored closed loop referral system, the MCO, ACO, or CIN can demonstrate participating providers' compliance for their contracted MCOs by sending reports of HRSN screening and referral data to AHCCCS. Clinics contracted with any health plans not covered under an ACO or CIN (or under an MCO, ACO, or CIN without a sponsored closed loop referral system) must use CommunityCares to satisfy the milestone.** **15% of Annual Payment**

Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
By September 30, 2024: A. Upload the practice's CommunityCares scope of work and onboarding plan. 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. C. Upload documentation identifying the team member(s) responsible for utilizing the administrative functions of	*By March 31, 2025:* E. Attest that all the organization's participating practices screened and documented results for at least 85% of the population seen by the practice between October 1, 2024 and March 31, 2025 using the specified HRSN screening tool and processes outlined in milestone 2.A and 2.D. *By September 30, 2025:* F. Attest that the practice has added information about practice operations and generated at least one practice-level report between

	CommunityCares, including periodically updating information about practice operations and generating reports. 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.	October 1, 2024 and September 30, 2025. If a practice-level report is unavailable, a system-level report with processes to evaluate at the practice/ regional level will suffice. G. Based *on an assessment of the practice's full population or a practice record review of a random sample of at least 20 members that wanted to receive assistance with an identified HRSN*, attest that practice made referrals in the CommunityCares system for at least 85% of the population between April 1, 2025 and September 30, 2025. **OR** H. Practices participating in an MCO, ACO, or CIN program that is currently screening for and identifying member requested assistance for HRSNs may satisfy the milestone by using the MCO, ACO, or CIN closed loop program as long as: a. The ACO/CIN program provides a report, as specified by AHCCCS, for all members referred for HRSN needs- at least one per clinic, AND b. The practice utilizes Community Cares to refer members not enrolled with a plan covered by the ACO/CIN (or enrolled under an MCO, ACO, or CIN without a sponsored closed loop referral system).

Core Component 4 Specifications	
System Collaboration Opportunities	Practices are responsible for HRSN screening and referrals of the members they see unless the member has already been screened in the year and no significant changes have occurred since the last screening (as determined by the provider) and documenting the screening and referral results in the member's electronic medical record. Some Networks have already developed screening and referral systems to reduce administrative burden for participating providers and Health Plans. Networks, Community Cares, and the 211 program can help providers identify local community resources. Providers can help AHCCCS and networks assess the impact of HRSN and access to resources to members' overall health by identifying screening results and referral status

	through claims. These analyses support community service providers demonstrate efficacy of their programs to stakeholders (e.g., donors) and AHCCCS in demonstrating efficacy of the Targeted Investments 2.0 program to CMS. AHCCCS further incentivizes providers participating in the Differential Adjusted Payments (DAP) program that utilize the Community Cares system via rate increases (providers may participate in TI 2.0 and DAP simultaneously).
Additional Resources	**AHCCCS Community Cares webpage**, **Contexture Community Cares webpage**, **Solari 211 program**, **AHCCCS Differential Adjustment Payments program (requirements updated annually)**
Methodology (Seen patients who needed screening)	The performance rate will be calculated as follows: (practice patients for which a documented screening was performed between 10/1/2024 and 3/1/2025) / (total patients seen* between 10/1/2024 and 3/1/2025). Note: The numerator may include patients with a documented screening even if the screening was performed by a health care partner. *Members seen is defined as members served at a participating clinic in the specified time period for an outpatient service excluding crisis response services and SMI-evaluations as identifiable through claims.
Methodology (Screened patients who desired a referral)	The performance rate should be calculated as follows: (practice patients seen* between 4/1/2025 and 9/30/2025 whose screening identified a need and who expressed a desire for assistance and for which the practice made a referral in Community Cares) / (all practice patients seen* between 4/1/2025 and 9/30/2025 whose screening identified a need for which the individual sought assistance). *Members seen is defined as members served at a participating clinic in the specified time period for an outpatient service excluding crisis response services and SMI-evaluations as identifiable through claims.
Example	Internal Referral: Referring a member to an in-house food pantry to receive a food box directly at the clinic. Internal referrals to social workers that refer to an external community provider to render the service do not qualify as an internal referral.

5 **Identify health inequities and health-related social needs (HRSNs) prevalent within the population attributed to the practice and implement plans to reduce identified inequities. Identification and implementation shall include:**

1. **Collecting 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.**
2. **At least annually stratifying 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.**
3. **Developing and implementing 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; CommunityCares data; Health Information Exchange data; and state, regional and/or national data for benchmarking purposes.**

20% of Annual Payment

Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
By May 31, 2024: 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. *By July 31, 2024:* B. NCQA ONLY- 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. *By September 30, 2024:* 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.	*By March 31, 2025:* G. Upload documents demonstrating the practices's process for creating a health equity plan to reduce identified inequities. H. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for NCQA HE 6.D (Factors 1, 3, 5). *By September 30, 2025:* I. Upload documents demonstrating the practice's processes for routinely evaluating the results from the implemented intervention to reduce identified inequities and revising the health equity plan to improve it.

	D. NCQA Only- Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 2.A b. NCQA HE 2.B (Factor 1) c. NCQA HE 2.C (Factor 1) d. NCQA HE 2.D e. NCQA HE 2.E E. Upload documentation that demonstrates the practice's policies and procedures for stratifying performance on quality incentive measures using clinical data stratified by a. (a) member-reported demographic data (i.e., the variables specified in milestone 5.C) and/or b. (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. F. NCQA Only - Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 6.A b. NCQA HE 6.B	

Core Component 5 Specifications	
System Collaboration Opportunities	Providers can collect demographic and HRSN information directly from the member and provide the most reliable data to AHCCCS and Networks to complete health equity analyses within their populations. Networks can help providers identify inequities in existing value-based incentives by joining demographic data to regular reports (e.g., adding patient ethnicity to a well-gap report). AHCCCS provides demographic information collected in the enrollment process to Networks and Providers and seeks to improve data reliability by validating with other sources. AHCCCS and Networks can identify specific factors significantly correlated with inequitable outcomes to refine policies, create campaigns, and provide targeted outreach. All entities can coordinate patient correspondence (e.g., mailers) to deduplicate and optimize successful engagement of

	specific individuals or communities in need. TIPQIC will stratify performance measure dashboards and discuss system-level trends to help all entities identify health inequities. TIPQIC and Contexture can help providers leverage their EHR system reporting to internally evaluate health inequities efficiently.
Additional Resources	CMS Health Equity Resource Center, NCQA Health Equity Resource Center
Methodology	Provider attribution is consistent with the methodology used for performance measures (currently TI 1.0 Y6 methodologies). Generally: PCP participants are responsible for members seen for primary care services and patients empaneled-to but not seen by the practice when the patient does not seek PCP services from another outpatient facility, BH participants are responsible for members seen by the organization for outpatient services (excluding crisis response and SMI evaluations as identified through claims) in the past 24 months, and Justice participants are responsible for members referred to the clinic from a justice partner or health plan in the previous 24 months. AHCCCS and ASU welcome feedback to improve these attribution methodologies in a standardized format with available data (e.g., “we’ll send you a list of members” satisfies neither criteria). AHCCCS requires Health Plans to reconcile PCP assignment with the member’s claims history by October, 2024 (and quarterly thereafter).

6	**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.** **A. 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.** **B. Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data, and to identify whether the member has practice-level care management services provided by another provider.** **C. Identifying when an attributed member becomes pregnant or gives birth.** **D. Notifying the member's health plan when the notification of pregnancy or birth was not generated by the health plan.** **E. Engaging caregiver(s) and guardian(s) for a follow-up appointment within 84 days.** **F. Educating the present caregiver(s) and guardian(s) about postpartum depression and anxiety.** **G. Screening present caregiver(s) and guardian(s) for postpartum depression and anxiety using appropriate evidence-based tools and documenting the results and discussion.** **20% of Annual Payment**	
	Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
	By September 30, 2024: A. Employ one behavioral health provider or prescriber (LPC, Psychologist, LCSW, LMFT, or physician) with a certification in Perinatal Mental Health per five participating clinics. Participants with less than five participating clinics must have one per 100 pregnant members. Participants with less than three participating clinics may utilize an external BHP with PMH-C (including virtual) instead of directly certifying their own staff. B. Identify the names and NPIs of providers/ prescribers trained and the names of provider organizations with which the site has developed communication and care management protocols.	*By September 30, 2025:* G. Based on a practice record review of a random sample of at least 20 Adult members whom the practice has newly identified as a caregiver of a newborn and as having received primary care services internally or a referral from an external provider:

	C. Document that the protocols cover how to: a. Receive referrals and prioritize follow-up with postpartum members by a provider or prescriber certified in PMH[1], b. Conduct warm hand-offs, c. Handle crises, d. Share information, e. Obtain consent, and f. Engage in provider-to-provider consultation. D. Develop policies and procedures related to identifying members that have become pregnant or given birth and notifying health plans when the notification of pregnancy or birth was not generated by the MCO. E. Develop policies and procedures related to engaging caregiver(s) and guardian(s) for a follow-up appointment within 84 days of childbirth. F. Develop policies and procedures related to anxiety and depression screening after childbirth, including: a. Educating the present caregiver(s) and guardian(s) b. about the prevalence of anxiety and depression after childbirth and the importance of seeking appropriate services.	a. If the behavioral health practice is co-located with primary care [including co-located via telehealth] attest that a warm hand-off[2] by a provider or care manager, behavioral health technician, or other licensed professional to a licensed professional, consistent with the practice's protocol, occurred 85% of the time. Appointments scheduling may be conducted by whomever the practices determine. b. If the practice is not co-located attest that these processes were followed for postpartum referrals that contained the information specified in the communication protocol 85% of the time, and that the member is outreached in person or telephone regarding the shared information and the referral status within 72 hours.

[1] Services can be provided by telehealth consistent with Arizona regulation.
[2]Warm handoff: The licensed behavioral health provider directly introduces the patient to the primary care provider at the time of the behavioral health visit.

	c. Using norm or -criterion- referenced screening tools to assess anxiety and depression for all present and appropriate caregivers during pregnancy or within one year of becoming a caregiver (e.g., birth of child). Norm-criterion-referenced screening tools specific to PPD, such as the Edinburgh, should only be administered to the used on a birthing parent. Practices should use other depression screening tools (e.g., PHQ-9) , while a screening tool approved for adults in general could be used for a non-birthing parent/caregiver. d. Documenting, in the member's electronic health record, which caregiver(s) and guardian(s) are present, the screening tool(s) used, discussion of the screening result(s) with the caregiver(s) and guardian(s) and referral details as appropriate.	

Core Component 6 Specifications	
System Collaboration Opportunities	TI Pediatric (Peds) PCP and Adult PCP participants must develop coordination and referral protocols with behavioral health resources to follow-up to a positive screen. MCOs can help identify BH providers in-network and distinguish those with perinatal mental health certification (PMH-C). TI participants can collaborate with other providers (e.g., hospitals, Pediatric providers) to be notified when an adult member gives birth. TI participants and MCOs can work with Contexture to leverage lab results that flag potential pregnancies. MCOs may create or enhance existing notification structures to ensure TI participants are notified of a pregnancy as soon as possible.
Additional Resources	ACOM417- Appointment Availability, Postpartum Support International (PSI) PMH-C program.
Methodology	Members seen is defined as members served at a participating clinic in the specified time period for an outpatient service excluding crisis response services and SMI-evaluations as identifiable through claims.