**Protocols and Systems Self-Audit**

|  |
| --- |
| **Complete the audit for the Adult Area of Concentration as included in your Targeted Investment 2.0 application.**This assessment tool helps ensure that the Year 2 TI requirements are implemented as described in your draft Year 2 Milestone documents and the **Equality Health Example Milestone Protocols & Policies**, and as specified in the [Year 2 Milestone Requirements](https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/Adult-PCP_TI_Years2-3Milestones.pdf), and the [Document Validation Guidelines](https://www.azahcccs.gov/PlansProviders/Downloads/TI/Doc.Validation-AdultPCP_TI_Year2.pdf). Additional recommendations are included in the **Implementation Priorities** section of the Audit that highlights time sensitive deadlines and includes administrative actions that can enhance the ability to meet TI milestone requirements. Note that Equality Health, LLC has developed these materials to assist providers in implementing TIP 2.0. This document is only a resource for the provider and is not intended to be the sole source of information that will be required to implement the program. These materials will need to be customized to the provider, based on the application they submitted for the program.  |

**Implementation Priorities**

Several Year 2 Milestones have implementation deadlines, in addition to process and procedure development. These dates should be noted so sufficient planning runway is built into the practice’s planning.

| **Core Components Priorities**  | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Target Dates/Action** |
| --- | --- | --- | --- | --- | --- |
| CC2 |  |  |  |  | * CC 2: Attest that the processes described in milestone 2B (Standards 2-4) have been implemented by **9/30/2024**.
 |
| CC3 |  |  |  |  | * CC3**C**: Attest that G and Z codes are utilized to document screening and referral details through claims by **9/30/2024**.
* CC3**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.
 |
| CC4 |  |  |  |  | * CC4**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.
 |

**Organizational and Administrative Systems and Resources**

Apply to all TI requirements

| **Administrative Functions** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| Assess and implement EHR Data aggregation/review systems capabilities; assign staff responsibility  |  |  |  |  | * EHR capabilities (vendor)
* Other
* REL data
* Stratification
 |
| Establish/enhance PDSA use to improve performance; assign staff to lead  |  |  |  |  | * EHN support
* QIC team
 |
| QIC |  |  |  |  | * Process improvement
* Data normalization
* dashboard
 |
| AHCCCS  |  |  |  |  | * CC “*Specifications*” section
* System Collaboration
* Additional Resources
* Methodology
* Examples
* Monthly newsletter
* Direct consultation with TI team as needed
* Utilize current doc versions; do not download/print
 |
| Staff engagement |  |  |  |  | * Establish Staff engagement plan
* Staff education
* TI Program/patient care
* Program Incentives
* Acknowledgement of change
* Other
* Population health
* Impact of HRSN on patients
* Data on health disparities-understanding patient needs
 |
| Provider engagement |  |  |  |  | * Familiarize all providers with TI goals and requirements including metrics
* Present outcome/performance data on regular basis
* Solicit input on TI related practice decisions such as data stratification
 |

**Milestone #1:**

Participate in the Targeted Investment Program Quality Improvement Collaborative (QIC) offered by the Arizona State University (15% of Annual Payment).

| **Milestone #1** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| The organization’s TI representative attended all 3 Year 2 QIC group meetings (Feb 5, May 9, August 8)  |  |  |  |  | * A TI QIC representative has been selected and if changed, AHCCCS has been updated
 |
| One representative from the participating organization has registered for the online learning platform |  |  |  |  | * 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).
 |
| 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. |  |  |  |  | * Online Project instructions are accessible through [Canvas](https://tipqic.org/perfimp.html).
* Equality Health may be able to assist participants with projects (e.g., root cause analyses)
 |

**Milestone #2:**

Implement the [National Culturally and Linguistically Appropriate Services (CLAS) Standards](https://thinkculturalhealth.hhs.gov/clas/standards), developed by the U.S. Department of Health and Human Services Office of Minority Health. (15% of Annual Payment).

| **Milestone #2** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Actions** |
| --- | --- | --- | --- | --- | --- |
| AHCCCS Clarification (6/14 Milestone doc version): Updated *Methodology* label to specify “Attributed Members.”Complete an organizational evaluation of current practices using the [National CLAS Standards implementation checklist](https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf), 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 currently).CLAS Checklist*Complete an organizational assessment specific to language assistance services to describe existing language assistance**services and to determine how they can be more effective and efficient.* |  |  |  |  | The plan must include:* Organization review of standards 2-4 (2.2 through 2.4)
* The timeframe in which the practice aims to implement each standard,
* The individual(s) who leading implementation of each standard,
* A list of actions the practice is taking to implement each standard, and
* A description of additional resources the practice may need to implement each standard and how the practice plans to obtain such resources
 |
| Build and support a culturally and linguistically diverse practice team. Document that the practice recruits and supports a diverse practice team. CLAS Checklist *Target recruitment efforts to the populations served to increase the recruitment of culturally and linguistically diverse individuals, through actions such as: posting job descriptions in multiple languages in local community media, holding job fairs in the community(ies) served, and/or working with leaders of local community institutions to create mentorship and training programs targeting populations served.*  |  |  |  |  | Select and implement example tactics from the EHN Toolkit such as: * job postings, as indicated, a preference for candidates from under-represented groups.
* assess the organization’s hiring, retention, and promotion data and compare the demographics of this data to the service community’s demographics.
* Establish volunteer, work-study, and internship programs in partnership with local health career training programs.
* **Implement actions by 9/30/2024**

Documents must include a description of:* How the practice team reflects the diversity of the population the practice serves,
* How the practice's current recruiting and hiring processes support diversity,
* How the practice promotes diversity among various staff roles (e.g., clinical staff, practice management, clerical),
* 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)
* How the practice includes information on providing culturally and linguistically appropriate care in staff training materials, and
* How the practice offers and incentivizes completion of training (in person or virtual) to all employees on providing culturally and linguistically appropriate care.
 |
| Offer language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of attributed members.CLAS Checklist *Complete an organizational assessment specific to language assistance services to describe existing language assistance**services and to determine how they can be more effective and efficient.* |  |  |  |  | Provide [CLAS Communication and Language Assistance](https://d.docs.live.net/cba72ad46648f495/GF%20Jacobson%20Consulting%20LLC/Equality%20Health/Year%202%20Resources/Offering%20language%20assistance%20services%20to%20individuals%20who%20have%20limited%20English%20proficiency%20and/or%20other%20communication%20needs%20informed%20by) including:* An organizational assessment specific to language assistance services
* Staff training in procedures (such as a script) to ensure that they inform individuals of the availability of language assistance.
* Provide notification that describes the available communication and language assistance and that is free of charge.
 |

**Milestone #3:**

Implement a process for screening for health-related social needs (HRSN) and connecting members seen to CBOs to address individual social needs. (20% of Annual Payment).

| **Milestone #3** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| Screen members served by the practice annually using an evidence based, standardized HRSN screening toolAHCCCS Clarification (6/14 Milestone doc version): * patients who “opt out” are in the numerator and denominator when a practice follows protocol for offering screening.
* 3H Due dates extended
* random sample requires “AHCCCS enrollment at some point in the program year”
 |  |  |  |  | Ensure Screening Tool Domains include (PRAPARE or SCRA): * housing instability,
* utility assistance,
* food insecurity,
* transportation needs
* interpersonal safety
* employment
* justice involvement.

Documentation includes: * Name of the Screening tool
* Available screening tool languages
* When and where data is collected (prior to visit, during visit; waiting room, exam room, etc.)
* Staff who conduct and collect the screen (CHW, MA, etc.)
* Consent for screening and referral including opt out provision.
 |
| Document screening results in the member’s Electronic Health Record (EHR) and claims (G codes and Z codes) and establish processes to maintain confidentiality of patient data. |  |  |  |  | * Ensure that the practice documents the process to record screening and referral results in the practice EHR.
* Ensure that G and [Z codes](https://www.cms.gov/files/document/zcodes-infographic.pdf) are utilized (when made available by AHCCCS) to document screening and referral details through claims by 9/30/2024
* G9919: Screening performed and positive. And provision of recommendation
* G9920 Screening Performed and negative.
* G9921: No screening performed, partial screening performed or positive screen without recommendation and reason not given or otherwise specified
* Note: while the G codes are not paid for Medicaid patients (and code will be rejected by MCO), AHCCCCS will be using the rejected codes as a. measurement tool.
 |
| Document how the practice educates thepatient/member, obtains consent, and discusses screening results. |  |  |  |  | * Script or description that explains for patient/caregiver why screening is done, how information will be used/shared, next steps if need is identified.
 |
| Identify, select, and establish partnerships with CBOs, especially those focused on shelter, food, utility assistance and transport, to deliver resources and/or interventions. |  |  |  |  | * Document the social needs prevalent within the practice’s population.
* Prioritize CBO relationships with CBOs that can address the prevalent social needs of the practice’s population.
* A registry of appropriate community service providers is maintained by the practice and updated from Community Cares and other resources
 |
| Develop referral and communication processes with each partner 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 |  |  |  |  | * Documentation that describes the referral and communication processes with partner CBOs, And/Or
* Documentation that describes use Community Cares for referring and communication with CBOs
 |
| Upload documentation on the practice's process to protect data sharing and confidentiality. |  |  |  |  | * Identify 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 devices (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
 |
| Upload documentation on the practice’s processes to maintain aregistry of community service providers through CommunityCares or another CLRS (N/A if no CLRS are utilized). |  |  |  |  | * Signed CommunityCares Access Agreement (CCA) to use of the Arizona CommunityCares closed loop referral system. (check <https://equalityhealthti.com/> for resources)

**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 criterion.

**If not using the Arizona CommunityCares system** * Attestation from a senior practice leader that the practice has developed and is actively maintaining a registry of CBOs in the practice service area.
* A current copy of the CBO registry
* The practice's process for selecting community service providers with which to establish agreements.
 |

**Milestone #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: (15% of Annual Payment).

| **Milestone #4** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| AHCCCS Clarification (6/14 Milestone doc version): * random sample requires “AHCCCS enrollment at some point in the program year”

Upload the practice’s CommunityCares Access Agreement CCA)and onboarding plan. |  |  |  |  | * 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
* 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).
* Signed scope of work to use of the CommunityCares Access Agreement (CCA)closed loop referral system.
 |
| Upload a signed attestation from senior practice leadership that team members have accounts to log into CommunityCares. |  |   |  |  | * The name(s) and title(s) of practice team member(s) who have accounts to log into CommunityCares,
* The name and title of the individual who will serve as the administrator responsible for generating reports using CommunityCares data, and
* The name, role, and signature of the senior practice leader
 |
| Upload documentation identifying the team member(s) responsible for utilizing the administrative functions of CommunityCares, including periodically updating informationabout practice operations and generating reports |  |  |  |  | Documentation includes:* Periodically updating information about practice operations:
* team member(s) responsible,
* the frequency of these updates,
* 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), 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),
* website URL, and
* whether the practice location has accommodations for individuals with physical disabilities, including in offices, exam room(s), equipment.
* Generating reports:
* team member(s) responsible.
* 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
* the frequency each report is generated.
 |
| 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. Clearly state whichsystems are used for each HealthPlan and age group (Adults andPediatrics). |  |  |  |  | Documentation includes:* How to request and document consent from patient to share information and refer to CBO for services.
* Description of explanation to member/family/caregiver of steps to expect once a referral is made.
* 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.
* 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.

**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.

**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 monthly by 4/30/2025.
 |

**Milestone #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. (15% of Annual Payment).

| **Milestone #5** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| Submit a completed AHCCCS Health Equity Collaboration Analysisusing the template provided by AHCCCS via [Google Form](https://docs.google.com/forms/d/e/1FAIpQLSc-DiCoEshmdzpAoFlufoHaO62wWFltGNR1NK6lkWuCBJNJhg/viewform) orsubmitting the [completed xls](https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/PrintableXLS_TI_20-HealthEquityCollaborationAnalysis.xlsx) toTargetedInvestments@azahcccs.gov.AHCCCS Clarification (6/14 Milestone doc version): * 5A & 5B Deadlines changed to August 31
* 5B: AHCCCS will provide the Gap Analysis template before July 2024
* Updated Methodology label to specify “Attributed Members.”
 |  |  |  |  | * Submit a completed AHCCCS Health Equity Collaboration Analysis using the template provided by AHCCCS
 |
| 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.\* *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.* |  |  |  |  | Documents include:* Process for collecting this 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)),
* 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,
* 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
* 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
 |
| Upload documentation that demonstrates the practice’s policies and procedures for stratifying performance on quality incentive measures using stratified clinical data |  |  |  |  | Method for generation of stratified metrics * EHR
* Other

Stratify quality incentive measures data by:* member-reported demographic data
* race/ethnicity,
* primary language,
* disability status,
* geography,
* sex assigned at birth,
* gender identity and
* sexual orientation.

And/Or* HRSN data collected in milestone 3 in the practice EHR.
* housing instability,
* utility assistance,
* food insecurity,
* transportation needs and
* interpersonal safety
* Documentation must include:
* Description of the source of referenced data (e.g., EMR, MCO gap-reports), including frequency of receiving the data and processes to pull or otherwise receive the data.
* If more than one source is used, how the data is matched from one system to another.
* How stratified metrics are generated (e.g., which EMR report)
* If an ACO/CIN is assisting the practice with this effort, how each ACO/CIN supports the clinic for mutual members and how the practice completes this effort for AHCCCS members not enrolled with the ACO/CIN.

(Report stratified performance for allsubpopulations, regardless of the size of the denominator) |

**Milestone #6:**

Identifying and engaging caregiver(s) and guardian(s) of a newborn to screen for anxiety and depression and coordinate with appropriate behavioral health provider(s) and/or case manager(s) to follow-up. (20% of Annual Payment).

| **Milestone #6** | **Y/N** | **If N Plan for completion** | **If N Target Date** | **Date Completed** | **Action** |
| --- | --- | --- | --- | --- | --- |
| 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 health plan. |  |  |  |  | * Written documentation of processes the practice employs to notify the member's health plan that a member is pregnant or a new parent, including indication of when the member was the birthing parent.
 |
| Develop policies and procedures related to engaging caregiver(s) and guardian(s) for a follow-up appointment within 84 days of childbirth. |  |  |  |  | Documents include:* Description of how the practice is informed that the member has given birth.
* Description of member outreach following the birth of a child to schedule a follow-up appointment, including how the practice makes multiple attempts at contacting the member using different outreach methods (e.g., phone call, text, mail), and accommodations for members who need to bring newborn/infant to appointment (e.g., separate waiting room for newborns);
* Description of the process for reminding members of an upcoming appointment.
* Description of the process for following up with member if the individual(s) do not show for appointment, including rescheduling appointment
 |
| Develop policies and procedures related to anxiety and depression screening after childbirth |  |  |  |  | Policies/procedures include: * Educating the present caregiver(s) and guardian(s) about the prevalence of anxiety and depression after childbirth and the importance of seeking appropriate services.
* Use of norm or criterion-referenced screening tools to assess anxiety and depression during pregnancy or within one year of becoming a caregiver (e.g., birth of child).
* Documentation 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.

  |
| Develop, maintain, and provide the patient a copy of a registry ofbehavioral health providers that can meet the identified need |  |  |  |  | * Document 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.
* Develop, maintain, and update a registry of behavioral health providers who can meet a need identified from the screening, including name, credentials, including certifications, address, availability of in-person and/or telehealth services, website (as applicable), languages spoken by the provider, availability of skilled interpreter services.
* Provide caregiver(s)/guardian(s) with a copy of the registry of behavioral health providers who can support an identified need;
* Obtain and document information regarding status of behavioral health providers Perinatal Mental Health Certification status and communicating status in registry provided to caregiver(s)/guardian(s);
* Obtain and document information regarding insurance accepted by behavioral health providers on the registry and communicating that information to caregiver(s)/guardian(s);
* The registry should include behavioral health providers who are 1) accepting new patients, and 2) are able to see a new patient consistent with the standards in ACOM 417.
* Submit current copy of registry of behavioral health providers, including name, credentials, address, availability of telehealth services, website (as applicable), languages spoken by the provider, availability of skilled interpreter services.
 |
| Develop coordination and referral protocols with AHCCCS Health Plans, a behavioral health provider, care manager, and/or appropriate case managers to document follow-up withcaregiver(s) and guardian(s) that screen positive for anxiety and/or depression |  |  |  |  | In accordance with the timelines specified in ACOM 417documentation must include all of the following:* Referring members,
* Conducting warm hand-offs,
* Handling crises,
* Sharing information,
* Obtaining consent,
* Engaging in provider-to-provider consultation, and
* Prioritizing referrals to a practitioner or prescriber certified in PMH and qualified to diagnose and treat anxiety and depression when possible.
 |