



Targeted
Investments

Core Component #3 Adult BH Area of Concentration

Screening Members to
Assess Social
Determinants of Health
(SDOH)



Key Concepts for Core Component #3- Screening Members to Assess SDOH

- This Core Component is vital for integration and collaboration among behavioral health and primary care providers that can benefit the patient in need.
- Practices should be using SDOH screens annually or as needed.
- This module contains examples of SDOH screening tools you can choose from.
- One consideration practices may have is to use a tool such as PRAPARE. PRAPARE is an electronic application that can integrate with your existing EHR and supports SDOH data collection and use. EHR's that support PRAPARE include:
 - E-Clinical Works
 - NextGen
 - Epic
 - GE-Centricity
- Please contact your Health Current account manager for additional support

Review of Core Component #3

<p>3. Screen all members to assess the status of common social determinants of health (SDOH), and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool.</p> <p>Tool examples include: the <u>Patient-Centered Assessment Method (PCAM)</u> , the <u>Health Leads Screening Toolkit</u> , the <u>Hennepin County Medical Center Life Style Overview</u> and the <u>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)</u>.</p>	
<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*)</p> <p>⏪⏩</p> <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019*)</p> <p>⏪⏩⏪⏩⏪⏩</p> <p>Practice Reporting Requirement to State</p>
<p>A. By September 30, 2018, identify which SDOH screening tool is being used by the practice.</p> <p>B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 6, based on information obtained through the screening.</p>	<p>Based on a practice record review of a random sample of 20 members, attest that:</p> <p>A. 85% of members were screened using the practice-identified screening tool</p> <p>B. 85% of the time, results of the screening were contained within the integrated care plan</p> <p>C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).</p>

Core Component #3

- Screen all members to assess the status of common social determinants of health (SDOH) and develop procedures for intervention or referral based on the results from use of a practice—identified, structured SDOH screening tool.
- If you intend to use a different screening tool, please contact the TI email box.

Click on the examples below:

- [Patient Centered Assessment Method \(PCAM\)](#)
- [The Health Leads Screening Toolkit](#)
- [Hennepin County Medical Center Lifestyle Overview](#)
- [The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PREPARE\)](#)

TI Year 2 Measurement Period

October 1, 2017-September 30, 2018

Practice Reporting Requirement to State:

- By **September 30, 2018**, identify which SDOH screening tool is being used by the practice

AND

- By **September 30, 2018**, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, which is to identify community-based resources as identified through the lists maintained by the Managed care Organizations (MCOs).

Attestation and Document Validation

- AHCCCS will be opening a TI Attestation Portal through **AHCCCS Online**
(<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>)
- The portal will be available for milestone attestation in June 2018.
- Not all of the Milestones will require providers to upload documentation through the Attestation Portal for review by AHCCCS.
- In order to attest to meeting this Core Component, participants will need to show they have an SDOH tool and have policies and procedures.
- More detailed information and guidance about how to use the TI Attestation Portal will be available prior to June 2018.

Sneak Peek of Targeted Investments Year 3



Sneak Peek: TI Year 3 Measurement Period October 1, 2018-September 30, 2019

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Sneak Peek: TI Year 3 Measurement Period October 1, 2018-September 30, 2019

Practice Reporting Requirement to State by 9/30/2019

Based on a random sample of 20 members, attest that :

- A. 85% of members were screened using the practice-identified screening
AND
- B. 85% of the time, results of the screening were contained within the integrated care plan
AND
- C. And that 85% of members screened scored positively on the screening tool, and received appropriate intervention(s) of referral(s)

Questions?

Please contact us at
targetedinvestments@azahcccs.gov
if you have any questions



Thank You.

