



Targeted
Investments

Core Component #3 Pediatric 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

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.

Tool examples include but are not limited to: the Patient-Centered Assessment Method (PCAM), the Health Leads Screening Toolkit, the Hennepin County Medical Center Life Style Overview and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).

<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, AND</p> <p>B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 7, 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, AND</p> <p>B. 85% of the time, results of the screening were contained within the integrated care plan, AND</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

<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 but are not limited to: 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>
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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.

