AHCCCS
Arizona Health Care Cost Containment System

Targeted Investments

Core Component #5 Pediatric PCP Area of Concentration

Screen all members to assess Social Determinants of Health (SDOH)

Key Concepts for Core Component #5- 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 #5

5.	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).	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** **(October 1, 2018–September 30, 2019**)** **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify which SDOH screening tool is being used by the practice, **AND** B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	Based on a practice record review of a random sample of 20 members, attest that: A. 85% of members were screened using the practice-identified screening tool, **AND** B. 85% of the time, results of the screening were contained within the integrated care plan, **AND** C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).

Core Component #5

- 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

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

5.	**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: 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).**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** **(October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify which SDOH screening tool is being used by the practice. B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	Based on a practice record review of a random sample of 20 members, attest that: A. 85% of members were screened using the practice-identified screening tool. B. 85% of the time, results of the screening were contained within the integrated care plan. C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).

Sneak Peek: Milestone Measurement Period 2 –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% if members were screened using the practice-identified screening tool, **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

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Thank You.

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