





Targeted Investments Program

Quality Improvement Collaborative #2

May 9, 2024: 11:30 AM to 1:00 PM

ASU Arizona State University

AHCCCS Arizona Health Care Cost Containment System

Zoom Expectations

At least one representative from each TI organization must have registered and attend the QIC session using that registration link.

Participants will automatically be muted and videos off as they join.

When interested in participating in the discussion, please raise your hand and unmute yourself.

Disclosure

This is a CME activity

Acknowledgment: This CME event is not supported by any commercial entity.

Disclosure: All speakers and members of the planning committee have no relevant financial relationships with a commercial interest to disclose.

Credit Statement: Arizona State University designates this live activity for a maximum of 1.5-credits from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1.5 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1.5 credit hour per session***
- ***Psychology – APA – 1.5 credit hour per session***
- ***Social Work – ACE – 1.5 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1.5 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*

Learning Objectives

1. Explain the benefits of HRSN screening for both patients and healthcare systems
2. Describe strategies to create a safe and supportive environment for patients to disclose their social needs
3. Discuss strategies for overcoming potential challenges and barriers to implementing HRSN screening

Agenda

Time	Topic	Presenter
11:30 AM	Welcome	Matthew Martin, PhD
11:35 AM	Programmatic Information and Updates, QIC Milestone, TI Online Projects	Taylor Vaughan, MPH Cameron Adams, MPP Matthew Martin, PhD
11:50 AM	Person-Centered HRSN Screening & Referral Conversations	Ariel Singer, MPH
12:25 PM	Peer Presentation	Emilia Gomez, MD, Pediatrics of Queen Creek
12:55 PM	Closing	Matthew Martin, PhD

Programmatic Information & Updates

Taylor Vaughan, MPH

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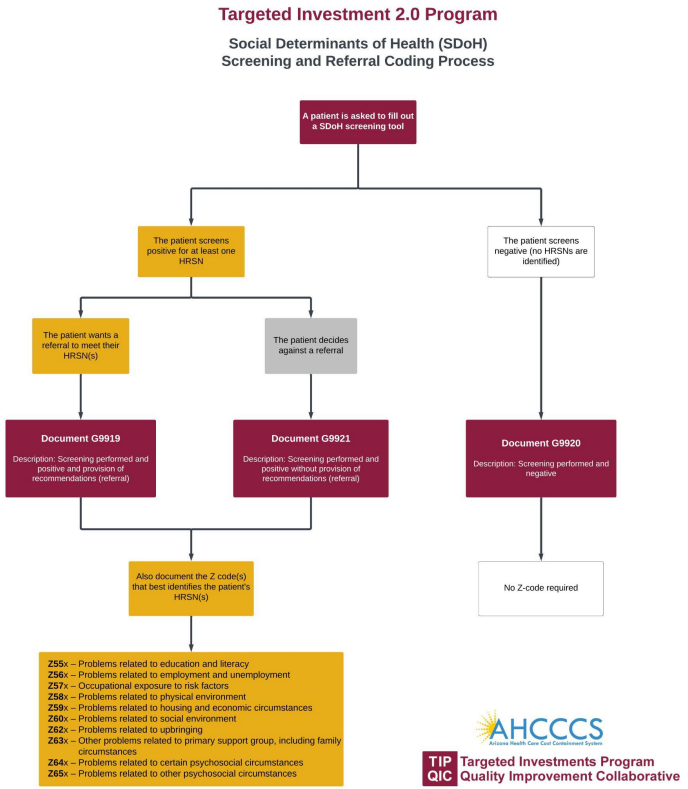
TI 2.0 SDoH G and Z Codes

- TI 2.0 will use SDoH G and Z codes to track SDoH screenings and referrals on the claim level.
- G and Z codes are not reimbursable in most outpatient settings by AHCCCS Medicaid, but using the G and Z codes on claims is required for you to attain the financial incentives associated with milestone #3.
- All SDoH materials will be available on the TIPQIC website



QIC Milestone

Cameron Adams, MPP

AHCCCS
Arizona Health Care Cost Containment System

QIC Milestone Requirements

Year 2: In order to satisfy the Year 2 QIC milestone, the TI participant must achieve all three of the following items:

- **QIC:** The organization's representative must have attended 100% of the Year 2 QIC group meetings. This includes attending the all-day in-person kick-off meeting (February 5, 2024) as well as attending the two 1.5-hour virtual QIC sessions (May 9, 2024 and August 8, 2024).
- **TI Online Platform:** One representative from the participating organization has registered for the online learning platform, Canvas.
- **TI Online Project:** The organization's representative has submitted a TI online project comprised of four deliverables representing at least one project for each AOC by the required due dates that meet minimum scoring rubric requirements for each deliverable. 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).

TI Online Project

Matt Martin, PhD, LMFT, CSSBB

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Arizona Health Care Cost Containment System

Quality Improvement Collaborative (QIC)

- At least one representative from each participating organization must have attended 100% of the Year 2 QIC group meetings. This includes attending:
  - February 5, 2024 Kick-Off Meeting
  - May 9, 2024 from 11:30 AM to 1:00 PM (TODAY)
  - August 8, 2024 from 11:30 AM to 1:00 PM

TI Online Platform Registration

- To access milestone-focused educational content as well as complete and upload the project activities, you will need to create a free account with the online learning platform, Canvas.
- Only one person per organization needs to create an account.
- Instructions to create an account:
  - 1. Go to Canvas Instructure log in page: "https://canvas.instructure.com/"
  - 2. Click on “Need a Canvas Account? Click Here, it’s Free”
  - 3. Choose “Student”
  - 4. Create your free account, using this code: MWDPFN
  - 5. Follow the instructions for activating your Canvas account
- After creating your account, you can access the curriculum directly through the link below. We recommend bookmarking the link in your browser.
  - https://canvas.instructure.com/courses/8575713

TI Online Project

The organization's representative will need to submit a TI online project representing at least one project for each AOC 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).

			TI Year 2 (October 1 2023-September 30-2024)		
Projects	**Component**	**Due Date**	**Q1**	**Q2**	**Q3**
Project A	Project Charter	June 30 2024		X	
	Project Map	June 30 2024		X	
	Root Cause Analysis	September 30 2024			X
	PDSA Cycle	September 30 2024			X

Each online project has **four** deliverables with due dates:

1. The project charter (June 30 2024)
2. The process map (June 30 2024)
3. The root cause analysis (September 30 2024)
4. The Plan-Do-Study-Act (PDSA) cycle (September 30 2024)

Subject Matter Expert on HRSN Screening

Ariel Singer, MPH

AHCCCS
Arizona Health Care Cost Containment System

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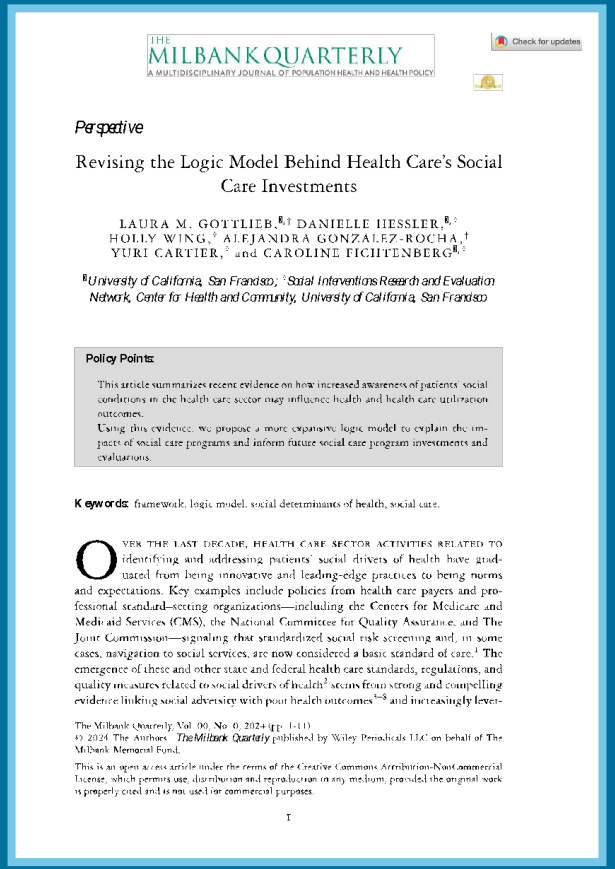
Guidance for

Person-Centered Screening & Referral Conversations

We all know social needs have a huge impact on health.

How does social needs screening help?

Emerging evidence leads to new hypotheses



THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Check for updates

Perspective

Revising the Logic Model Behind Health Care's Social Care Investments

LAURA M. GOTTLIEB,[1,†] DANIELLE HESSLER,[1,‡] HOLLY WING,[1] ALEJANDRA GONZALEZ-ROCHA,[1,†] YURI CARTIER,[2] and CAROLINE FICHTENBERG[1,‡]

[1]*University of California, San Francisco;* [2]*Social Interventions Research and Evaluation Network, Center for Health and Community, University of California, San Francisco*

Policy Points:

This article summarizes recent evidence on how increased awareness of patients' social conditions in the health care sector may influence health and health care utilization outcomes.

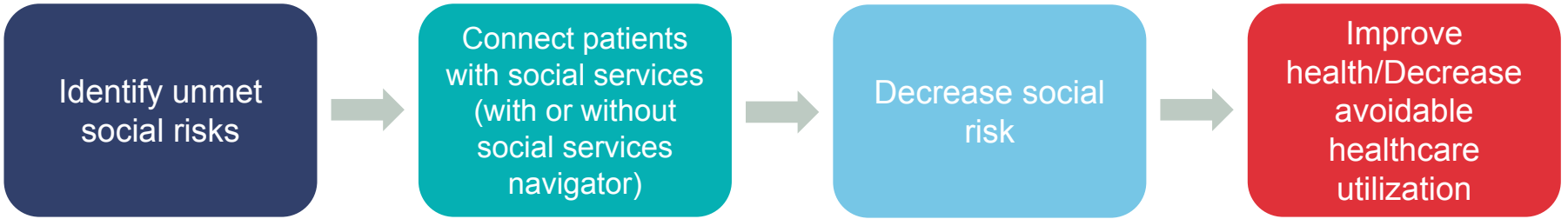
Using this evidence, we propose a more expansive logic model to explain the impacts of social care programs and inform future social care program investments and evaluations.

Keywords: framework, logic model, social determinants of health, social care.

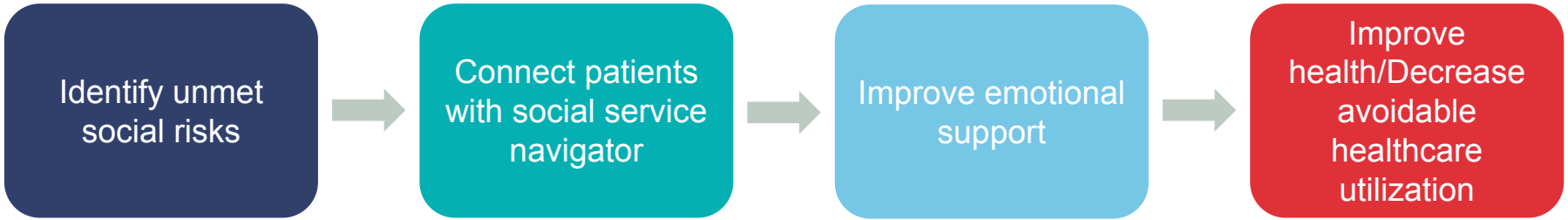
OVER THE LAST DECADE, HEALTH CARE SECTOR ACTIVITIES RELATED TO identifying and addressing patients' social drivers of health have graduated from being innovative and leading-edge practices to being norms and expectations. Key examples include policies from health care payers and professional standard–setting organizations—including the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance, and The Joint Commission—signaling that standardized social risk screening and, in some cases, navigation to social services, are now considered a basic standard of care.[1] The emergence of these and other state and federal health care standards, regulations, and quality measures related to social drivers of health[2] stems from strong and compelling evidence linking social adversity with poor health outcomes[3–8] and increasingly fever-

The Milbank Quarterly, Vol. 00, No. 0, 2024 (pp. 1–11)

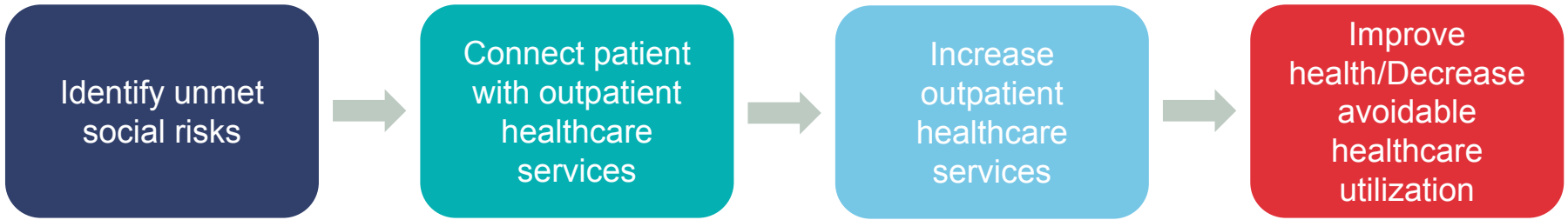
The initial hypothesis



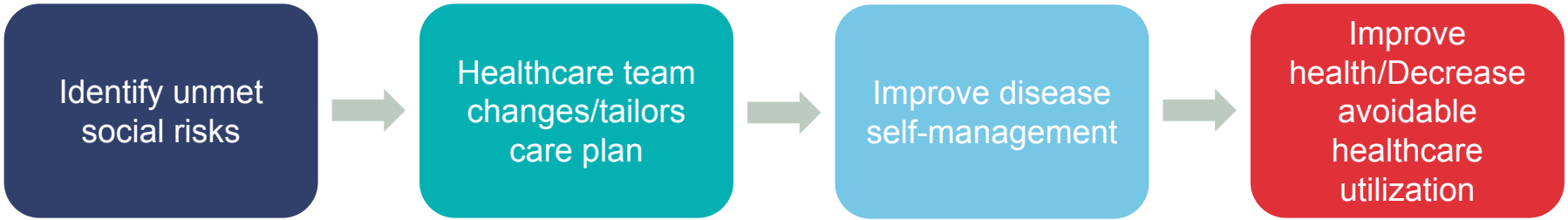
Additional possibilities: Emotional support/healing relationships pathway



Additional possibilities: Health care services connections pathway



Additional possibilities: Tailored clinical care pathway



The ACT Center: Together, we move research into action for healthier people and communities

ACT CENTER
Accelerating Care Transformation

act-center.org

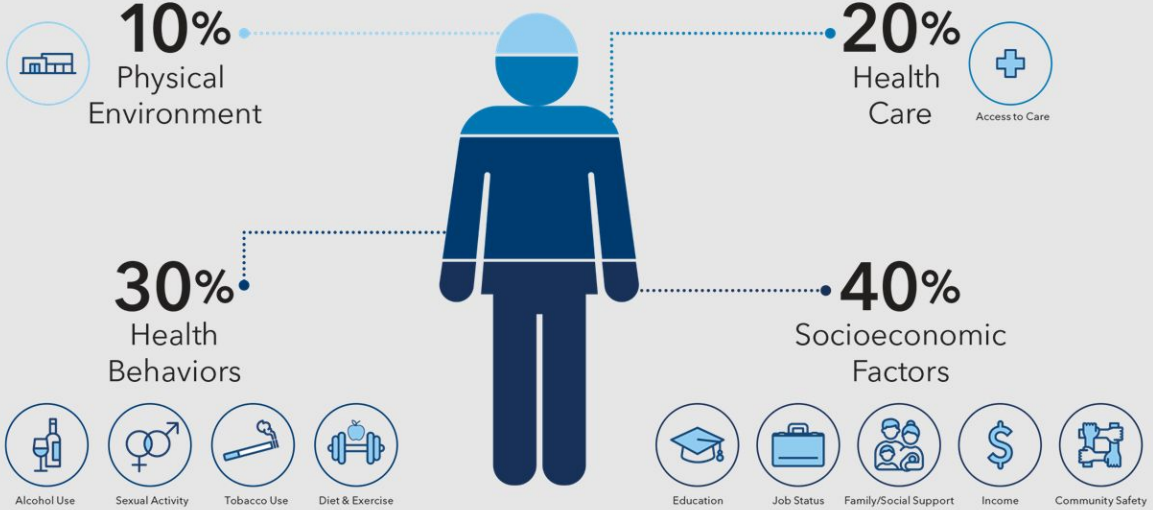
Research plays an essential role in solving health care's toughest challenges.

The Center for Accelerating Care Transformation (ACT Center) exists to find **faster, more practical, and more representative ways** to use research to create better systems of care that improve health and health equity for whole communities.

KPWA's vision for Integrated Social Health: Universal social health screening

ACT CENTER
Accelerating Care Transformation

Whole-person care elevates social health on par with physical and mental health. The goal is to make screening our patients for access to things like food, transportation, and housing as common as taking their vitals.

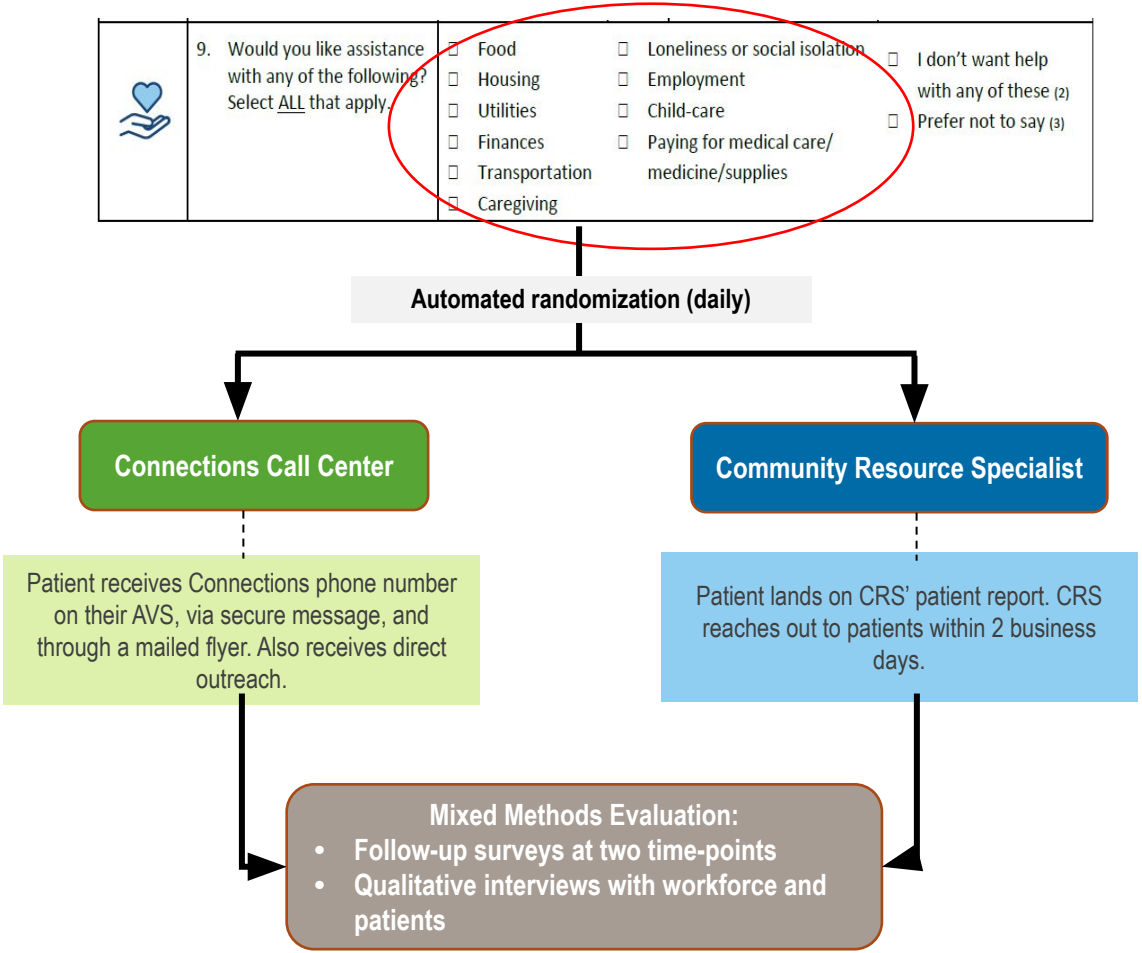


1. **A new clinical standard to *reliably and equitably* identify members and *personalize care for better outcomes.***
2. Population Health that recognizes social health factors in risk-stratification and *reaches out to those at risk for barriers to care.*
3. Insight into our community needs and resources and informs how to make *meaningful contributions to our community.*

ACT Center
Social Health Evaluation

Launched August 2022 to learn which types of patients:

- Need more proactive and intensive support from a Community Resource Specialist
- Can get their needs addressed by working with a national call center



Primary Outcome: Total count in social needs

What we heard from patients

Reducing the burden of social risks	This rarely happened. Services simply don't exist or very few are eligible.
Emotional support/healing relationships	Many patients who did not receive any resources report that their needs were met.
Health care services connections	Patients care concerned about the focus on social health competing for time and attention, when they already don't have enough time with their PCP.
Tailored clinical care	Only one patient reported their care plan changing as a result of social needs screening.

What is Collaborative Screening?

What is Collaborative Screening?

What is Collaborative Screening?

Framework of strategies and skills for:

Creating supportive, respectful screening conversations

Promoting equity by creating safe and trustworthy screening interactions for everyone

What are Design Principles [1]

- Design principles are a “set of values that act as a compass” for your approach
- They are guideposts that keep your whole team on the same path as you navigate the complexities of service delivery

Why Use The Principles [2]

- Support a shared problem-solving approach
- Promote efficiency
- Create consistency

How to Use The Principles

- Set up and improve your standard approach
- Problem-solve when facing a difficult decision or tough case
- Help resolve disagreements on the team
- Make aligned and adaptive decisions in response to variation

Where the Collaborative Screening Design Principles Come From:

- **Stakeholder input gathered through focus groups and interviews**
  - Patients
  - Community health workers and patient navigators
  - Experts in trauma-informed care
  - Clinical leaders in medical and behavioral health
  - Operational and health equity leaders
- **Peer-reviewed literature**

- Build on Them
- Add to Them
- Make Them Your Own

My goal:

- Curate the wisdom of the collective
- Describe both design principles and specific implementation ideas
- Pragmatic, relevant, and actionable

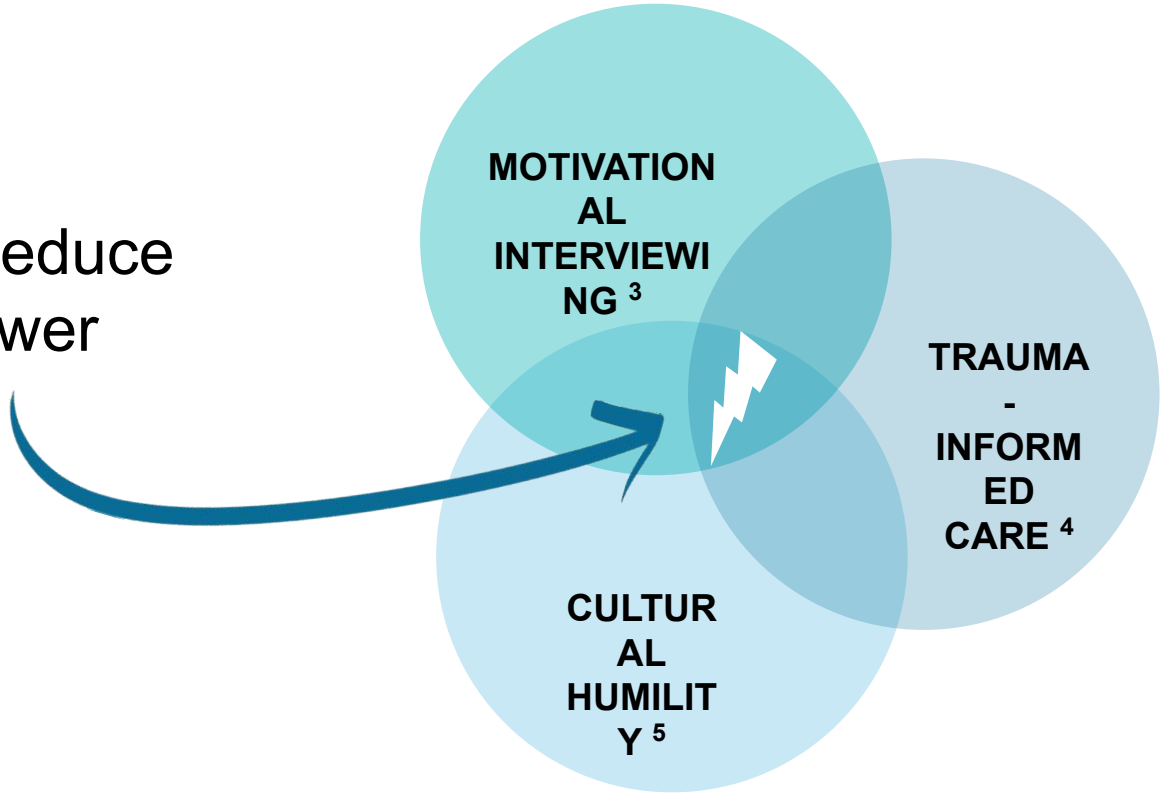
Design Principles

Design Principles

Person-Centered Screening Conversations:

- ❑ Recognize and reduce differences in power
- ❑ Prioritize transparency
- ❑ Demonstrate respect
- ❑ Focus on strengths
- ❑ Let the client lead

Recognize and Reduce Differences in Power



Recognize and Reduce Differences in Power

Recognize and Reduce Differences in Power

- ❑ Acknowledge and honor privacy and autonomy
- ❑ Ask for individual perspectives and priorities
- ❑ Identify subtle behaviors that diminish differences in power

Prioritize Transparency

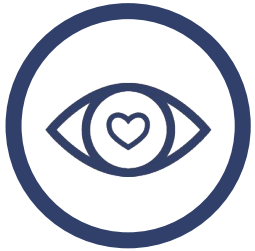
Safety

Trust & Transparency

Peer Support

Collaboratio n

Empowerment



Humility & Responsiveness

Trauma-Informed Care Principles

Prioritize Transparency

Prioritize Transparency

- Always offer a written and verbal, plain-language explanation for why you are conducting the screening, how their personal information will be used, with whom it will be shared, and what the options are for next steps
- Acknowledge that your clinic or agency may not be able to offer resources in response to all needs, and that the screening process is not an application for resources

Demonstrate Respect

- Be active about it
- Understand that this is a meeting of two experts

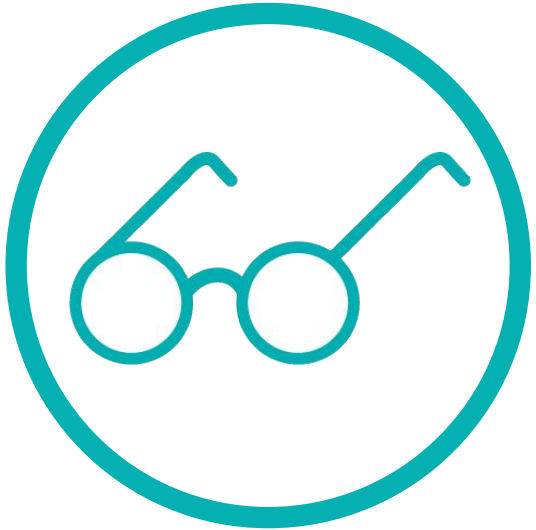
Demonstrate Respect

Demonstrate Respect

- Approach your interactions with an awareness of the stigma and judgment associated with many demographic circumstances, social needs, and personal behaviors [7]
- Ask people how they want to be addressed—for example, their pronouns and preferred name
- Use person-centered and neutral language to convey non-judgment
- Ask people how culture and identity impacts health and well-being [8]
- Orient yourself towards families and not just individuals

Focus on Strengths

- Look at people with strengths-colored glasses
- Counter-balance the deficit focus of screening



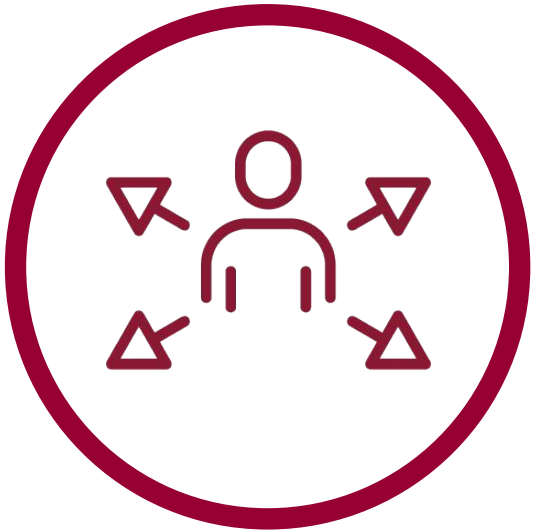
Focus on Strengths

Focus on Strengths

- Ask people about their interests and hobbies, their strengths and supports, and what brings them joy or makes them laugh [9]
- Provide verbal affirmations [10, 11]

Let the Client Lead

- Reinforces the redistribution of power
- Shows respect



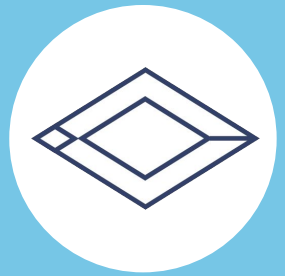
Let the Client Lead

Let the Client Lead

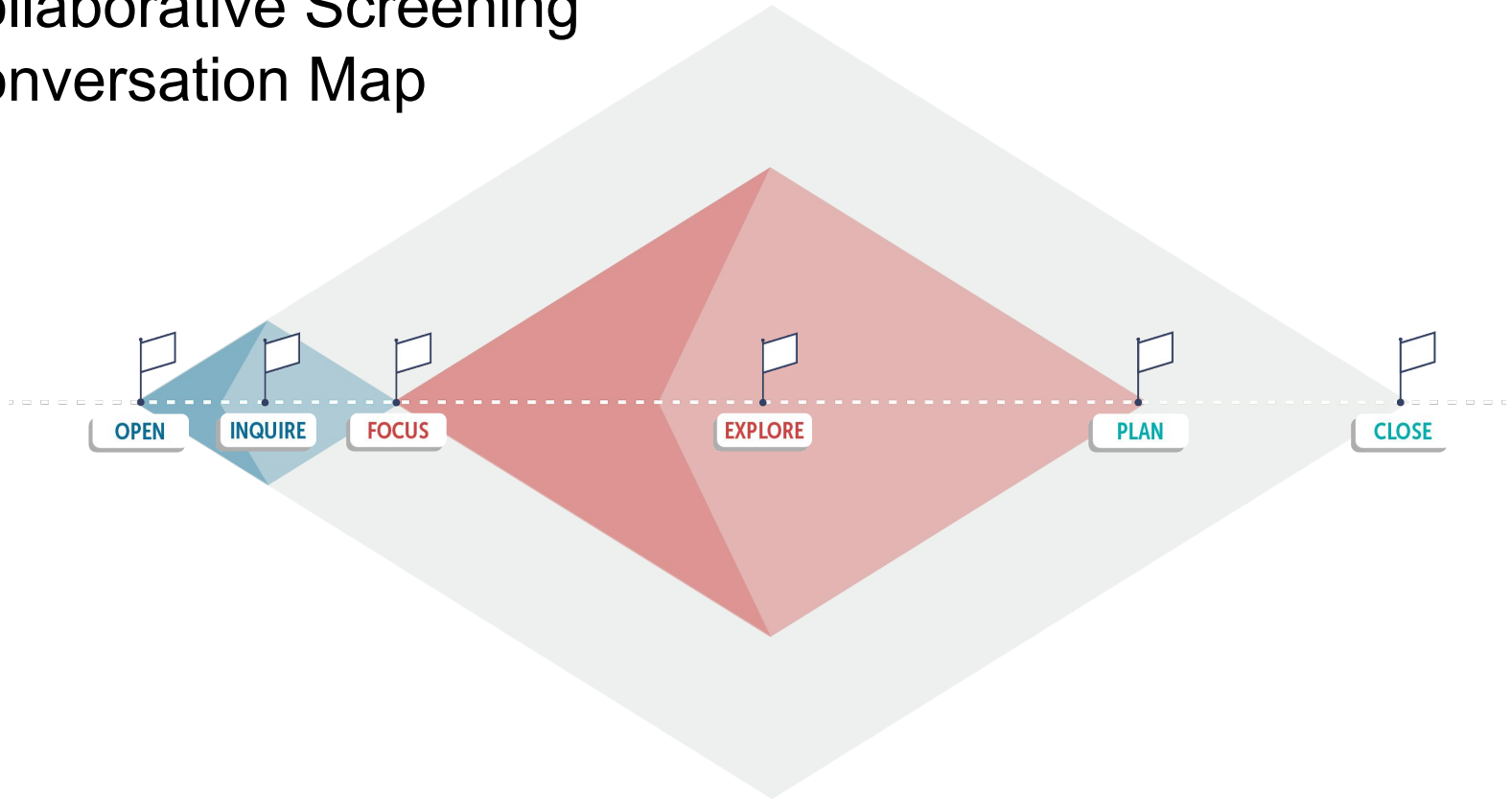
- Let people set the pace for disclosure
- Look for cues and respond to personal circumstances that may impact the conversation

Collaborative Screening

Conversation Map



Collaborative Screening Conversation Map



Putting It All Together

OPEN

- Introduce yourself
- Explain the purpose, goals, and limits of screening and follow up
- Create choices
  - Ask permission to ask questions
  - Tell them it's OK not to answer all of the questions
- Ask if they have questions

INQUIRE

- Conduct screening or summarize results
- Listen with empathy
- Recognize efforts and strengths
- Ask open questions about priorities

FOCUS

- Revisit or restate priorities
- Check for agreement

EXPLORE

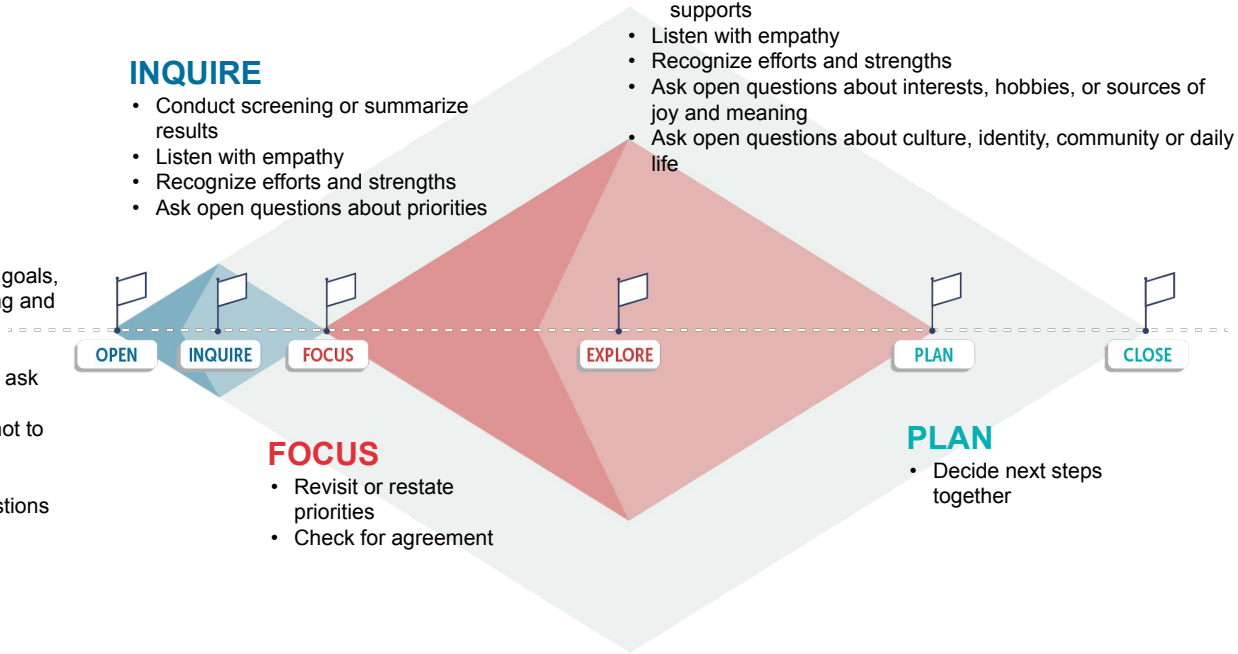
- Create dialogue with Ask-Offer-Ask
  - Learn about preferences, knowledge and prior experiences
  - Share and discuss options for resources, referrals and supports
- Listen with empathy
- Recognize efforts and strengths
- Ask open questions about interests, hobbies, or sources of joy and meaning
- Ask open questions about culture, identity, community or daily life

PLAN

- Decide next steps together

CLOSE

- Explain follow-up timeline and how you may share information with others
- Summarize next steps and confirm understanding using teach-back



Collaborative Screening Questions?

Reach Out for More Information

connect@arielsinger.com

collaborativescreening.com

Citations

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Peer Presentation

Dr. Emilia Gomez, Pediatrics of Queen Creek

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Arizona Health Care Cost Containment System

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Health Related Social Needs

Emilia Gomez, MD
Pediatrics of Queen Creek
Coolidge Pediatrics
Main Street Pediatrics

SCREENING TOOLS

- Given as a paper copy for families to fill out at the time of checking in based on which insurance they use
- We give it at every visit to every family

Health Access Survey (HAS)

Choose one answer for each question. Answer every question as best as they apply to you. Your answers may help your care team understand your unique situation. Your care team may also be able to connect you with resources that may support health.

First Name		Last Name	
AHCCCS ID:		Today's Date:	
Date of Birth:		Sex at Birth:	☐ Male. ☐ Female. ☐ Unknown. ☐ Prefer not to answer
Language preferred for healthcare?	☐ English ☐ Spanish ☐ Farsi ☐ Arabic ☐ Vietnamese ☐ Chinese ☐ Other_____ ☐ Prefer not to answer		

1. How often do you visit places of recreation (such as parks, gardens, libraries, community centers)?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

2. How often do you need help finding a ride to your health care services?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

3. How often do you need help reading or understanding health care forms, labels, or instructions?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

4. How often do you rely on family or friends to help you with medical needs?
☐ Very Often ☐ Often☐ ☐ Some of the time ☐ Rarely ☐ Never

5. How often do you change, skip, or forget to take your prescribed medicine?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

6. How often do you or your family have the opportunity for better jobs?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

7. How often do you eat fresh fruits or vegetables?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

8. How often do your health problems get in the way of your spiritual or religious life?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

9. How often do you use medicine or remedies from outside the U.S.?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

10. How often do you seek care from healers other than your doctor?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

11. How often are you able to get the type of medical care that you need?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

12. How often do you feel discriminated against or bullied in your community (such as work, school, home, health care system, social group)?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

13. How often do you treat medical problems using folk remedies?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

Turn the page →

EQUALITY HEALTH

14. How often do you have enough money to buy the things you need to live everyday (such as food, clothing, housing, or utilities)?
☐ Very Often ☐ Often ☐ Some of the time ☐ Rarely ☐ Never

15. In terms of your satisfaction, how would you rate your health care overall?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

16. Overall, how would you rate your health?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

17. How easy or hard is it for you to do your usual physical activities (such as walking or climbing stairs)?
☐ Very Easy ☐ Easy ☐ Easy sometimes, Hard sometimes ☐ Hard ☐ Very hard or unable to do

18. In the past 4 weeks, did your health make it easy or hard for you to do your daily work or activities, both at home and away from home?
☐ Very Easy ☐ Easy ☐ Easy sometimes, Hard sometimes ☐ Hard ☐ Very hard or unable to do

19. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a lot ☐ Extremely

20. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?
☐ Not at all ☐ Very little ☐ Somewhat ☐ Quite a lot ☐ Could not do daily activities

Thank you for your answers. Providing the best possible care to you/ your family is important to us. Please tell us a little more about yourself:

How do you identify (check all that apply)	☐ American Indian or Alaska Native. ☐ Asian. ☐ Black or African American. ☐ Hispanic or Latino. ☐ Middle Eastern or Northern African ☐ Native Hawaiian or Other Pacific Islander. ☐ White. ☐ Other: _____ ☐ Prefer not to answer.	Primary language(s) (check all that apply):	☐ English ☐ Spanish ☐ Farsi ☐ Arabic ☐ Vietnamese ☐ Chinese ☐ Other _____ ☐ Prefer not to answer

Have you ever been involved with the justice/legal system?	☐ Yes	☐ No	☐ Prefer not to answer

End of survey. Thank You!

Social Needs Survey

Our goal is to provide the best possible care for your child and family. This screening will ask you non-medical questions to help us better understand any needs you may have and connect you with available community resources. Most of these resources are free of charge.

Please complete this form and return to the office staff prior to today's visit. Please print clearly.

Patient Name: _____ DOB: _____ Sex: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Caregiver Name: _____ Relationship to Patient: _____

Email: _____ Phone: _____

Do you ever eat less than you feel you should because there isn't enough money for food?	☐ Yes	☐ No
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	☐ Yes	☐ No
Are you worried that in the next 2 months you may not have stable housing?	☐ Yes	☐ No
Do problems getting childcare make it difficult for you to work or study?	☐ Yes	☐ No
Do you feel you live in an unsafe place?	☐ Yes	☐ No
Are you in a relationship in which you or your child have been hurt or threatened?	☐ Yes	☐ No
Do you often feel that you lack companionship? (friends, family, church, etc.)	☐ Yes	☐ No
Do you feel overly stressed? (tense, nervous, anxious, or can't sleep)	☐ Yes	☐ No
Are you a refugee in need of legal assistance?	☐ Yes	☐ No
Are you or anyone you live with unable to get any of the following?		
Health Care	☐ Yes	☐ No
Phone	☐ Yes	☐ No
Clothing	☐ Yes	☐ No
Medication	☐ Yes	☐ No
Utilities	☐ Yes	☐ No
Employment	☐ Yes	☐ No
Are any of your needs urgent? (For example: you don't have food tonight, you don't have a place to sleep tonight)	☐ Yes	☐ No
If you answered "Yes" to any boxes above, would you like to receive assistance with any of those needs?	☐ Yes	☐ No
What is your preferred method of communication?	☐ *Call*	☐ *Email*

FOR OFFICE USE ONLY

Practice Name: _____ Screening Date: _____ Refer to PCCN ICC? ☐ Yes ☐ No

Patient Insurance: _____ Patient Insurance ID #: _____

Referring Physician/Provider (please print):

If referring to PCCN ICC, please fax this form to 602-933-4331 or email to pccncaremanagement@phoenixchildrens.com

To score this screening: Yes=1, No=0. Any score >0 should be documented as a positive screen. Total Score: ____

This tool was developed by combining elements from PRAPARE, Health Leads, and other clinically validated tools.

CODING PROTOCOLS

- G CODES- All EHR templates make provider choose the appropriate one:
  - Positive G9919
  - Negative G9920
- Z CODES- every visit will add
  - Encounter for screening for other disorder - Z13.89
  - If screening is positive provider adds most appropriate z code

WORKFLOW

1. Family checks in, front office gives survey, family fills out screening while waiting to be roomed and/or waiting for provider
2. Provider identifies positive screenings, codes accordingly
3. All surveys get scanned by medical assistants and front office, and any positive ones get sent to our care coordinator

WORKFLOW

4. Care coordinator reaches out to families with resources or sends to ACOs that have a care coordinator team

5. Care coordinator keeps a file of positive screened families, makes sure resources are given to families and closes case once family confirmed that they have received resources

6. Audits are made each week to ensure families have received the screening

1. Care coordinator keeps an excel file with all families identified and reaches out to them to make sure they got the resources needed.

2. Care coordinator documents both in our tracking file and in the patient's chart that resources were given and that family was reached or left a voicemail to.

CLOSING THE LOOP

Hurdles

PAST ONES

- Front Staff forgetting to give screening
- Providers upset/overwhelmed of another screening needing to be scored
- Providers forgetting to add the Z codes when positive screenings

CURRENT ONES

- Families declining screening tool
- Families screening positive but not wanting to be reached out to
- Inability to get families to confirm that their needs were met

Thank you

Discussion

All

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Closing & Next Steps

Matthew Martin, PhD

AHCCCS
Arizona Health Care Cost Containment System

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Next Steps

- AHCCCS Information Session - Monday, May 13th from 11 AM to 12 PM
  - Provide an orientation and demonstration of the TI Online Platform
  - Discuss the TI Online Projects
- Continuing Education Units (CEUs)
  - The post-event evaluation survey will appear in your browser when the meeting ends.
  - In order to secure CEUs you must complete this survey.
  - If you are unable to find the survey, please email TIPQIC@asu.edu.

Thank You!

Please email TIPQIC@asu.edu if any questions

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