AHCCCS Targeted Investments Program

Adult A Quality Improvement Collaborative

William Riley, PhD
George Runger, PhD

Session #3
April 2, 2020

ASU College of Health Solutions
Arizona State University

AHCCCS Arizona Health Care Cost Containment System | Targeted Investments

ASU College of Health Solutions
Arizona State University
Center for Health Information and Research

Disclosures

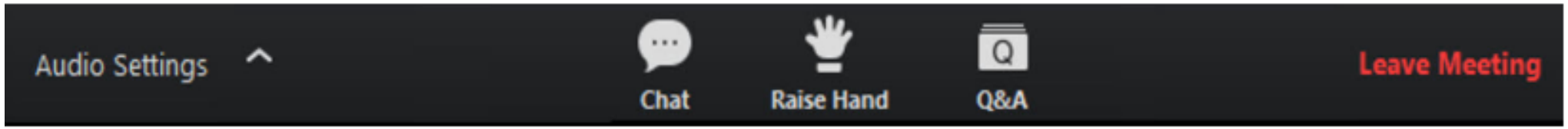
There are no disclosures for this presentation

Reminders & Updates

- Attendance
  - To track attendance, please ensure clinical and administrative representative log-in separately by computer via the link provided in the invite
- Dashboard
  - Each organization should have received an email requesting contact information for up to 3 dashboard licenses
  - Adult PCP providers in Adult A have been provided access to the dashboard
  - Over the next several days, the remaining Adult PCP providers and Peds PCP providers will be provided access
  - BH providers will be provided access once the attribution process is finalized

QIC Participation

- All participants will be automatically muted when joining the Zoom webinar
- All questions should be directed to the Q&A box
- If a participant would like to speak or we are requesting verbal participation, select “raise hand” to be unmuted



ASU QIC Team

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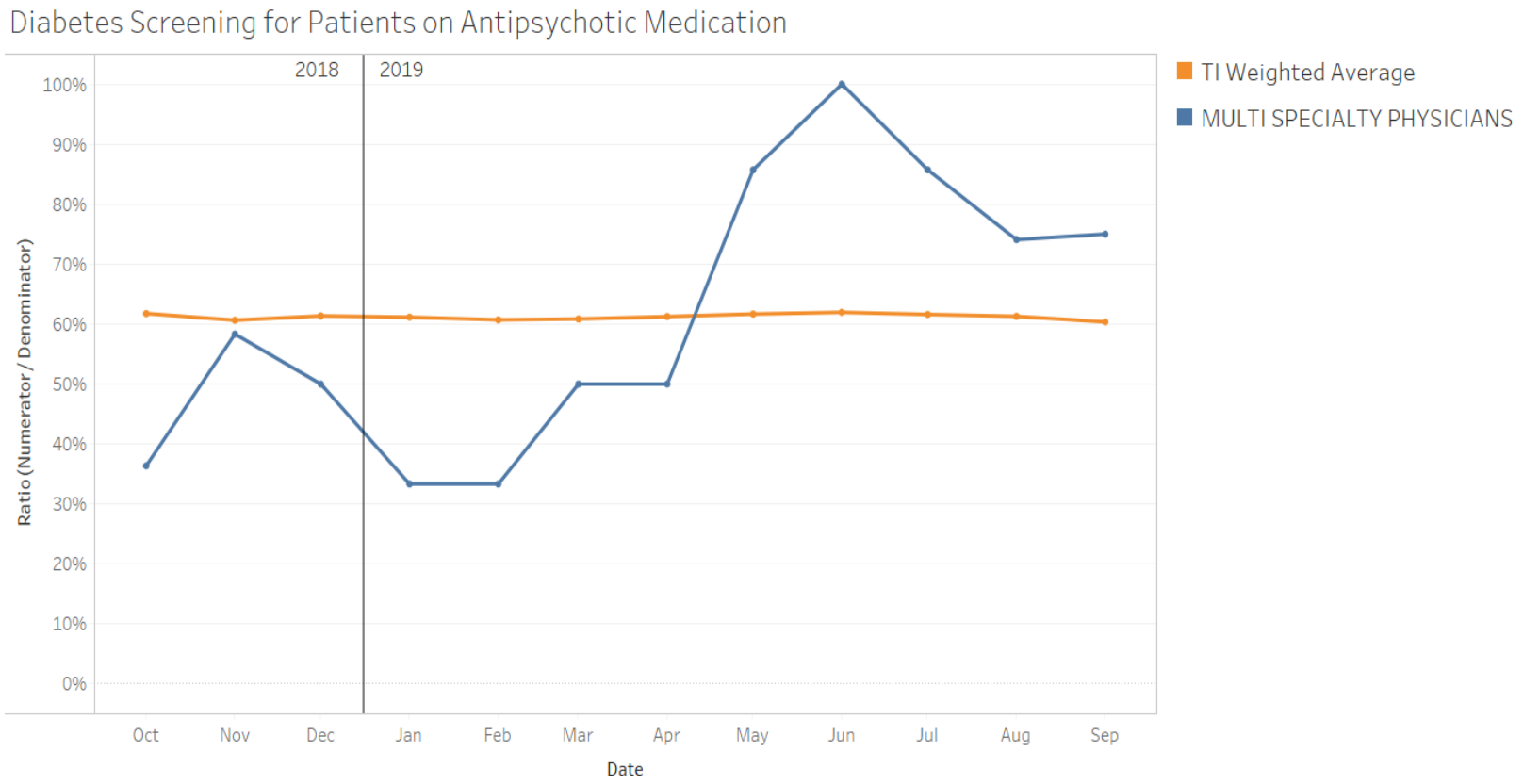
Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:40 AM	Overview • Agenda • Objectives • Feedback	Bill Riley
11:40 – 12:30 PM	Peer Learning • Diabetic Screening • 30 Day Follow-up	Presenter: Multi Specialty Physicians Respondent: Cope Community Services Presenter: Cope Community Services Respondent: Banner University Primary Care Physicians
12:30 PM – 12:40 PM	Update on Target Setting	George Runger
12:40 PM – 12:50 PM	Q&A	All
12:50 PM – 1:00 PM	Next Steps • Post Event Survey	Kailey Love

Learning Objectives

1. Evaluate milestone performance using trend analysis.
2. Identify failure modes in the milestone performance.
3. Critically apply improvements to milestone performance.

Diabetic Screening Presenter: Multi Specialty Physicians

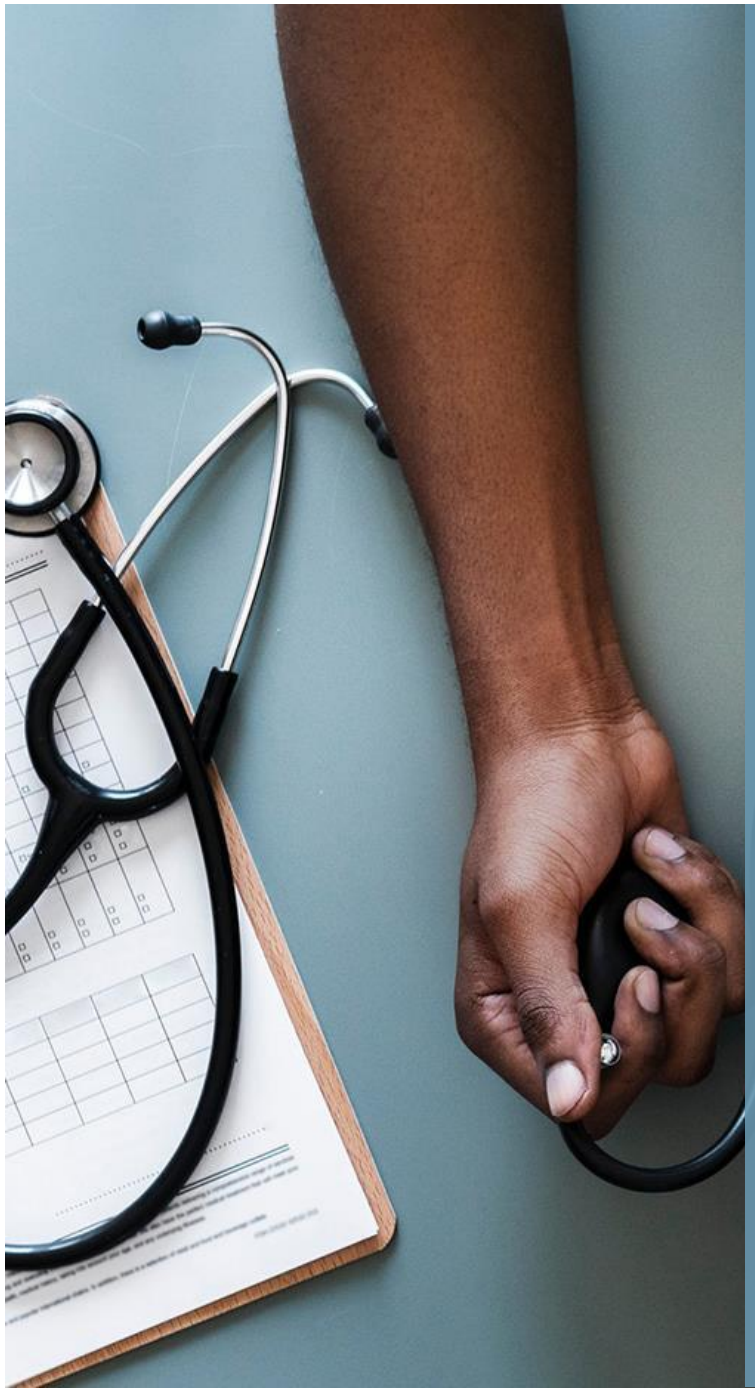


Performance Management Questions

- Process Stability
  - What type of variation is present?
    - Common Cause or Special Cause
- Process Capability
  - Performance of stable process
- Process Acceptability
  - Is milestone target met?

Metric: Diabetic Screening
Presenter: Multi Specialty Physicians

- Please identify at least three features of your current process that have contributed to why your performance on the Diabetic Screening metric is strong.
- What led you to develop each of the steps to improve the performance for this Metric?
- What obstacles did you overcome in order to develop the steps in #2?
- What do you feel are the top steps that you still need to improve? What needs to be done for you to make this improvement?



TIPQIC: Adult PCP

Multi-Specialty Physicians

Brenda Kamrath

Clinic Administrator

Andrea Durand, DBH, LCSW

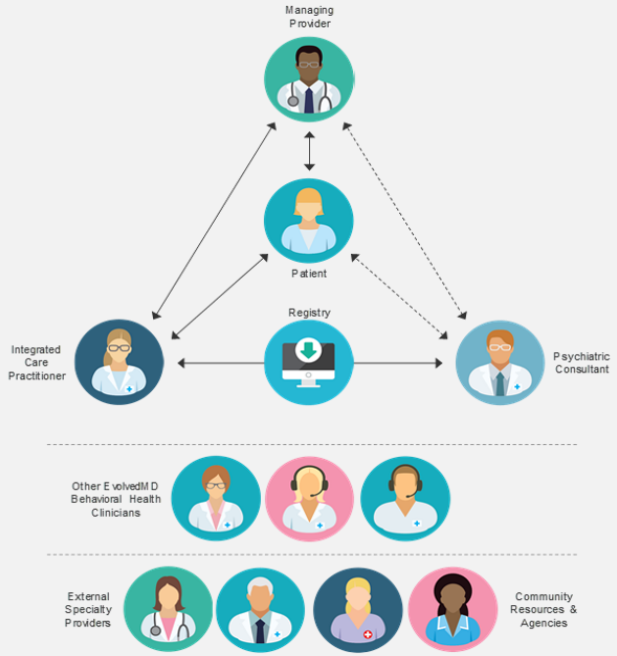
Director of Behavioral Health Integration

MSP

Multi-Specialty Physicians

Identify at least three features of your current process that have contributed to why your performance on Diabetic Screening is strong.

It has already been a longstanding policy of MSP to screen all patients who are on anti-psychotic medications for diabetes. The policy has been implemented even more diligently since integrating behavioral health into the practice



We have been fully integrated using the Psychiatric Collaborative Care Model (CoCM) for 2 ½ years. The model allows our onsite behavioral health managers to staff all patients with a psychiatrist for medication recommendations, allowing us to keep many patients in house

We are continually finding ways to educate both the physical and behavioral health staff on the comorbidities of chronic diseases and mental health through monthly trainings. When the metric first came out, phase 1 required all behavioral health managers to do a CEU training on diabetes and mental health so they could better understand the need

MSP
Multi-Specialty Physicians

What led you to develop each of the steps to improve the performance for this Metric?

WORKPLACE CULTURE

Since making the commitment to integrate behavioral health into the clinic we have focused on clinic culture, establishing the belief system that the physical is as important as the behavioral. This allowed us to work collaboratively on implementing the screening policy.

IDENTIFYING PATIENT NEED

We learned early on during integrating that patients who are stable and established on anti-psychotics would prefer to get ongoing treatment at their PCP office rather than navigate the complexities of outpatient behavioral health agencies.

PROCESS IMPROVEMENT

Another lesson we learned early on is that the interdisciplinary team collaborates much better through continuous education and consistent communication. This is why the Diabetes and mental health training was Phase 1.

What do you feel are the top steps that you still need to improve?

Patient Outreach

- Phase 2:Using patient report data to outreach patients who have fallen through the cracks
- This phase of the metric has been stalled due to COVID-19 being a priority

Metric Goals

- Developing a better understanding of the metric percentages so that we can create goals to work towards

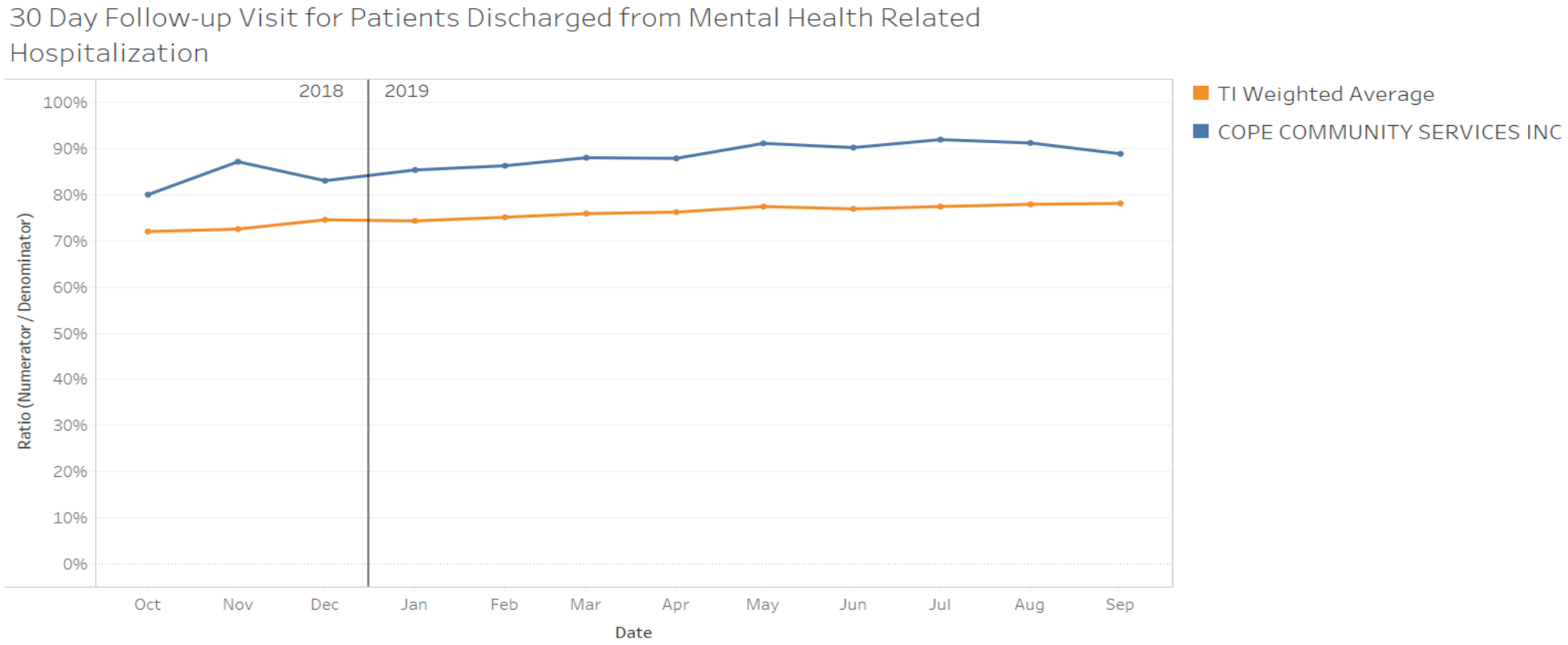
What needs to be done for you to make this improvement?

1. Develop a strategy to outreach patients that is COVID-19 sensitive
2. Once metric goals are reported by TIPQIC, ensure the new strategy is aligned with those same goals
3. Implement protocol to applicable clinic staff

Discussion Questions
Respondent: Cope Community Services

- Please give your response to Multi Specialty Physicians regarding what was helpful to you from their presentation for your organization.
- Please identify 2 or 3 challenges that you have had with Diabetic Screening. Explain why each of these have been difficult.
- Ask Multi Specialty Physicians if they had a similar challenge and what they did to overcome the challenge.

Metric: 30 Day Follow-up
Presenter: Cope Community Services



Presenter: 30 Day Follow-up Cope Community Services

- Please identify at least three features of your current process that have contributed to why your performance on the 30-Day Follow-up metric is strong.
- What led you to develop each of the steps to improve the performance for this Metric?
- What obstacles did you overcome in order to develop the steps in #2?
- What do you feel are the top steps that you still need to improve? What needs to be done for you to make this improvement?

COPE Community Services, Inc.

Creating Pathways to Better Health

Jenifer Regan

Rachel Vega

ASU College of Health Solutions
Arizona State University

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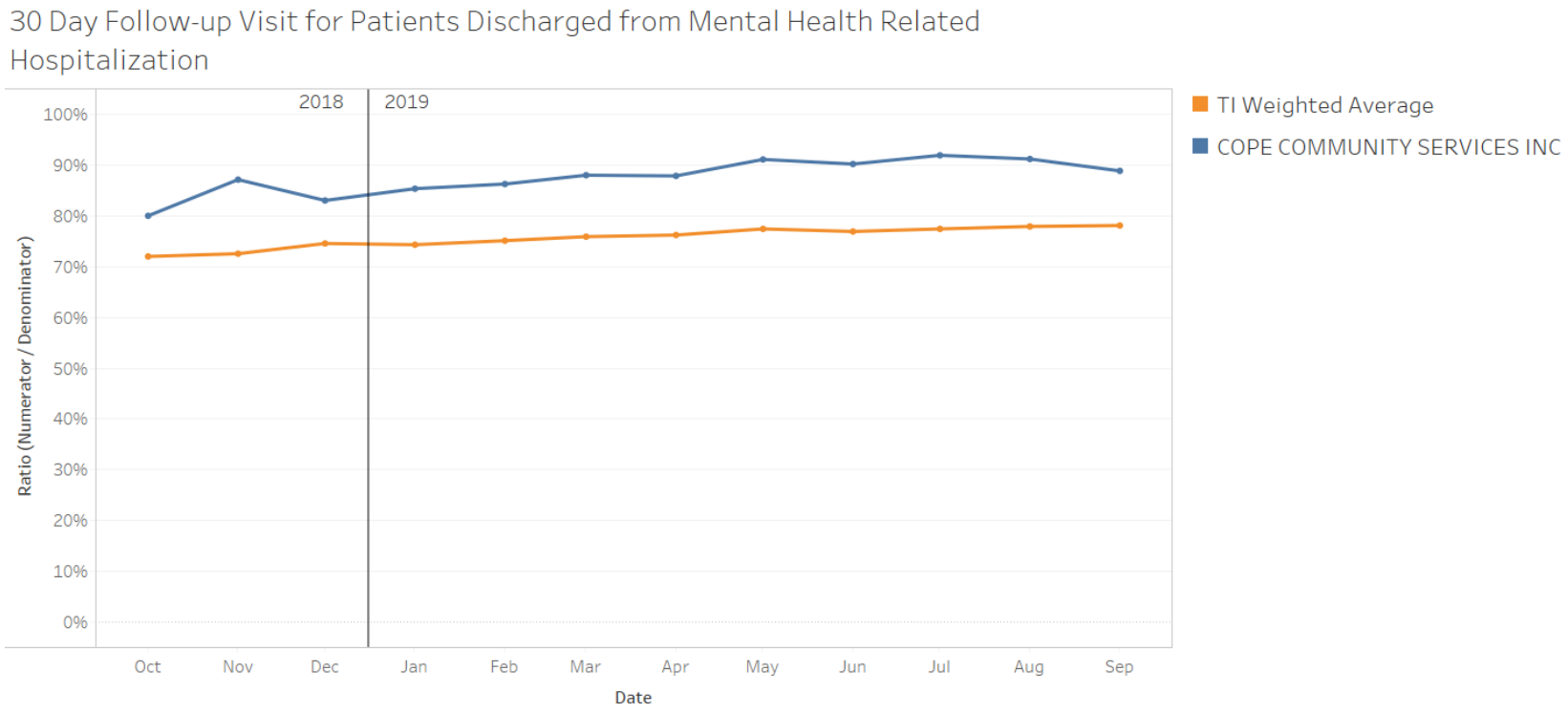
About COPE

- COPE Community Services is a private, nonprofit healthcare organization that creates pathways to better health by offering innovative solutions for behavioral and physical healthcare, wellness, and recovery to individuals and families.
- COPE offers comprehensive programs, specialty services, resources, and support to address general mental health and substance abuse issues, serious mental illness, physical healthcare, and wellness concerns.

COPE
COMMUNITY
SERVICES
INCORPORATED

30 day follow up from hospital discharge



Three strategies that contribute to compliance

- Strong Discharge Planning
- Electronic Health Record
- Use of health current data

Strong Discharge Planning

- Hospital discharge planners
- Collaboration between inpatient and outpatient teams
- Follow up appointments
- Peer support services
- Afterhours support

Electronic Health Record

- HIMS health record

- Compliance report capabilities
  - Appointment status report.
  - Internal monitoring of measure.
  - Easy access to programmers to update and change reports as needed.

Health Current data

- HIE alerts and real time feedback

- Profile set up
  - Full patient roster submitted on a weekly basis- which reports on all hospitalizations and emergency room visits

  - High Risk roster submitted on a weekly basis which generates daily alerts.
    - Information goes to their assigned high risk care manager in real time to ensure coordination of care and discharge planning.

Obstacles we had to overcome

- Continuous quality improvement

- Biggest barriers-
  - Not always notified by inpatient teams of admissions.
  - Inpatient team does not always know who the member is assigned to.
  - Not all inpatient facilities patriciate in the HIE.

What we still want to improve

- This measurement is satisfied by the service being completed by a physician or independently licensed staff.

- We will now begin exploring how we can enhance our current triage model to capture these faster, intending to see additional ways for warm hand offs.

What we still want to improve

- This measurement is satisfied by the service being completed by a physician or independently licensed staff.

HEDIS Measure	HEDIS Tips	Sample Codes Used
Follow-Up After Hospitalization For Mental Illness (FUH) Members who were discharged following hospitalization for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentages of discharges for which the member received follow-up within 7 days of discharge. • The percentage of discharges for which the member received follow-up within 30 days of discharge. **Ages:** 6 years and older *Performed: Jan. 1–Dec. 1 of measurement year**	• Schedule the 7-day follow-up visit within 5 days of discharge to allow flexibility in rescheduling. • If the member's appointment does not occur within the first 7 days post-discharge, please schedule the appointment to occur within 30 days.	**ICD-10-Dx:** Use the appropriate code family: F, T **CPT Codes:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99495, 99496, 99510 **Telehealth POS:** 02 **HCPCS:** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010-H2020, M0064, T1015 **CPT Codes:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **WITH POS:** 03, 05, 07, 09, 11-20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Next Steps to Improve

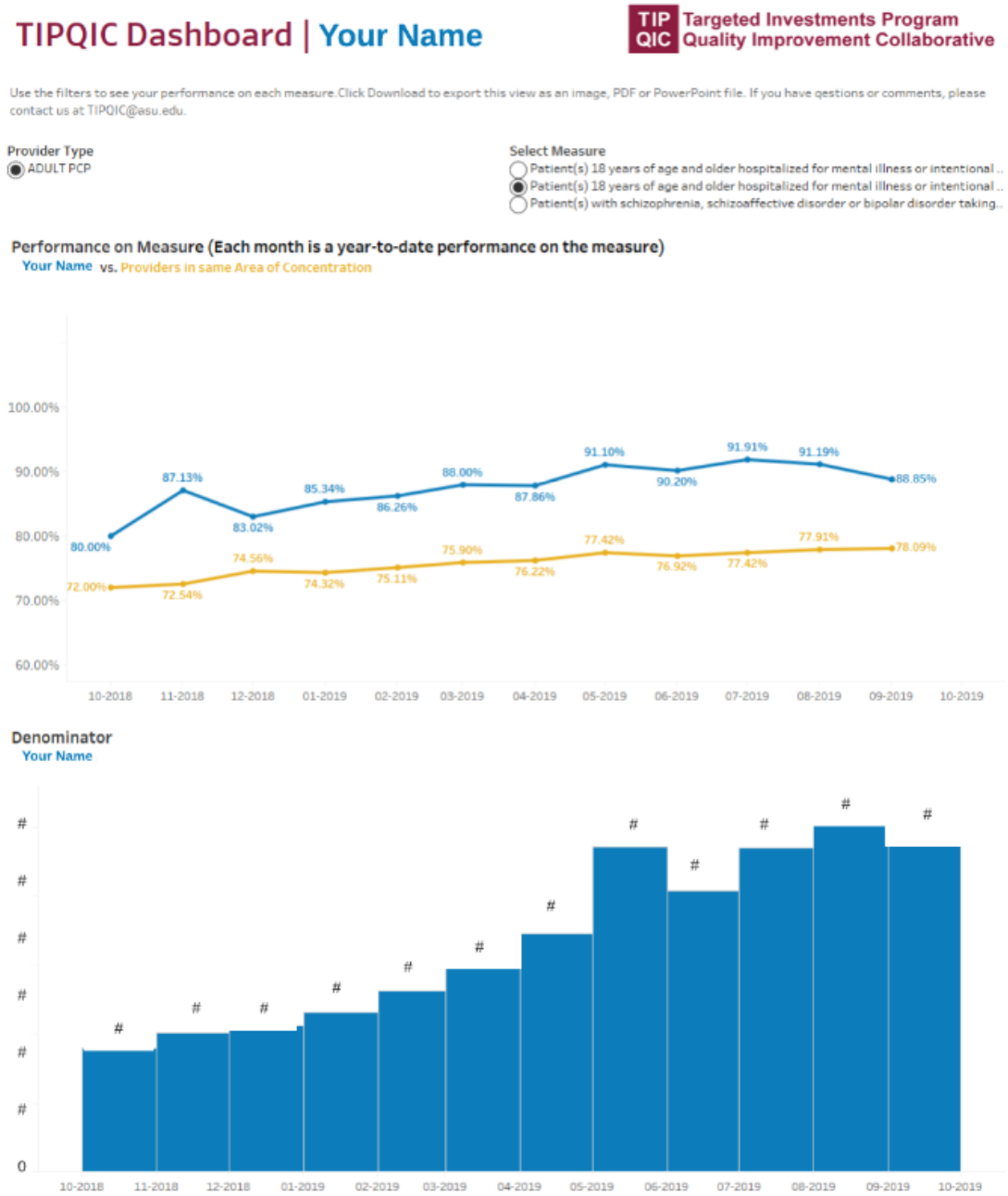
- COPE will begin to look at our triage processes and seek additional opportunities for patient to see a licensed provider.

- Ideally, we can look for ways to improve upon our practice of warm hand offs for patients who present for other support services.

Discussion Questions
Respondent: Banner University Primary Care Physicians

- Please give your response to Cope Community Services regarding what was helpful to you from their presentation for your organization.
- Please identify 2 or 3 challenges that you have had with 30 Day Follow-up. Explain why each of these have been difficult.
- Ask Cope Community Services if they had a similar challenge and what they did to overcome the challenge.

Dashboard Example

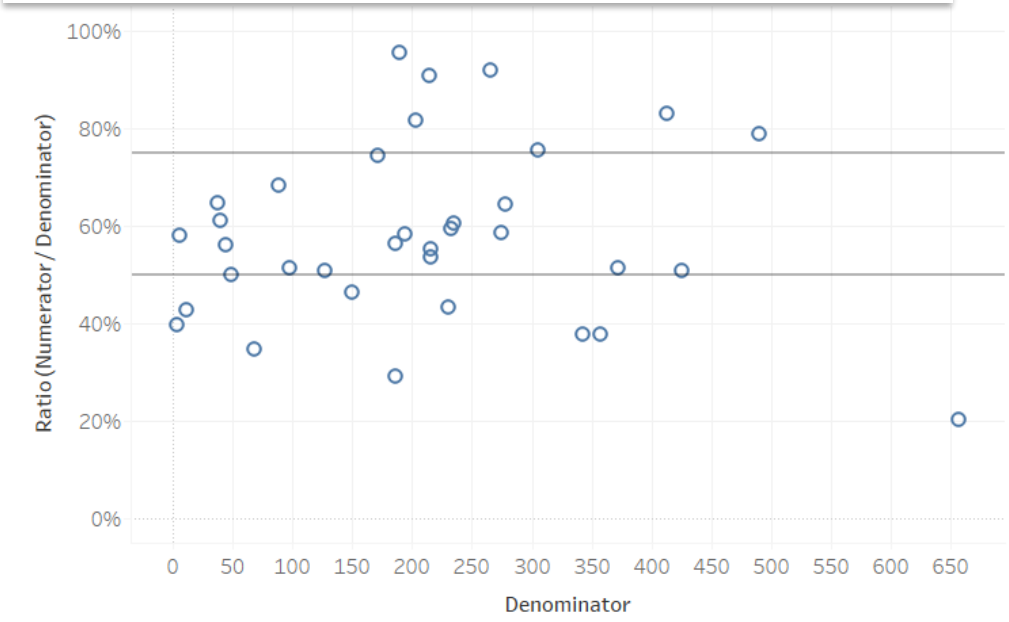


PCP Target Setting Methodology Update

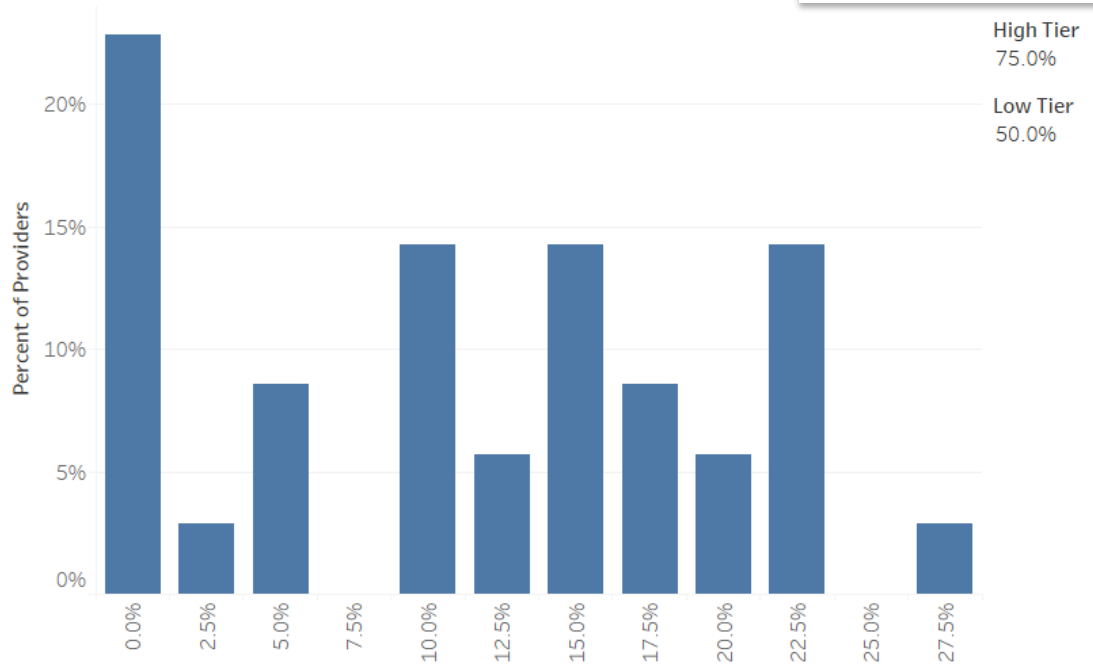
- Goal is to drive aggregate performance and encourage participants to achieve goals
- Reviewed
  - National Performance
  - AHCCCS Historical Performance
  - TIP Historical Performance
  - AHCCCS Minimal Performance Standards (MPS)
- Comprehensive analysis conducted
- Committee made recommendations based on blinded data

PCP Target Setting Visual

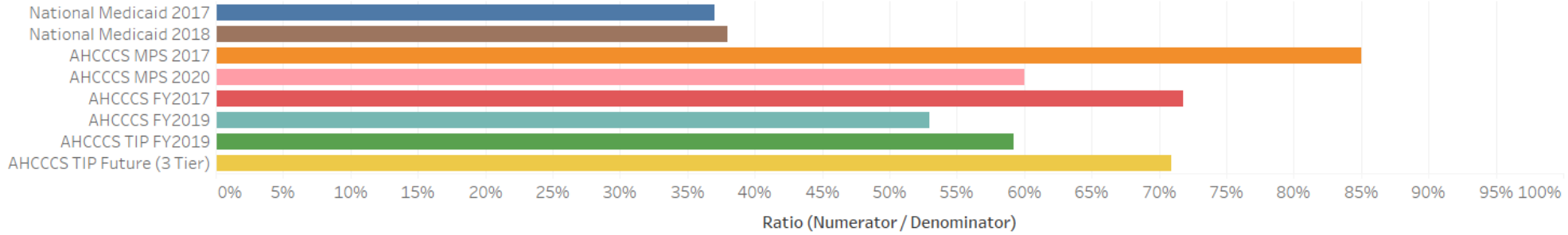
Example Data



Percentage-point change by provider



Aggregate Ratios



Q&A

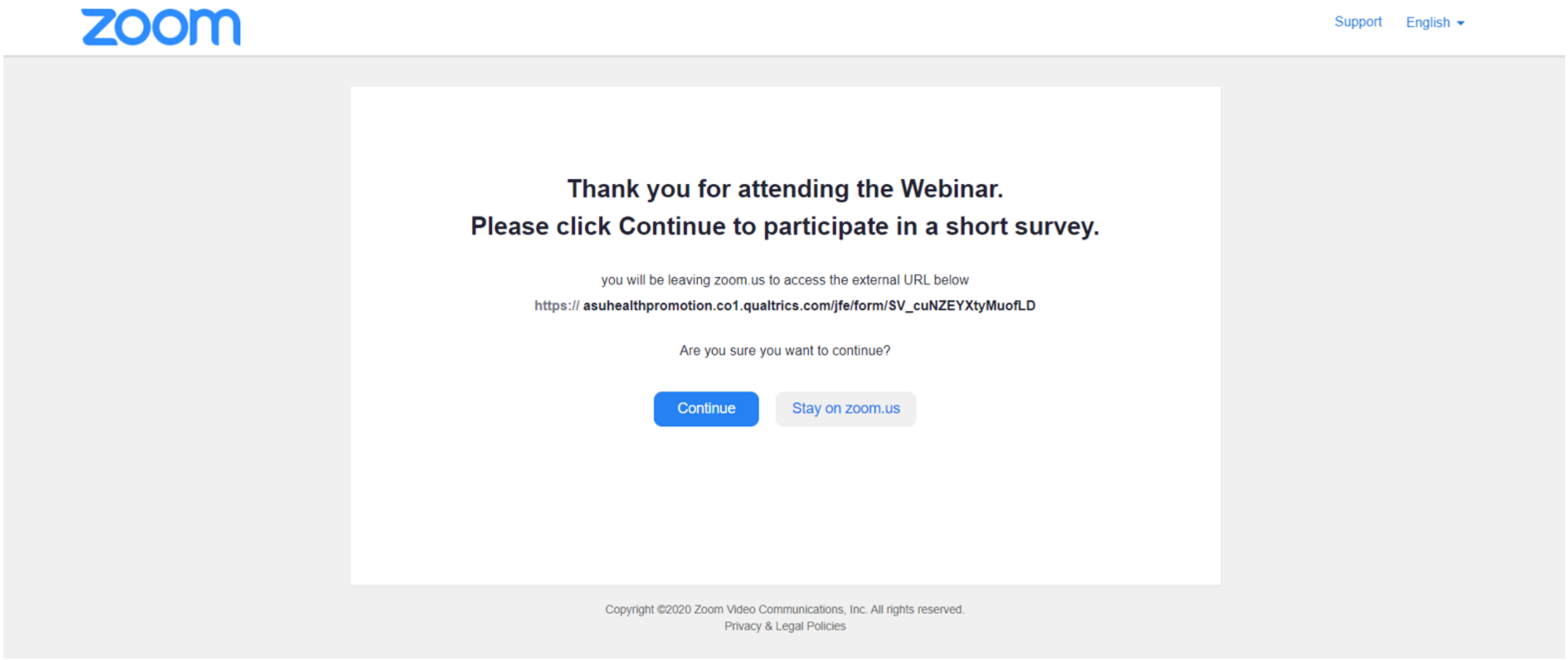
- Please insert any questions in the Q&A box

Next Steps

- Next Steps
  - Post-Event Survey: 2 Parts
    - General Feedback Questions
    - Continuing Education Evaluation
  - Continuing Education will be awarded post all 2020 QIC sessions (November 2020)

- Questions or concerns?
  - Please contact ASU QIC team at TIPQIC@asu.edu if questions or concerns regarding performance data

Post-Event Survey



Thank you!

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