AHCCCS Targeted Investments Program

Adult B Quality Improvement Collaborative

William Riley, PhD
George Runger, PhD

Session #3
April 8, 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

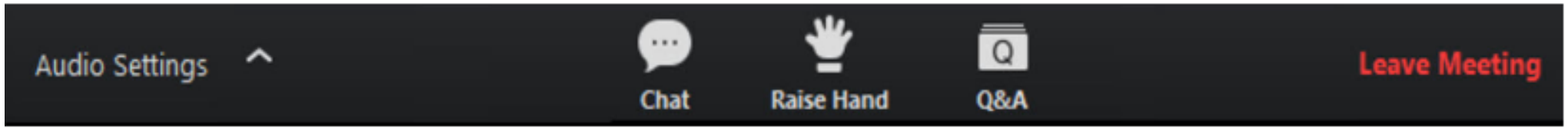
There are no disclosures for this presentation

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
  - All Adult and Peds PCP providers have been provided access to the dashboard
  - 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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Center Administrator
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Charlton Wilson, MD
Medical Director
Mercy Care

Neil Robbins, PhD
Data Scientist Specialist
ASU

Agenda

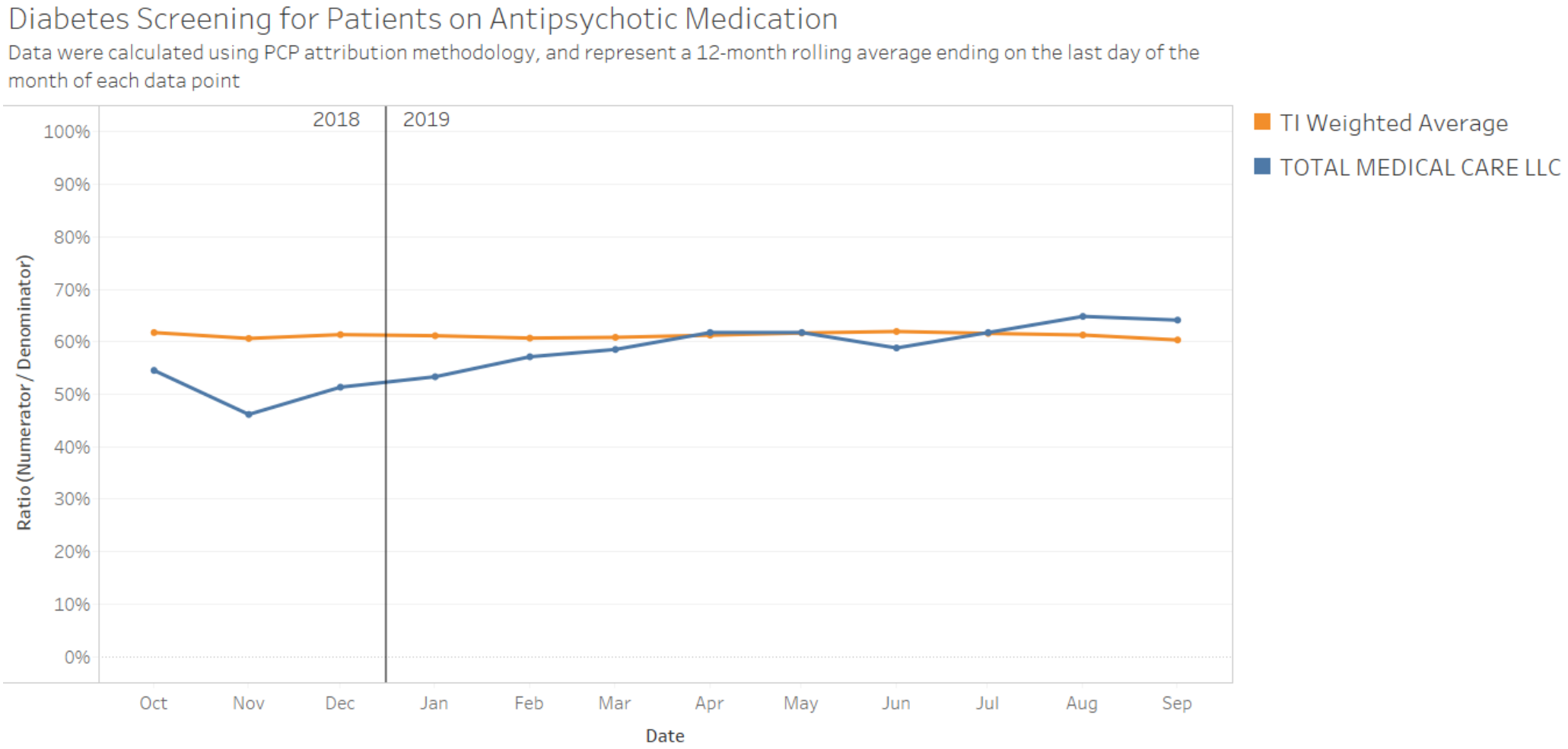
TIME	TOPIC	PRESENTER
11:30 AM – 11:40 AM	Overview • Agenda • Objectives • Feedback	Bill Riley
11:40 – 12:30 PM	Peer Learning • Diabetic Screening • 30 Day Follow-up	Presenter: Total Medical Care Respondent: Phoenician Medical Center Presenter: Southwest Behavioral Health Services Respondent: Forty Third Med Assoc.
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

Feedback

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: Total Medical Care



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: Total Medical Care

- Please identify at least three features of your current process that have contributed to why your performance on this 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?

Total Medical Care

Diabetic Screening Metric

Diabetes Screening for Patients on Antipsychotic Medication

Dr. Ahmad Z. Qasimyar

Anabil Frisby

Three features of our current process that have contributed to why our performance on this metric is strong.

1. Utilization of registry processor reports within our EMR system.
2. Patient record alerts.
3. In-house laboratory access, extended office hours, and weekend hours.

- Each feature was developed in order to improve our performance on this metric and the overall patient care experience.

REGISTRY PROCESSOR

Registry Processor

- A registry processor within our EMR system was utilized in order to be able to be to identify a patient population that falls into this specific metric. All of the patient's who have had a documented diagnosis of Bipolar disorder or Schizophrenia were generated into a list via the registry processor.
- An outreach to each individual patient was made and with that outreach a chart telephone note, a patient record alert, and an appointment was made in an effort to continue contributing to the diabetic screening metric for the well-being of the patient.

Patient Record Alerts

Patient Record Alerts

- Patient record alerts were put into practice with the idea that specific patients have certain high-risk clinical needs and/or behavior problems. This alert is configured to "pop up" during the patient look-up process.
- Providers and medical staff have the ability to create, inactivate, edit, and view patient record flag alerts.
- These record alerts have aided us in the process of informing our clinical staff of patient's clinical needs.

In-House Laboratory, Extended Office Hours, & Weekend hours

In-House Laboratory, Extended Office Hours, & Weekend hours

- Our office has always had the advantage of an in-house laboratory, extended office hours and weekend hours.
- This has allowed our clinic to offer patients with more flexibility; as our office accepts walk-in visits, scheduled appointments, has extended office hours, and is opened on the weekends.

*Due to COVID19 business hours/days have been changed temporarily.

How we overcame obstacles to develop features to improve our performance on this metric.

Registry Processor

- The initiation of the utilization of our EMR's registry processor was difficult as several steps were required in order to populate the specific patient list we needed. We worked closely with our EMR provider (e-MD's) and Lisa Morey, manager of provider network services, from Equality Health in order to obtain the necessary training for the usage of the registry.

Patient Record Alerts

- Our challenge with patient record alerts is assuring that low-value EMR alerts are not placed; as this can lead to the failure to notice high-value alerts. We are very selective on the patient's that these alerts are placed on ----as these alerts are useful for updates and reminders.

In-House Lab, Extended Hours, & Weekend Hours

- Our facility has had an in-house lab, extended hours, and weekend hours for years, however, adjustments to these features have been made in order to offer patients with more flexibility. Our in-house lab now closes half an hour later then than the past and all of the back-office staff is trained to provide phlebotomy services after our in-house lab, Sonora Quest, leaves for the day.

Diabetic Screening Metric Improvement Opportunities

- We believe that there is always room for improvement--- our staff continues to constantly improve our quality of care by coming forth with new ideas or suggestions.
- For the purpose of a diabetic screening for patients on antipsychotic medications we believe that a better integration and communication between behavioral health providers and primary care providers is essential in order to continue improving this measure. Better communication with our current co-located behavioral health provider can assist us with diabetic screening metric improvement opportunities.
- Encounters for screening examination for mental health and behavioral disorders is also another improvement opportunity that our office can benefit from, such as the PhQ-2, and PHQ-9. screenings. As there may be patients who suffer from bipolar disorder or schizophrenia disorder but have yet to be properly assessed and diagnosed.

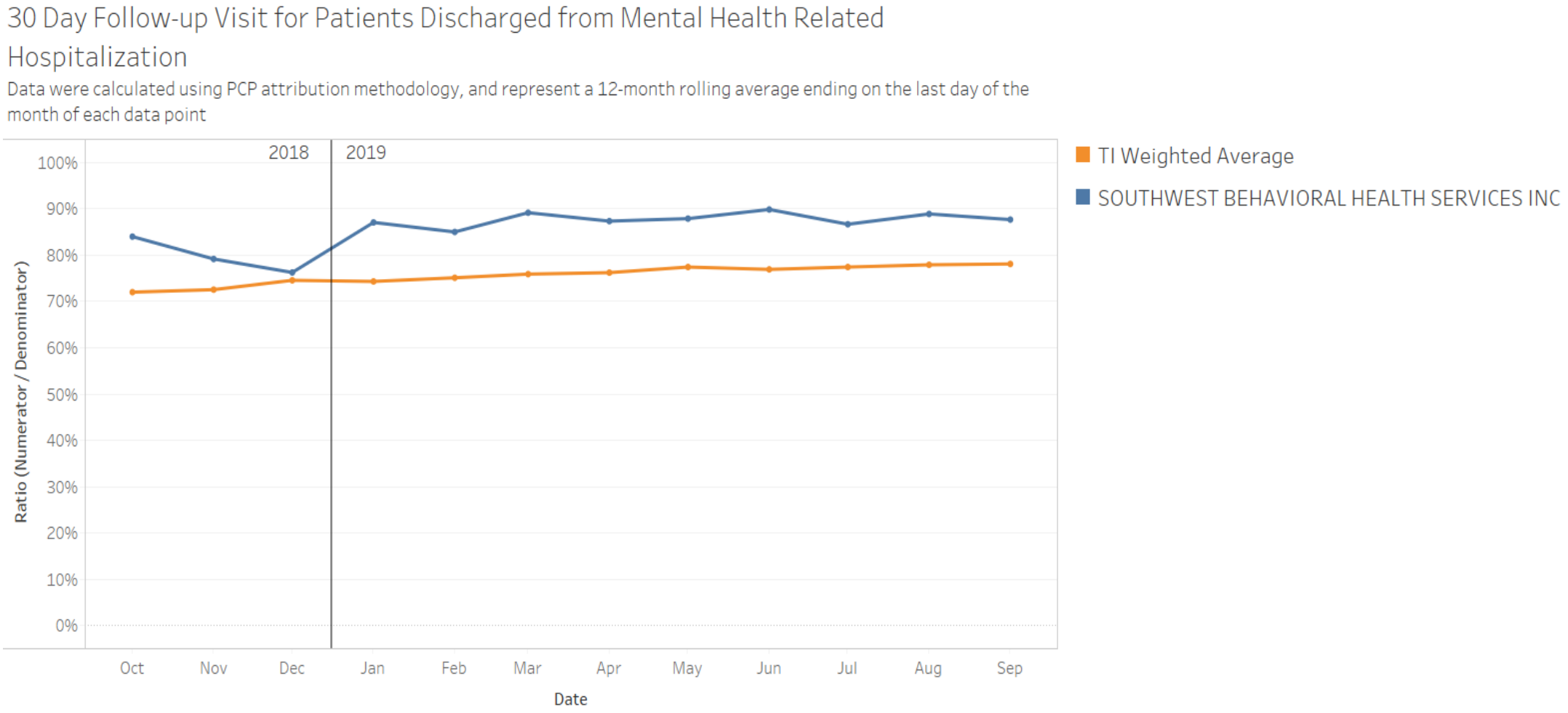
Diabetes Screening for Patients on Antipsychotic Medication

- **Questions or comments?**

Discussion Questions
Respondent: Phoenician Medical Center

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

Metric: 30 Day Follow-up
Presenter: Southwest Behavioral Health Services



Metric: 30 Day Follow-up
Presenter: SBHS

- Please identify at least three features of your current process that have contributed to why your performance on this 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?

SOUTHWEST BEHAVIORAL & HEALTH SERVICES

Hospital Navigation Program

Dominic Miller, LMSW, MPA
Vice President Outpatient Services

Marcie Herzog, LPC
Director of High Risk Populations

April 2020

HOSPITAL NAVIGATION PROGRAM

Focused Team

Implementation of a team focused on care transitions related to hospital admissions and discharge planning

Tracking Model

Developed a model that tracks existing members from first inpatient admission to 6 months after discharge

Coordination

Ensures daily coordination with hospital team while member is inpatient

Scheduling

Ensures scheduling of follow up BHMP appointment (72 hours) and clinician appointment (7 days) after discharge

Easier Intake

Implements intake for admitted members in the hospital setting if not already enrolled in program

Peer Groups

Monthly peer to peer consultation groups formulated by clinical team, BHMP, and Primary Care Provider to review care plan for high risk members on High Risk Registry

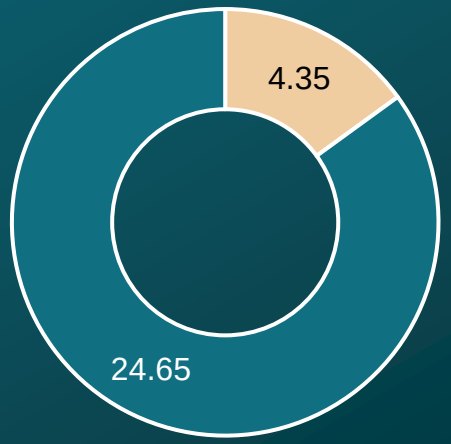
HOSPITAL NAVIGATION PROGRAM

Clinical Tracking Metrics:

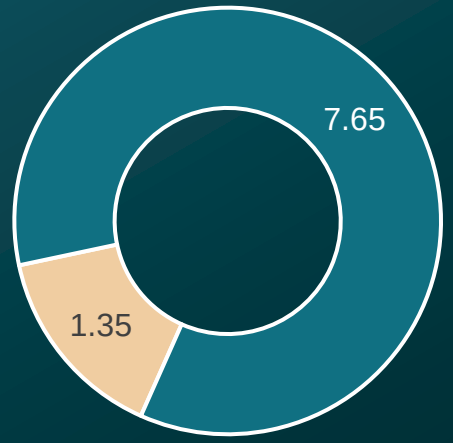
- Clinical Team Assignments (therapist, BHMP, etc)
- Inpatient Facility Information
- Date SBH was notified of admission
- Date of actual admission
- 24 hour hospital visit by navigator
- Safety/Support Plan is updated
- Peer to Peer (doc to doc) completed
- SMI Eval Request (if indicated)
- 72 Hour Prescriber appointment and completion
- Readmission data
- Number of services provided while inpatient
- Appointment completion percentage
- Inpatient Length of Stay
- 6 months of tracking after discharge

HOSPITAL NAVIGATION PROGRAM

- Recidivism – 80% adult and 85% child not readmitted
- Appointment completion – 85% compared to 64% in 2017
- Cost savings - $10k for a week of inpatient care
- Integrated care – PCP and FNP



Adult Readmission
2018 Quarter 1&2



Child Readmission
2018 Quarter 1&2

Year	Demographic Group	Readmit	Discharged
2018 Q1&2	Adult	4.35	24.65
2018 Q1&2	Child	1.35	7.65

POPULATION HEALTHCARE NEEDS AND HISTORICAL TRENDS

Increase of High-Risk members including frequent flyers to inpatient settings

Lack of completion of hospital discharge appointments with treating clinicians and prescribers

Estimated $1000 to $2000 in daily costs for hospital stay

SBH found increase in readmission is associated with physical health co-morbidities

Frequent change in care for these members including changing medications and clinical teams (enrolled in multiple providers for similar services)

NEEDS & TRENDS

INTEGRATING THE HEALTH INFORMATION EXCHANGE

1	2	3	4
Integrated care and holistic approach	HN Team utilizes HIE to inform coordination of care and communication between enrolled providers and Primary Care teams	Uncover medical co-morbidities that drive treatment changes to address medical and psychiatric needs	ADT alerts are used to inform HN Team of inpatient admission

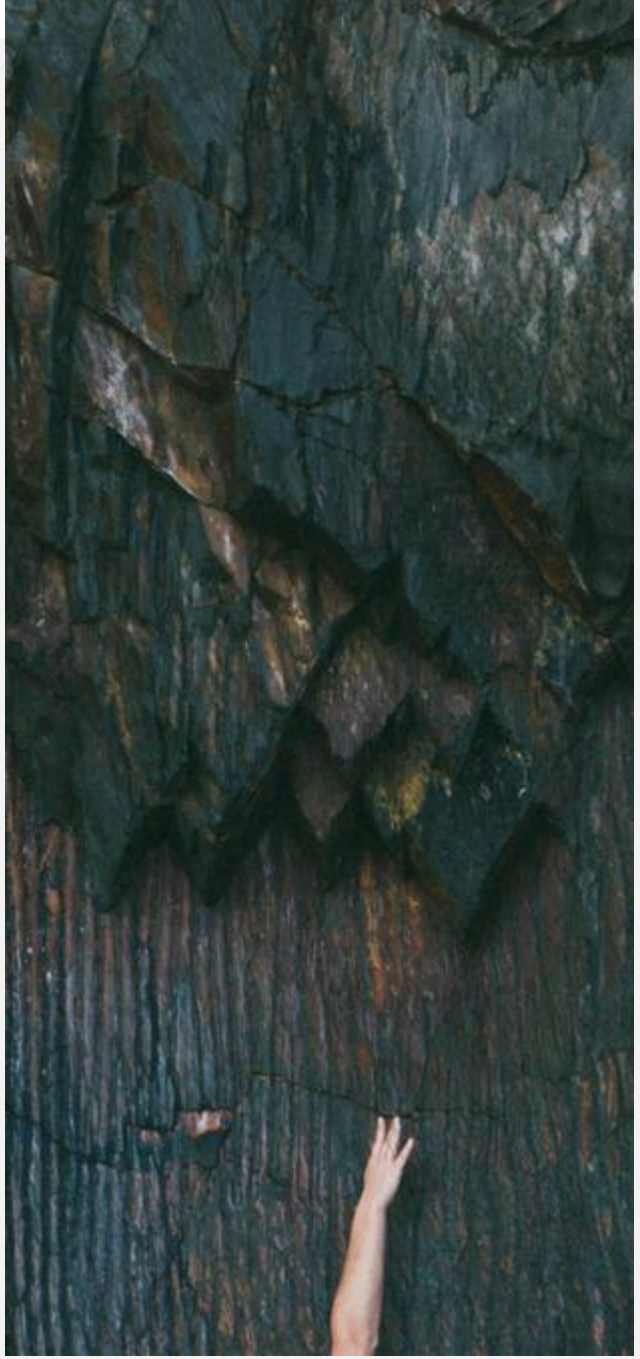
CHALLENGES

I. 42 CFR Part 2 protecting Substance Use Disorder personal health information – extra layer for consent

II. Developing framework to track inpatient stay and discharge data over 6 months

III. Building ‘Medical Neighborhood’ and familiarizing hospitals with our program

IV. Capturing Medicaid reimbursable encounters



VALUE PROPOSITION AND MOVING FORWARD

I. Estimated savings of $1000 - $2000 a day by diverting readmissions

II. Ongoing utilization management review of HN Team to inform appropriate staffing levels and success of program quarter over quarter

III. Utilization of HN Team to meet Value Based Contracting Measures with various health plans

IV. Practice earns on successfully met value-based indicators

V. Expansion into rural areas

THANK YOU

SOUTHWEST BEHAVIORAL & HEALTH SERVICES

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DISCUSSION QUESTIONS
RESPONDENT: FORTY THIRD MED ASSOC.

- Please give your response regarding what was helpful to you from the presentation for your organization.
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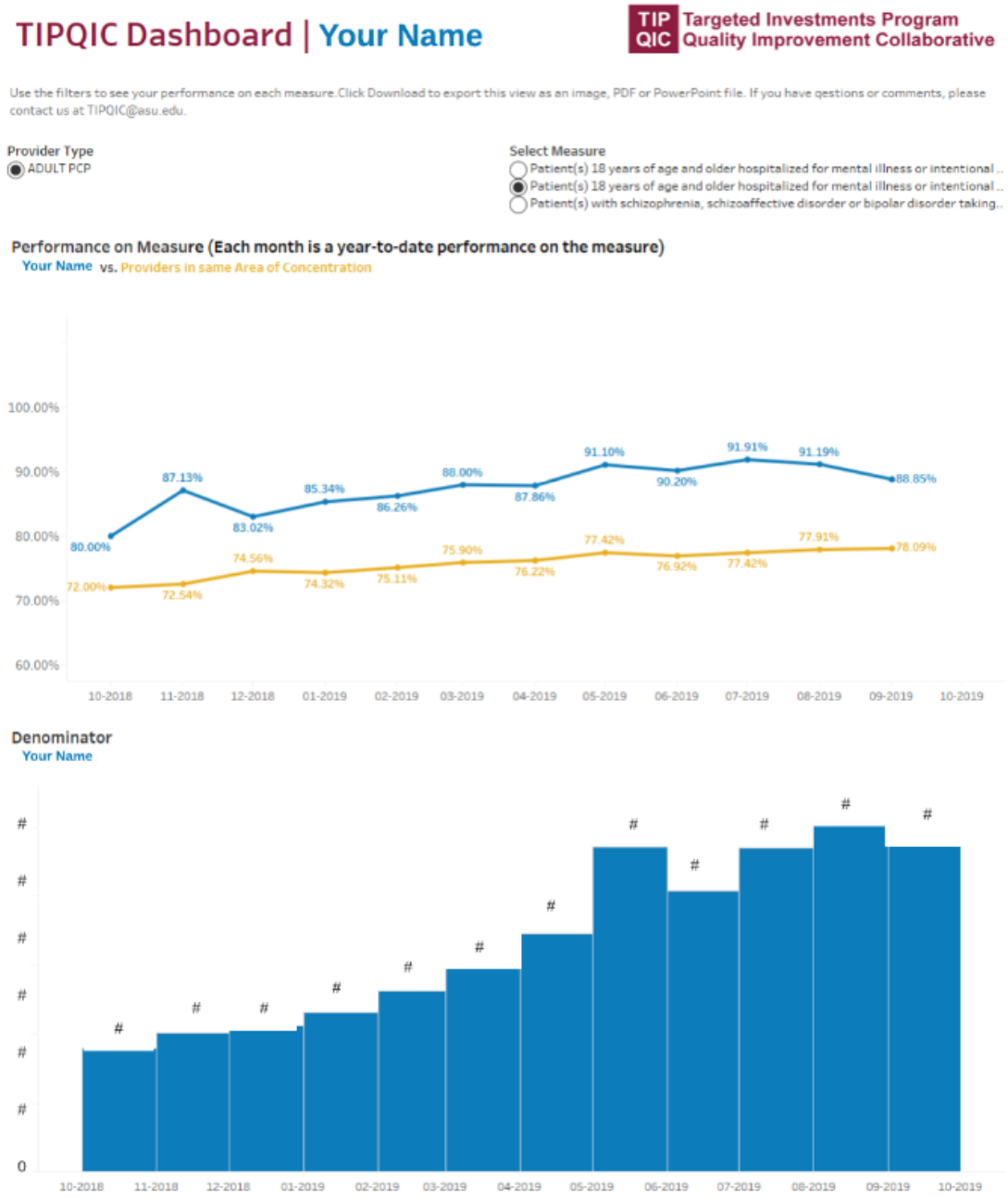
Dashboard Example

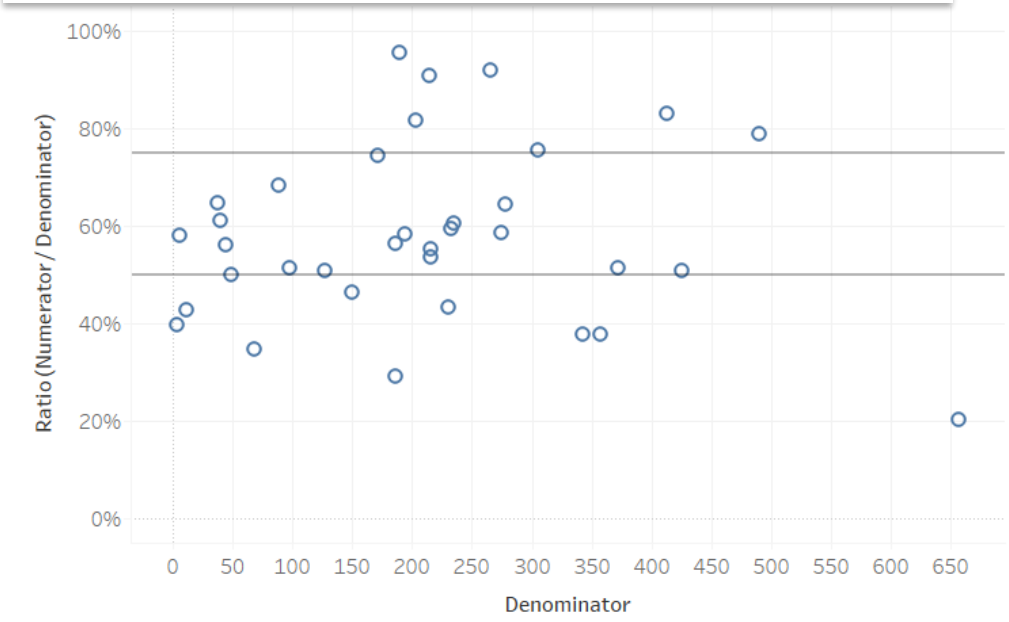


PCP Target Setting Methodology Update

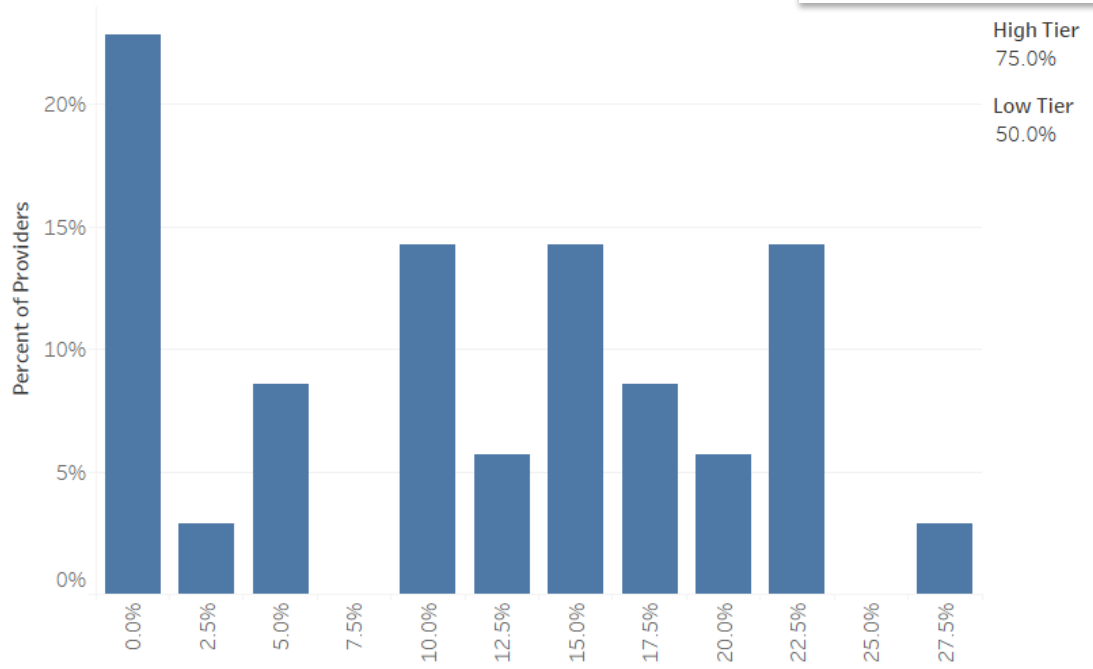
- Goal is to drive aggregate performance and encourage participants to achieve goals
- Reviewed
  - National Performance
  - AHCCCS Historical Performance
  - TIP Historical Performance
  - AHCCCS Minimal Performance Standards (MPS)
- Comprehensive analysis conducted
- Committee made recommendations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

PCP Target Setting Visual

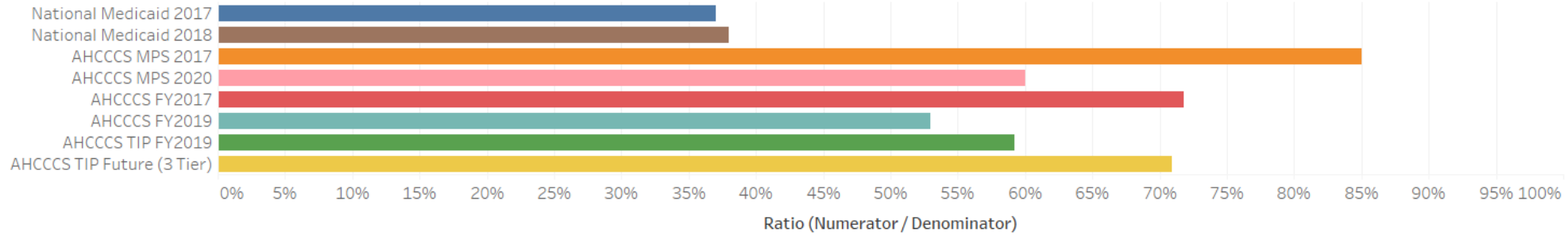
Example Data



Percentage-point change by provider



Aggregate Ratios



Q&A

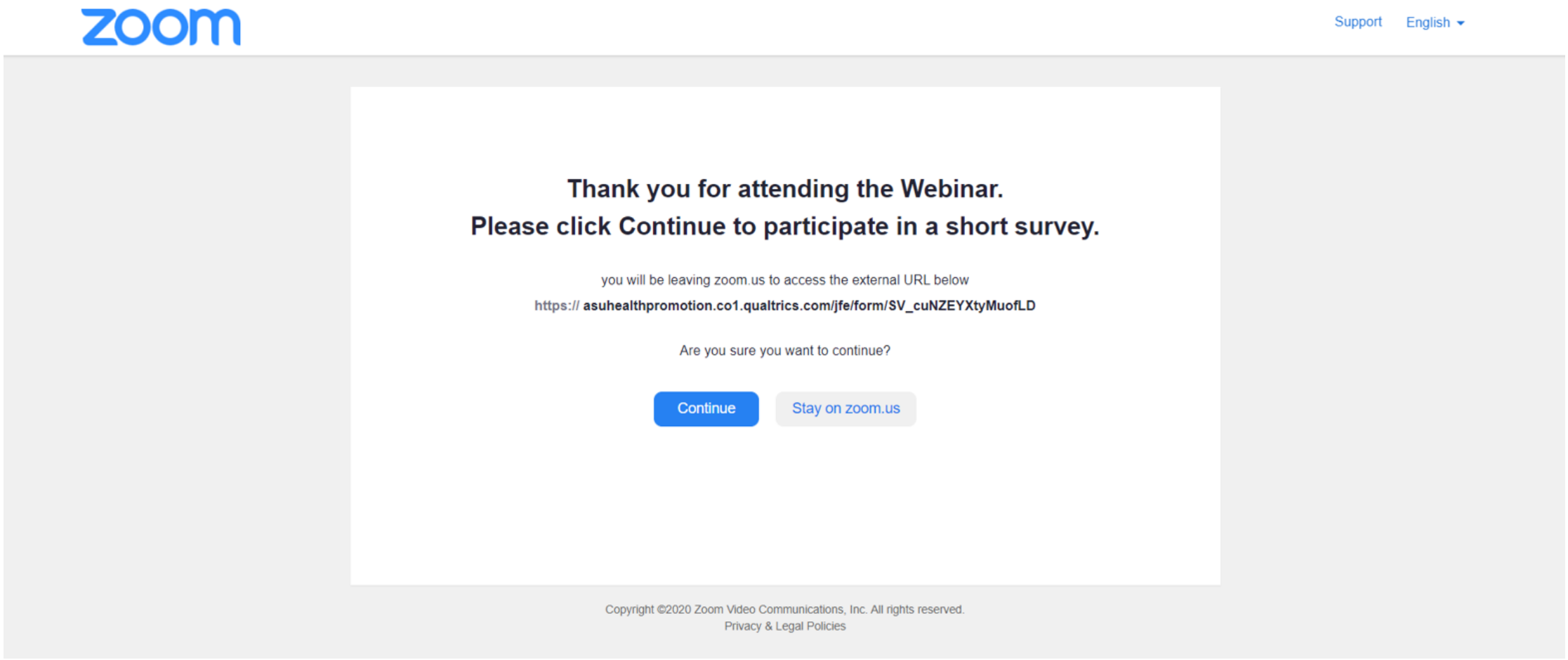
- Please insert any questions in the Q&A box

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!

TIPQIC@asu.edu

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