AHCCCS Targeted Investments Program

Peds A Quality Improvement Collaborative

Charlton Wilson, MD

Session #6
August 4, 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

Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	Overview • Agenda • Data Update	Kailey Love Neil Robbins, PhD
11:35 AM – 12:00 PM	Using Data to Reduce Costs & Improve Care – Targeted Investments QIC Program	Health Current
12:00 PM – 12:15 PM	Health Information Exchange Use Case	District Medical Group
12:15 PM – 12:50 PM	Discussion and Q&A	All
12:50 PM – 1:00 PM	Next Steps • Post Event Survey	Kailey Love

Data Updates

- Dashboard last updated 7/30/2020
  - Performance periods ending March 2019 – March 2020
  - Based on claims adjudicated as of May 31, 2020

- Why do our previously reported denominators (or performance) change when the dashboard is updated?
  - Changes can be caused by addition of, removal of, or revision to one or more of the following:
    1. Adjudicated claims
    2. Member eligibility
    3. Outcome of the attribution process
       - Each member's attribution is re-evaluated for all report periods prior to the Dashboard update
    4. Provider IDs or Group Billing IDs
    5. Allowed billing codes
       - E.g., inclusion of Collaborative Care Model codes for follow-up after hospitalization measures

Data Updates continued

- Response to COVID-19
  - We are monitoring the data as well as CMS and NCQA Guidelines
- Inclusion of Telehealth & Telephonic visits
  - Anticipate additional telehealth and telephonic codes will be included
  - We are reviewing AHCCCS Temporary and Permanent Telephonic Codes Sets as well as NCQA guidance for 2020
  - We will notify TI-Participants of decisions via email, QICs, and website
- Please look at www.TIPQIC.org for additional details

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Have any questions for the TIP Data Team?

Please e-mail TIPQIC@asu.edu to schedule a Zoom meeting

Provider meetings often cover topics such as:

- How to read the Dashboard
- Attribution methods
- HEDIS performance criteria
- Performance reporting

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Using Data to Reduce Costs & Improve Care – Targeted Investments QIC Program

Christy Dye, MPH
Chief Business Development Officer

Peter Steinken, Pharm.D.
Director of Community Engagement

August 2020

Learning Objectives

1. Demonstrate how to retrieve relevant information regarding four Targeted Investment Program measures from Health Current.
2. Apply methods and strategies for customizing HIE data and services to know when a patient encounter requires action to meet a Targeted Investment Program measure.

How the HIE Can Help to Achieve Targeted Investment Program Measures

HIE vs. Other Data Sources

Source	Strengths/Weaknesses
HIE	• Frequency can be customized to provider need • Comprehensive (all treating providers) • Part 2 limitations for some providers & services
EHR	• Provider services/data only
Claims	• Lagged • Contingent on quality, completeness of coding • Comprehensive (all treating providers)
Staff	• Anecdotal
Special Data Extracts (ACO, health plan, CIN)	• Targeted • May only be partial population

TI Performance Measures & HIE Data Support

Y4 Measure	Performance Goal	HIE Service
Pediatric Wellness Visits	# of visits in first 15 months of life	HIE Portal, ADT Alerts, HIE Data Reports
Diabetes Screening	A1c test during measurement year	HIE Portal, LAB Alerts, HIE Data Reports
Hospitalization for Mental Illness	Follow up from discharge 7/30 days	HIE Portal, ADT Alerts
Metabolic Monitoring	Metabolic testing in measurement year	HIE Portal, LAB Alerts

Using the HIE Portal

HIE Portal

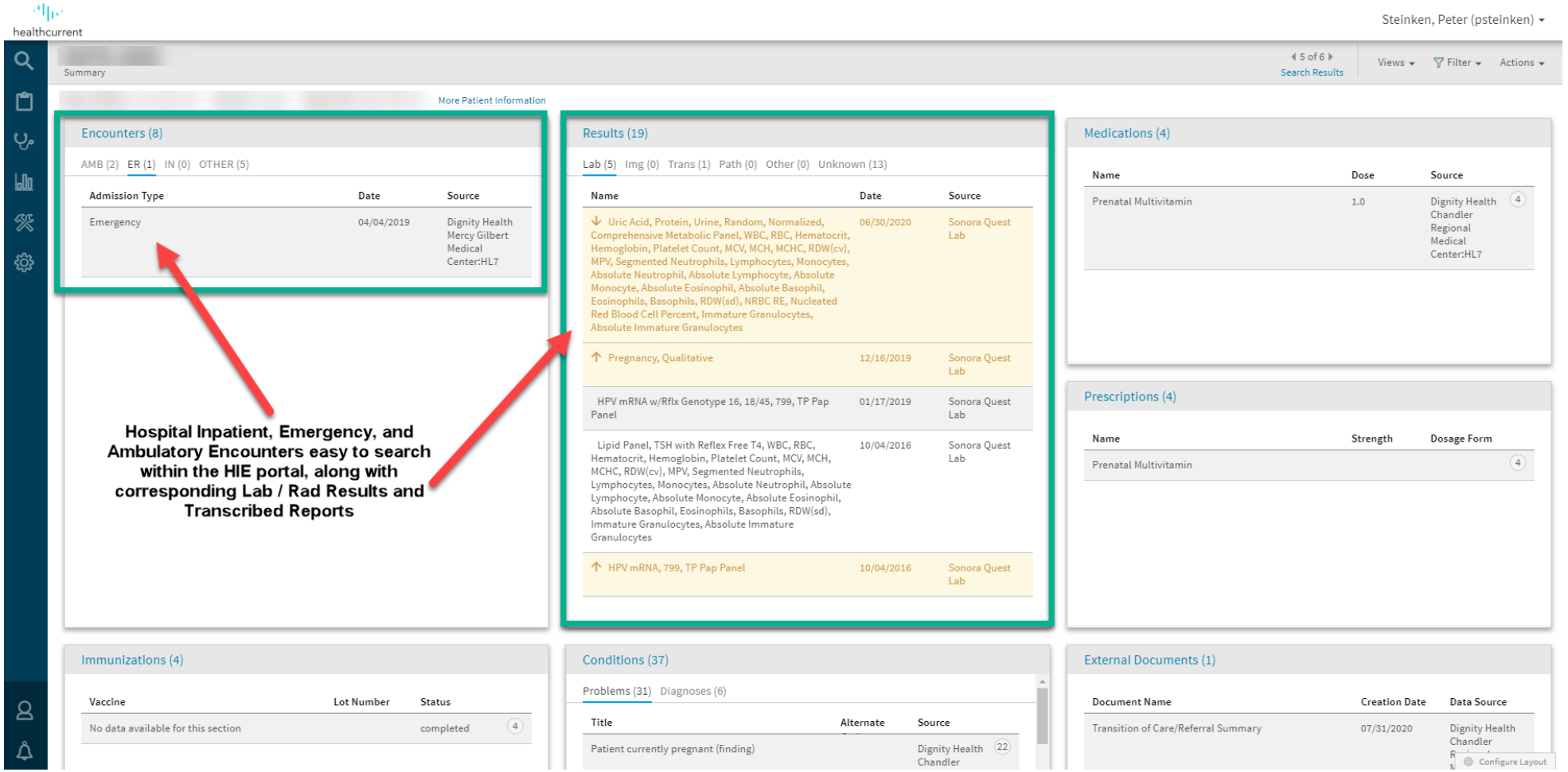
Secure online access to a consolidated patient record, including specialized view of SMI patient crisis data

- Includes all treating physical care providers. Can include behavioral health services with patient consent.
- Individualized – one patient at a time
- Used by care managers & clinicians to identify the complete patient history for care coordination, transitions of care, changes, etc.
- Can use 36-month period for population health activities (risk stratification, outreach campaigns, etc.)

Data Available (varies by data source)

- Demographics
- Encounters (Inpatient/ED/Outpatient)
- Results (Lab/Rad/Trans)
- Allergies/Adverse Reactions
- Medications/Prescriptions
- Conditions (Diagnosis/Problems)
- Procedures/Treatments
- Immunizations
- Vital Signs
- Advance Directives
- Payers
- Family History
- Social History
- Clinical Documents
  - Discharge Summary
  - CCD/CCDA
  - Emergency Room Report
  - Encounter Summary
  - Progress Notes
  - Transition of Care/Referral Summary
  - History & Physical Report
  - Operative Note
  - Consultation Note
  - BH Court Orders

Finding Visits, Hospitalizations & Clinical Lab Results



Using HIE Alerts

Patient Alerts

Event-driven notifications triggered by admissions, discharges, registrations and clinical/laboratory results

- Notification that an identified event has happened to a member of a pre-defined population (e.g. high needs patients, chronic care panels, SMI, condition-specific panels)
- Used by care managers, case managers & clinicians for monitoring care plan activities (e.g. annual labs, needed tests) & utilization of services

Setting Up Alerts for Visits, Hospitalizations & Lab Results

Upload your list of patients to the HIE

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Health Current Specification for Patient Panel Data Load														
2															
3									5 or 10 digits	yyyymmdd	M, F, or U	9 digits (no dashes)	(123) 456-7890	(123) 456-7890	A for Add D for Delete
4	Required Value	Required Value	Required Value	Suggested	Required Value	Required Value	Required Value	Required Value	Required Value	Required Value	Required Value	Optional	Optional	Optional	Required Value
5	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
6	Unique Patient ID	Last Name	First Name	Middle Name	Street Address1	Street Address2	City	State (2 Letter Abbreviation)	ZIP	DOB	Gender	SSN	Home Phone	Work Phone	Transaction Code
7															
8															
9															
10															
11															
12															
13															

Types of Alerts

Admission / Discharge / Transfer (ADT)

- Emergency Department Visits
- Hospital Inpatient Admits
- Outpatient Treatment Visits

Laboratory Results

- By Ordering Provider
- Out of Range Results
- COVID-19 Lab Results/Antibody Tests

Alert Delivery

Real-time Alerts

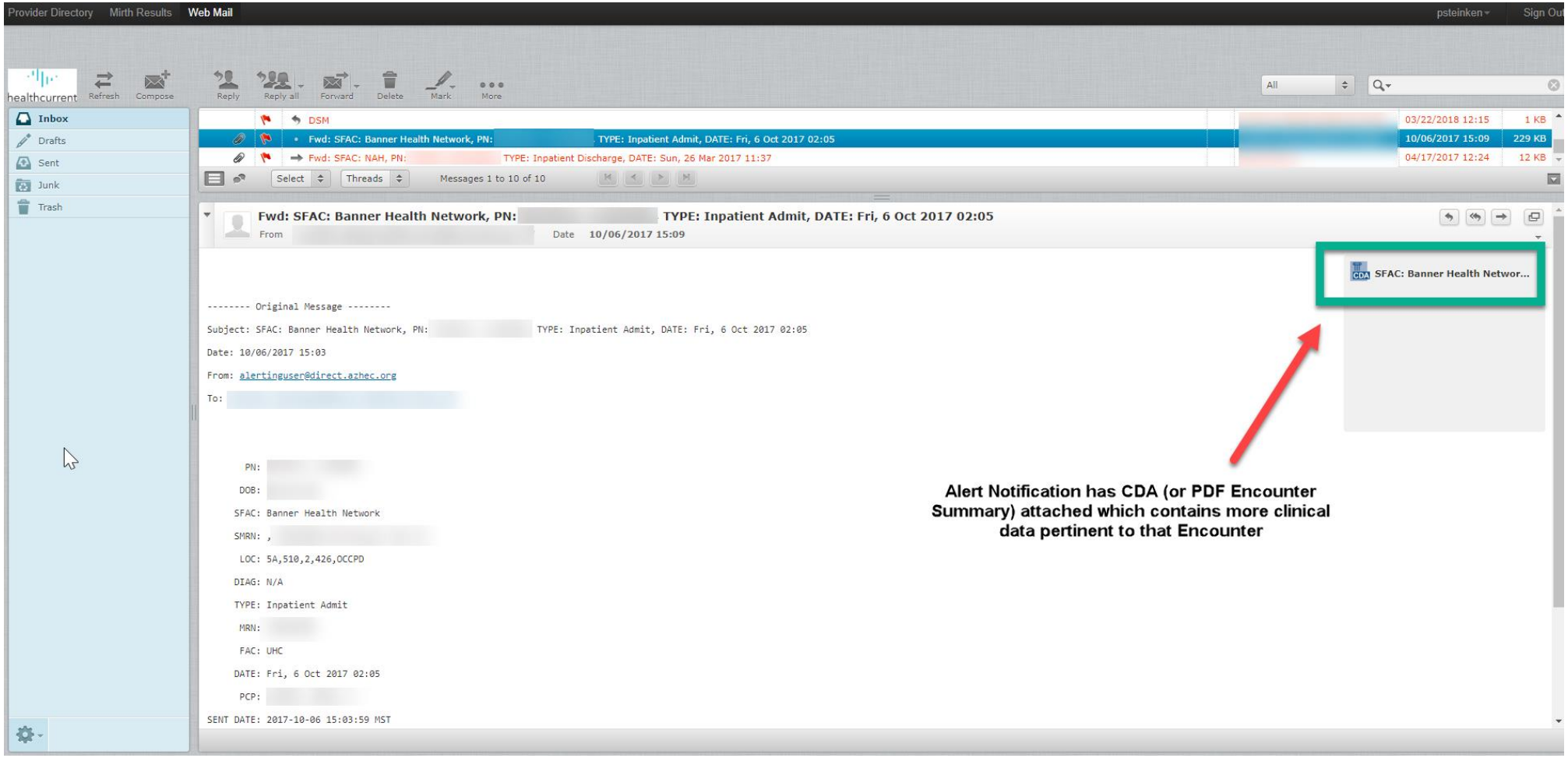
- Individualized based on identified event
- Immediate care team response, next day coordination of care, follow through on tests ordered

Batch Alerts

- Aggregate reports for all patients experiencing the event or condition being monitored
- Can be trended to monitor performance over time at a team/clinic level

Setting Up Alerts for Visits, Hospitalizations & Lab Results

Real-time Alerts sent via Direct Secure Messaging



Setting Up Alerts for Visits, Hospitalizations & Lab Results

Batch Alerts sent via Direct Secure Messaging or SFTP

[redacted] Batch Notifications

Banner Health :	ED Admit				2018-07-18 07:30 AM		
Patient	DOB	Source MRN	PCP	Diagnosis	Facility MRN	Date	Location
[redacted]	[redacted]	[redacted]:BH-Desert Med Ctr	GERALD R SHOCKEY	N/A	[redacted]	17-Jul-2018 07:39 AM	N/A
[redacted]	[redacted]	[redacted]:BH-Page Community Hosp	SCOTT D SADLER	N/A	[redacted]	17-Jul-2018 10:51 AM	N/A
[redacted]	[redacted]	[redacted]:BH-Boswell Med Ctr	RAMA	N/A	[redacted]	17-Jul-2018 12:19 AM	N/A
[redacted]	[redacted]	[redacted]:BH-Page Community Hosp	DAVID	N/A	[redacted]	17-Jul-2018 10:43 PM	N/A

Dignity Health Chandler Regional Medical Center :	ED Admit				2018-07-18 07:30 AM		
Patient	DOB	Source MRN	PCP	Diagnosis	Facility MRN	Date	Location
[redacted]	[redacted]	[redacted]	TERESA M AYELA-UWANGUE	N/A	[redacted]	17-Jul-2018 09:07 AM	EMERGENCY DEPT|undefined

HonorHealth Osborn Hospital :	ED Discharge				2018-07-18 07:30 AM		
Patient	DOB	Source MRN	PCP	Diagnosis	Facility MRN	Date	Location
[redacted]	[redacted]	[redacted]:HH-NMH	SUSAN	786.52-Painful respiration R07.89-Other chest pain	[redacted]	17-Jul-2018 04:34 AM	SCOTTSDALE OSBORN MEDICAL

```
Sending Facility, Visit Type, Sending ID, Patient, DOB, Patient ID, PCP, Diagnosis, Date, Time, Location
Banner Health,ED Admit,[redacted]N/A, NO,N/A,11-Jan-2019,07:28 PM,N/A
Banner Health,ED Discharge,[redacted]N/A, NO,N/A,12-Jan-2019,10:40 PM,N/A
Banner Health,ED Admit,[redacted]N/A, NO,N/A,12-Jan-2019,01:24 PM,N/A
Banner Health,ED Discharge[redacted]N/A, BLANK,N/A,12-Jan-2019,03:16 PM,N/A
```

Alert Decisions

Pilot:

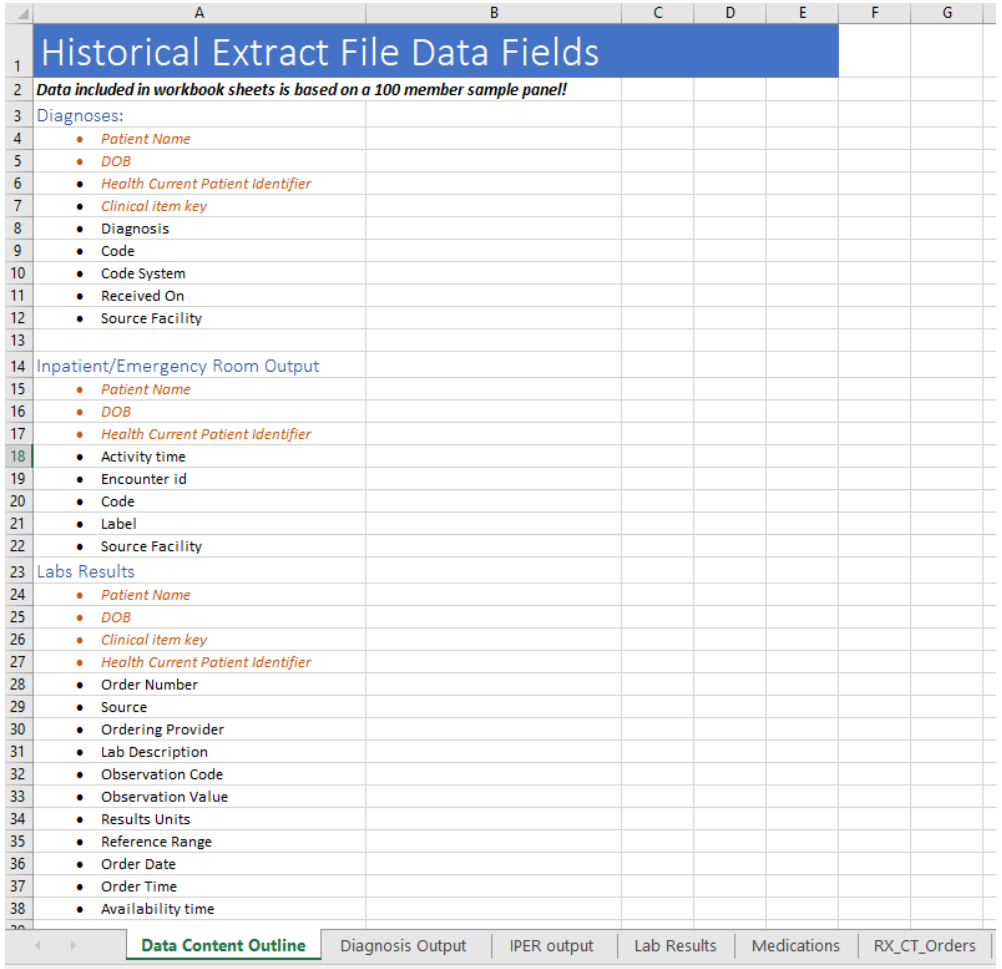
- Which patients?
- Which alerts?
- Who will receive alerts?
  - Primary and backup / Manager and staff
- How will they be managed?
  - Addressed
  - Complete
  - Documentation

Rollout:

- How to expand use?

HIE Data Reports

Historical “look-back” Reports for Diagnoses, Encounters, Lab Results, etc.

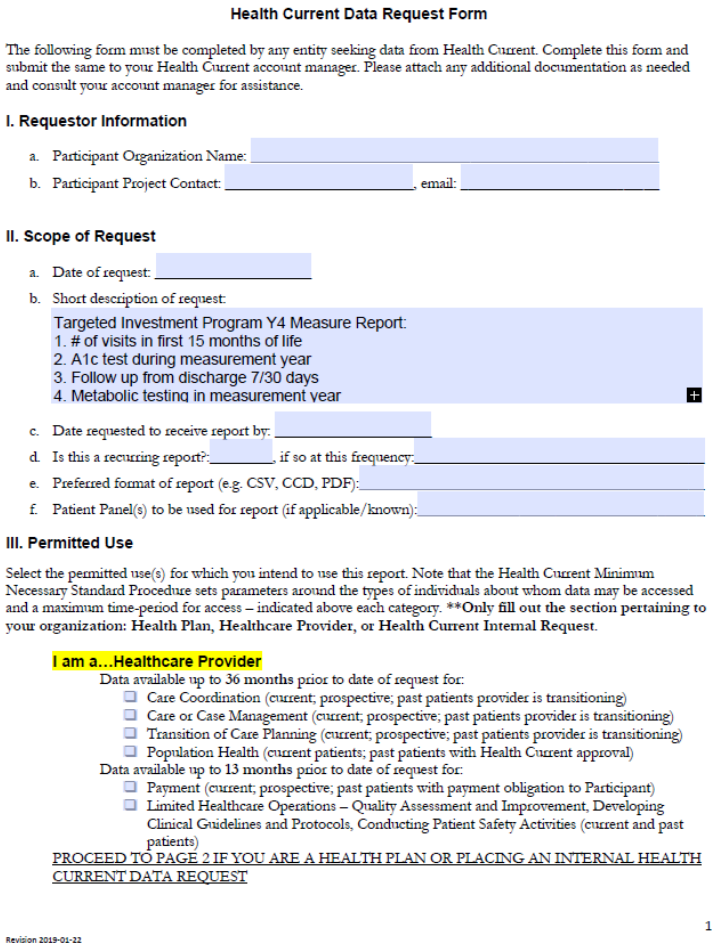


	A	B	C	D	E	F	G
1	Historical Extract File Data Fields						
2	*Data included in workbook sheets is based on a 100 member sample panel!*						
3	Diagnoses:						
4	• *Patient Name*						
5	• *DOB*						
6	• *Health Current Patient Identifier*						
7	• *Clinical item key*						
8	• Diagnosis						
9	• Code						
10	• Code System						
11	• Received On						
12	• Source Facility						
13							
14	Inpatient/Emergency Room Output						
15	• *Patient Name*						
16	• *DOB*						
17	• *Health Current Patient Identifier*						
18	• Activity time						
19	• Encounter id						
20	• Code						
21	• Label						
22	• Source Facility						
23	Labs Results						
24	• *Patient Name*						
25	• *DOB*						
26	• *Clinical item key*						
27	• *Health Current Patient Identifier*						
28	• Order Number						
29	• Source						
30	• Ordering Provider						
31	• Lab Description						
32	• Observation Code						
33	• Observation Value						
34	• Results Units						
35	• Reference Range						
36	• Order Date						
37	• Order Time						
38	• Availability time						

Data Content Outline | Diagnosis Output | IPER output | Lab Results | Medications | RX_CT_Orders

Future Initiatives to Support TI Providers

HIE Data Reports



Health Current Data Request Form

The following form must be completed by any entity seeking data from Health Current. Complete this form and submit the same to your Health Current account manager. Please attach any additional documentation as needed and consult your account manager for assistance.

I. Requestor Information

a. Participant Organization Name: _____

b. Participant Project Contact: _____, email: _____

II. Scope of Request

a. Date of request: _____

b. Short description of request:

Targeted Investment Program Y4 Measure Report:
1. # of visits in first 15 months of life
2. A1c test during measurement year
3. Follow up from discharge 7/30 days
4. Metabolic testing in measurement year

c. Date requested to receive report by: _____

d. Is this a recurring report?:_____, if so at this frequency:_____

e. Preferred format of report (e.g. CSV, CCD, PDF):_____

f. Patient Panel(s) to be used for report (if applicable/known):_____

III. Permitted Use

Select the permitted use(s) for which you intend to use this report. Note that the Health Current Minimum Necessary Standard Procedure sets parameters around the types of individuals about whom data may be accessed and a maximum time-period for access – indicated above each category. **Only fill out the section pertaining to your organization: Health Plan, Healthcare Provider, or Health Current Internal Request.

I am a…Healthcare Provider

Data available up to 36 **months** prior to date of request for:

- ☐ Care Coordination (current; prospective; past patients provider is transitioning)
- ☐ Care or Case Management (current; prospective; past patients provider is transitioning)
- ☐ Transition of Care Planning (current; prospective; past patients provider is transitioning)
- ☐ Population Health (current patients; past patients with Health Current approval)

Data available up to 13 **months** prior to date of request for:

- ☐ Payment (current; prospective; past patients with payment obligation to Participant)
- ☐ Limited Healthcare Operations – Quality Assessment and Improvement, Developing Clinical Guidelines and Protocols, Conducting Patient Safety Activities (current and past patients)

PROCEED TO PAGE 2 IF YOU ARE A HEALTH PLAN OR PLACING AN INTERNAL HEALTH CURRENT DATA REQUEST

1

Revision 2019-01-22

Imagine fully informed health.

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Imagine fully informed health

Health Current District Medical Group Use Case

VERONICA OJEDA, PHYSICIAN PRACTICE TRANSFORMATION MANAGER

HARLYN V. CHACON, LMSW- CARE MANAGER

NATASHA FLORES- SPECIALTY CARE COORDINATOR

District Medical Group
Children's Rehabilitative Services

DMG CRS was created to support the unique needs of our patients and their families.

- 25+ medical specialties in one clinic
- Appointments with multiple specialists in one day, when possible
- One electronic medical record to support coordinated care
- Social workers, patient advocates and child life on-site

Our team of pediatric specialists include:

- Primary care
- Dental health
- Physical therapy
- Occupational therapy
- Orthopedics
- Speech therapy
- Audiology
- Plastic surgery
- Behavioral health
- Cardiology
- Neurology
- Urology
- Pulmonology
- Neurosurgery
- ENT
- Neurotology
- Comprehensive assessments
- Social workers
- Nutrition and diet specialists
- Child life specialists

Health Current use within District Medical Group-Children's Rehabilitative Services

Opt Out Form – documents a patient's decision to opt out of having his or her health information available in the health information exchange (HIE). DMG will notify Health Current within fifteen (15) days of receipt of a patient's completed Opt Out Form.

Opt Back In Form – documents a patient's decision to opt back in to having his or her health information available in the HIE.

Health Information Request Form – documents a patient's request to receive a copy sent via certified mail of his or her health information that is available in the HIE and/or a list of providers who have viewed the patient's information in the HIE.

RESOURCES:

- https://healthcurrent.org/hie-participants/patient-rights-process/
- https://healthcurrent.org/wp-content/uploads/2017/12/AZ-HIO-Statute_FINAL_04-17.pdf
- https://healthcurrent.org/hie-participants/patient-rights-process/

Secure fax numbers: (602) 324-5596 or (520) 300-8364

Medicare/Medicaid Requirements

Medicare Access and Children's Health Insurance (CHIP) Reauthorization Act of 2015 (MACRA)/Quality Payment Program(QPP)/Merit-Based Incentive Payment (MIPS)

Improvement Activity- IA_CC_13 Medium weight

Ensure that there is bilateral exchange of necessary patient information to guide patient care, such as Open Notes, that could include one or more of the following:- Participate in a Health Information Exchange if available; and/or- Use structured referral notes.

Targeted Investment Program

- Primary Care milestone 9
- Behavioral Health milestone 6

Participate in the health information exchange with Health Current in the bidirectional exchange of data with Arizona's Health Information Exchange Organization (HIE). Bidirectional exchange includes both sending and receiving transmitted core data for all HIE participating patients.

Engagement and Utilization

- Developed policy and protocols
- Admission, Discharge and Transfer (ADT) Alert Workflow
- On going training for support staff to access the HIE
- Maintain access for Part 2 data (Behavioral Health information)
- Ability to download directly to EMR from HIE
- Ability to provide more complete health information from various locations
- Care Coordination

Patient Panels receiving ADTs

- High Risk Registry
- Primary Care
- Behavioral Health
- Covid-19

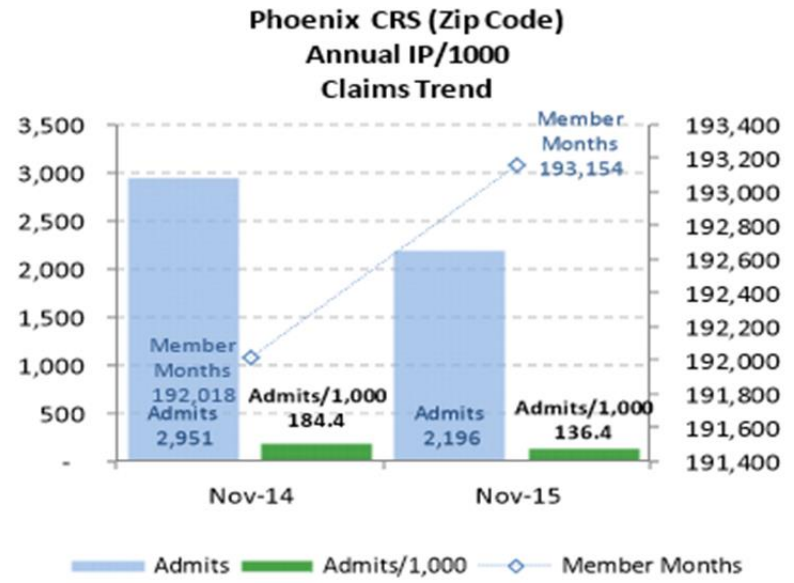
ADT notification workflow

- ADT notifications are initiated by contact between the identified patient panel(s) and the participating emergency room or inpatient hospitals. Core data exchange is securely transmitted to the DMG CRS HIE inbox.
- ADT Alerts are received by Director of Operations, Care Coordinator and Care Manager
  - Contact the patient to make an appointment within 7 days/ 30 days
  - Print or download date of discharge summary (if available) for provider review prior to the patients appointment
  - Scan documents in the patients chart-EMR

Value Based Care

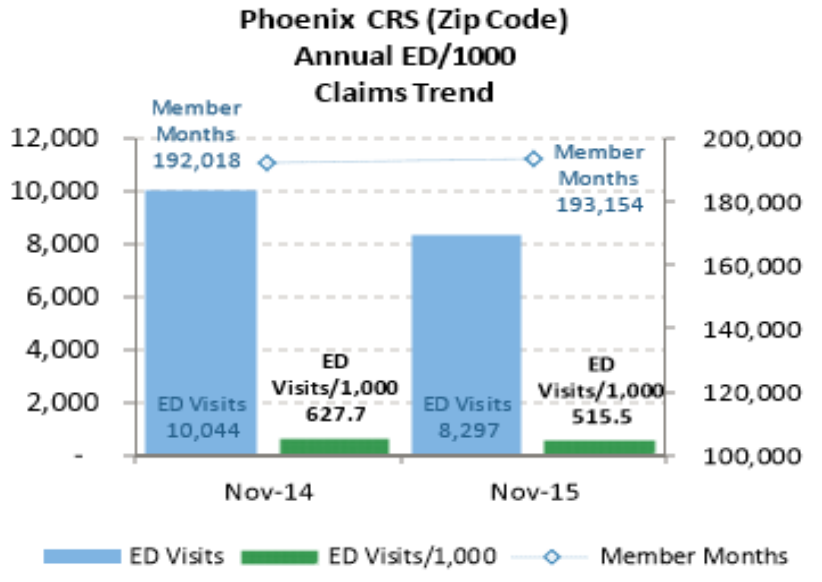
- Reduce Avoidable ER Visits leverage daily ADT notifications to manage care transitions and reduce avoidable emergency visits.
- Reduce Avoidable Admissions leverage daily discharge notifications to manage post-discharge care transitions and reduce readmissions.
- Reduce Well Child/Dental and Immunization GAPS
- Improve Access to Care utilize practice scheduling data to improve same-day access and reduce no-shows.
- Improve High Risk Patient Care- Identify the practice's most fragile members and manage barriers to care.

Achieving Results



	Previous	Current	Net Change	Goal
12 Mo Totals	184.4	136.4	-26%	
	Progress Against Goal			

IP rates per 1,000 have decreased by 26% for the Phoenix MSIC (Regional)



	Previous	Current	Net Change	Goal
12 Mo Totals	627.7	515.5	-18%	
	Progress Against Goal			

ED rates per 1,000 have decreased by 18% for the Phoenix MSIC (Regional)

Experience with Health Current

- Ease of uploading patient panel list(s)
- Communication and updates sent regularly
- On-going trainings provided

Health Current Opportunities

- Solution on interfacing documents within the EMR
- Remedy duplicate charts within the platform
- Ensure alerts are being received for patient panels

Q&A

- Please insert any questions in the Q&A box

Next Steps

- Next Steps
  - Post-Event Survey: 2 Parts
    - General Feedback Questions – New 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

Thank you!

TIPQIC@asu.edu

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