## **AHCCCS Targeted Investments Program**

# **Adult A Quality Improvement Collaborative**

William Riley, PhD

Session #6 August 6, 2020







# **Disclosures**

There are no disclosures for this presentation

# **Agenda**

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	<ul><li>Overview</li><li>Agenda</li><li>Data Update</li></ul>	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	Cope Community Services
12:15 PM – 12:50 PM	Discussion and Q&A	All
12:50 PM – 1:00 PM	<ul><li>Next Steps</li><li>Post Event Survey</li></ul>	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 <u>www.TIPQIC.org</u> for additional details



Center for Health Information and Research

# Have any questions for the TIP Data Team?

Please e-mail <u>TIPQIC@asu.edu</u> to schedule a Zoom meeting

# Provider meetings often cover topics such as:

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



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



# **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.)



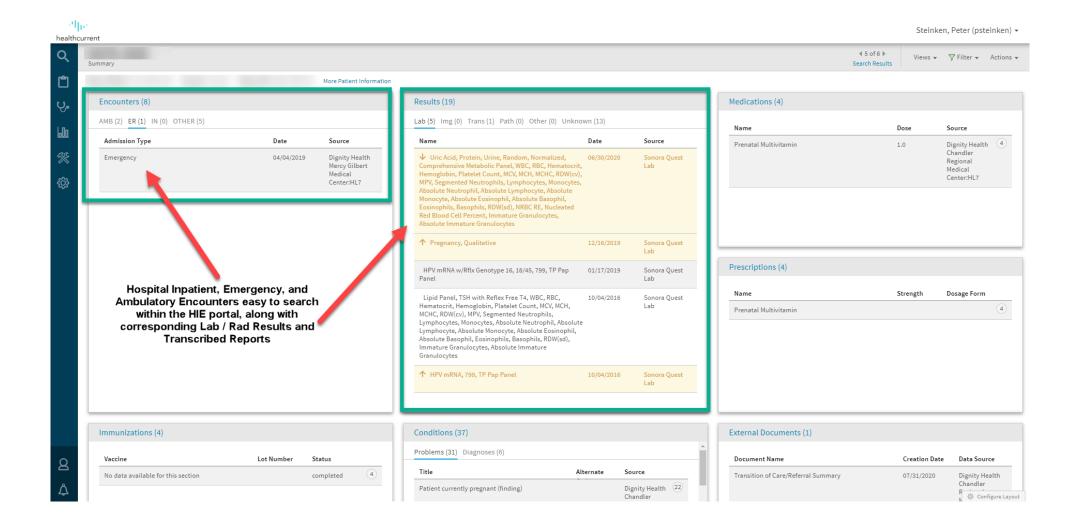
## Data Available (varies by data source)

- 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**

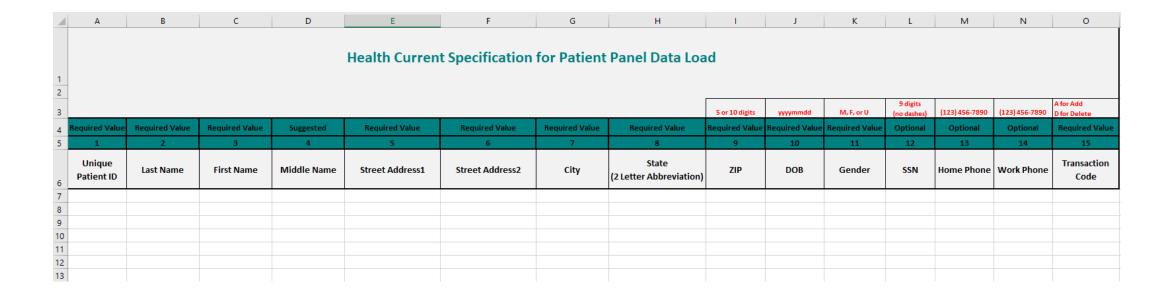
Event-driven notifications triggered by admissions, discharges, registrations and clinical/laboratory results

- 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





# **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

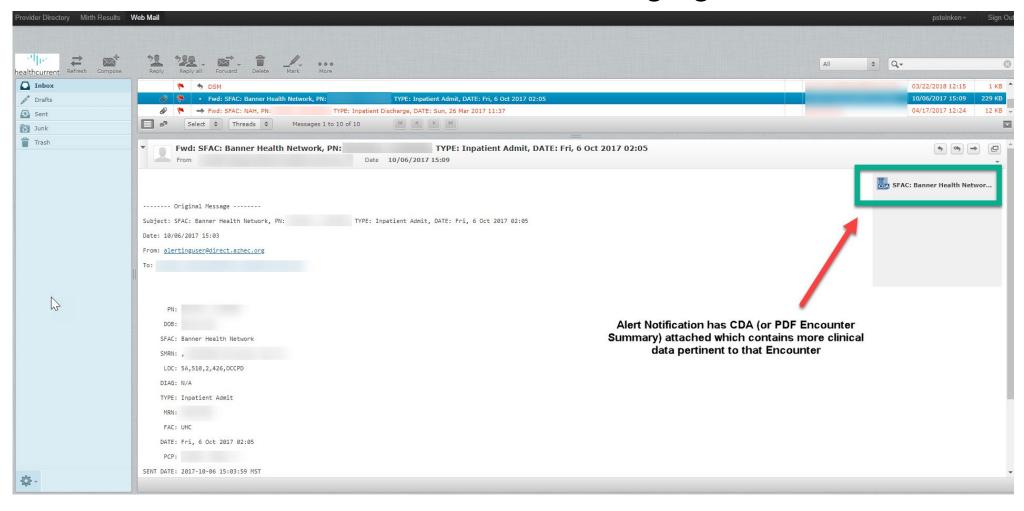
### Batch Alerts

- 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

	_	_	-		Batch	n Notifi	catior	าร	
Banner Health :		ED Admit					2018-07	-18 07:30	AM
Patient	DOB	Source MRN	PCP		Diagnosis		Facility M	IRN Date	Location
		:BH-Det	sert GERALD R SHO	OCKEY	N/A		-	17-Ju 07:39	
		:BH-Pag Community Hosp	ge SCOTT D SADL	ER	N/A		-	17-Ju 10:51	
	_	:BH-Bos Med Ctr	swell RAMA		N/A		_	17-Ju 12:19	
		:BH-Pag Community Hosp	ge DAVID		N/A			17-Ju 10:43	
Dignity Health Chandler Medical Center :	Regional	ED Admit					2018-07-18	07:30 AM	
Patient	DOB	Source MRN	PCP	Di	agnosis		Facility MRN	Date	Location
		_	TERESA M AYELA-UWANGUE	N/A	4		_	17-Jul-201 09:07 AM	B EMERGENCY DEPT undefined
HonorHealth Osborn Ho	spital :	ED Discharge	,			2	018-07-18 07	:30 AM	
Patient	DOB	Source MRN	PCP	Diag	gnosis	F	acility MRN	Date	Location
		:HH-NMH	SUSAN		52-Painful respiration 89-Other chest pain			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,

Banner Health, ED Discharge,

N/A, NO,N/A,12-Jan-2019,01:24 PM,N/A

Banner Health, ED Discharge

N/A, NO,N/A,12-Jan-2019,01:24 PM,N/A

Banner Health, ED Discharge

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:

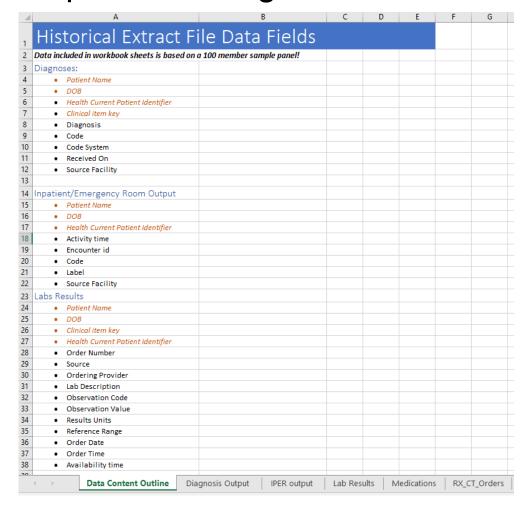
How to expand use?



## **HIE Data Reports**

Historical "look-back" Reports for Diagnoses, Encounters, Lab Results,

etc.



neathcurrent

## **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.

#### 

#### 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

Revision 2019-01-22

# imagine fully informed neath.



Imagine fully informed health

# COPE Community Services, Inc. & Health Current's HIE

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Working Together To Improve Care

Rachel Vega, BHP QM Targeted Investment Specialist

Jenifer Regan, MA
Director of Youth and Family Services

# Why engage with Health Current?

- COPE medical services. We are not in it alone.
- Communication barriers.
- Accurate information.
- Timely information.

# Discovering how it can work for COPE

- Previous participation.
- What can we do with this?
- Patient Panels.

• A clearer picture.

# Why use HIE and getting started

Outreach to Health Current.

Review of capabilities.

• Consent process.

• Let's set it up!

# Our experience with Health Current

- Prompt response.
- Productive meetings.
- Helpful updates and support.
- A few honorable mentions.

# Examples of processes

Batch report.

• Real time notifications and example.

• Patient query before and during care.

# Batch Report

Cope Community Services Batch Notifications	Today 05:00
Cope Community Services Batch Notifications	Mon 05:00
Cope Community Services Batch Notifications	Sun 05:00
Cope Community Services Batch Notifications	Sat 05:00
Cope Community Services Batch Notifications	Fri 05:00

4	1	2	3	4	5	6	7	8	9	10	11	
1	Sending Facility	Visit Type	Sending ID	Patient	DOB	Patient ID	PCP	Diagnosis	Date	Time	Location	
2	Banner University	ED Admit	18659334				RN CONVE	N/A	27-Jul-2020	08:26 AM	484	
3	Banner University I	ED Admit	8311458				NO FAMILY	N/A	28-Jul-2020	12:28 AM	484	

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# Real Time Alerts

<b>Q</b> + −	0	100		Subject	*	From	<u>Date</u> \$	Size
	D		<ul> <li>SFAC: Yavapai Regional Medical Center: HL7, PN:</li> </ul>	TYPE: ED Admit, EVENT DATE: 202007280931		azhiealerts@direct.healthcurren	Today 09:31	9 KB
	D		SFAC: Banner University Medical Center Tucson: HL7, PN: I	TYPE: ED Admit, EVENT DATE: 202007280806		azhiealerts@direct.healthcurren	Today 08:06	7 KB
	Ø		<ul><li>SFAC: St. Mary's Hospital:HL7, PN:</li></ul>	TYPE: ED Discharge, EVENT DATE: 202007272230	*	azhiealerts@direct.healthcu	Today 01:09	7 KB

PN:

DOB:

SFAC: Tucson Medical Center:HL7

SMRN: 5070474:TMC

LOC: TMC, EMERGENCY DEPARTMENT, TMC

DIAG: N/A

TYPE: ED Discharge

PATIENT ID: /

FAC: Cope Community Services:PG

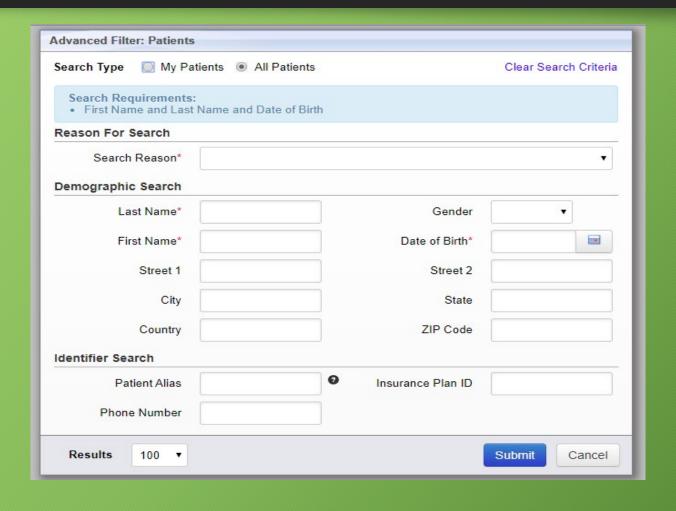
EVENT DATE: 202007272044

PCP:

SENT DATE: 202007270845

Sent via Mirth Mail

# Query Individual Patient Record



# Query Result

Conditions (5)				Labo	ratories (14)	Transcriptions (0)	Imaging (0)	Other Orders (0)
☐ Name Date	Source		<u> </u>		Date	Name	Source	•
Patient encount 03/03/2020	TMC				07/28/2020	OR Storz Images	TMC	
☐ Vaginal delivery 06/10/2017	TMC				03/03/2020	Type & Screen	TMC	
☐ Term pregnanc 06/09/2017	TMC				02/28/2020	Choriogonadotropin (p	reg TMC	
☐ Normal labor (fi 06/09/2017	TMC				02/28/2020	Type & Screen	TMC	
<u>305058001</u>	TMC	2			02/28/2020	CBC W Auto Differentia	al p TMC	
			▼					
Medications (2)			Ť	Aller	gies (1)			
Medications (2)  Date Name	Source				gies (1) ergen	Reactions	Reported	
				■ AII	•	Reactions UNK	Reported 06/18/2007	
☐ Date Name	TMC			■ AII	ergen		•	
Date Name 03/03/2020 oxyCODONE-ac.	TMC			■ AII	ergen		•	
Date Name 03/03/2020 oxyCODONE-ac.	TMC			■ AII	ergen		•	

# Examples in complex care

"I work with clients with developmental disabilities and TBI. Some of them have difficulty communicating regarding their ailments and emotions and others cannot communicate them at all; this frequently results in sudden onset, acting out behaviors. These behaviors range from aggression toward others, property damage, and hurting themselves. Usually the caregivers want to bring them in and have the psychiatric provider treat the behaviors with psychotropic medications. This is inappropriate if this is the patient's way of communicating that something is wrong. Prior to HIE, it was difficult to get information from medical facilities. I had one patient who required several ambulance trips to the hospital before the staff there understood my role and would talk to me. The patient ended up having an extremely high ammonia level that was causing his aggressive behavior. He spent twenty two days in the hospital and it required a medication change. We still have to monitor this patient's ammonia levels closely."

# Other positive results

Frequently, I would have a patient 'disappear' and would call hospitals to find out they were there. Since HIE, I am notified as soon as I have a patient go in the hospital. Sometimes, it is someone who has been acting out and we get a new perspective.

I had a client hospitalized with COVID 19 near the beginning of the month. Prior to hospitalization, the caregivers thought his refusal to walk and his urinary incontinence were behavioral and wanted more psychotropic medication. I had you send me his discharge summary during team meeting and read pertinent parts of it to the team. It turned out the COVID, a blood clot, and a pressure sore on his heal were why he wasn't walking and DDD nurse now sees a need for a referral to endocrinologist because she thinks his diabetes is the cause of his incontinence. This has given the treatment team more to work with and consider before determining these symptoms as just behavioral. Since having HIE information, I have also had clients where medical doctors ruled out physical causes of behaviors and we dealt with the behavior with medications or a behavioral modification plan. I think HIE is one of the best things to happen for my patients.

Karin Brands, Recovery Coach/Case Manager

# HIE and Targeted Investments

# Shaping Care Management

- A broader and clearer picture
- Comprehensive assessment
- Prevention of gaps

# Leveraging Health Current

- Warm Hand Off.
- Triage, rooming, and care space.
- POC information.
- More integrated care plans with clearer health goals.

# The right HIE format for COPE

- Type and Frequency of notifications.
- Distribution of information to teams.
- Considerations of staff time and expectations.

# **Workflow Considerations**

- Patient appointment Process
- Rooming Space
- Point of Care information

# HIE wish list

## HEDIS items; claims based information

- Prevent duplication of services and tests.
- Assisting organizations to meet population metrics and health goals.

## Increase of participating facilities/providers

• SNF, Urgent Care, Private practitioners.

## Format of reports: PCP feedback

• Discharge information.

# Always room for improvement

Interested in feedback from cohorts on other ways to utilize HIE

Thank you for this opportunity and for listening.

# THANK YOU

Rachel Vega, BHP QM Targeted Investment Specialist COPE Community Services, Inc 924 N. Alvernon Way, Suite 110 Tucson, AZ 85711 520-207-9348

# **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 <u>TIPQIC@asu.edu</u> if questions or concerns regarding performance data

# Thank you!

TIPQIC@asu.edu





