Justice AOC Quality Improvement Collaborative Session #1: 10/15/25

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Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Targeted Investment Team

ASU TIPQIC

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- Matthew Martin, PhD
- Kailey Love, MBA, MS
- Taylor Vaughan, MPH
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- Samantha Basch, MS
- Francisca Dibarrart, PhD
- Min Jang, PhD

AHCCCS Targeted Investment

- Julie Ambur
- Christina Quast
- Jane Otenyo
- Vishal Etikala

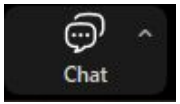
Agenda

Time	Topic	Presenter
12:00 PM to 12:03 PM	Opening	William Riley, PhD
12:03 PM to 12:15 PM	Measure Overview & Network Performance	Kailey Love, MBA, MS
12:15 PM to 12:35 PM	Measure Details: Definition, Coding, Targets, Attribution	George Runger, PhD Taylor Vaughan, MPH
12:35 PM to 12:45 PM	Common Barriers & Best Practices	Matthew Martin, PhD
12:45 PM to 12:57 PM	Discussion	Matthew Martin, PhD
12:57 PM to 1:00 PM	Closing	Kailey Love, MBA, MS

Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

Guidelines

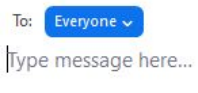


Do not enter your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.

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

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.



Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

Disclosure

This is a CME activity

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

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Credit Statement: Arizona State University designates this live activity for a maximum of 1-credit from the following:

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

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

Measure Overview & Network Performance

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Table 1 Targeted Investments (TI) 2.0 Year 4 Milestones and Incentive Percentages			
MILESTONES	JUSTICE INCENTIVE % OF ANNUAL PAYMENT		
M1. Performance Measures	50		
	IET-E	FUA7	FUM7
	20	15	15
M2. Screening and Referral Systems for Nonmedical Drivers of Health	25		
M3. Closed Loop Referral System (CLRS)	15		
M4. Quality Improvement Collaboratives (QICs)	10		

Table 2 Targeted Investments (TI) 2.0 Year 4 QIC Schedule with Milestones and Incentive Percentages		
MILESTONES	QIC Focus	JUSTICE INCENTIVE % OF ANNUAL PAYMENT
M1. Performance Measures		50
	Oct QIC	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Engagement (IET-E) - 20%
	Dec QIC	Follow-Up After Emergency Department Visit for Substance Use within 7 Days (FUA7) - 15%
	Feb QIC	Follow-Up After Emergency Department Visit for Mental Illness within 7 Days (FUM7) - 15%

Justice QIC Curriculum Overview

Justice AOC Measures	TI Year 4: 10/1/2025 - 9/30/2026											
	O	N	D	J	F	M	A	M	J	J	A	S
IET-E	QIC						QIC					
FUA			QIC						QIC			
FUM					QIC						QIC	
Optional Resources	Ongoing Performance Improvement Project (PIP)											
	Ongoing Technical Assistance & Consultation											

- **QIC's** in October, December, and February are **required**
  - Each QIC will focus on the a HEDIS measure as indicated in the above table
- ***QIC's*** in April, June, and August are ***optional***
  - The focus of these sessions may shift based on performance and other priorities

Justice

Performance Measure	Measure Description	TI AOC Performance*	All AHCCCS Performance*	2023 CMS AZ Average[1]	2023 HEDIS National Average[2]
✷ = Proposed 2026 ACOM306 Measure; ✻ = MAC 2024 Scorecard Measure; ❦ = 2025 CMS Core Set Measure; ✱ = 2024 UDS Quality of Care Measure; + = 2024 SAMHSA CCBHC Quality Measure; ✪ = NCQA HEDIS Stratified Measure; ❋ = MAC QRS Measure					
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Engagement (IET-E) ✷ ❋ + ✪ ❋	**The percentage of patients 18 years and older with any substance use disorder event who initiated treatment and engaged in ongoing treatment within 34 days of the initiation visit.**	**48.4%**	**22.9%**	**16.9%**	**14.8%**
Follow-Up After Emergency Department Visit for Substance Use within 7 Days (FUA7)	Percentage of ED visits among adult beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within seven days	50.6%	40.4%	35.2%	24.1%
Follow-Up After Emergency Department Visit for Mental Illness within 7 Days (FUM7) ✷ ✻ ❦ + ✪	Percentage of adult beneficiaries with a follow-up visit seven days after an ED visit for mental illness	54.4%	54.6%	44.9%	39.6%

*Report period ending May 31, 2025

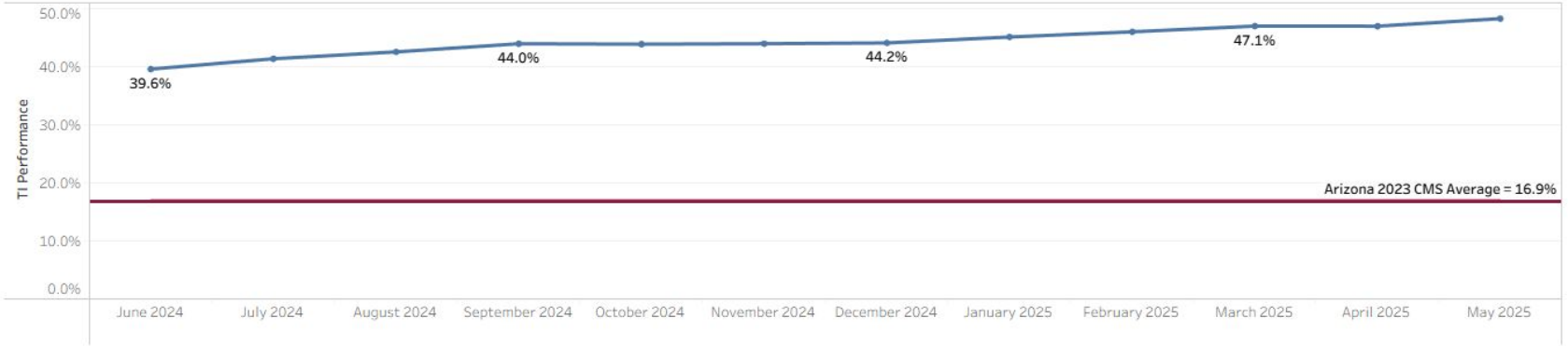
1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

IET-E Network Performance

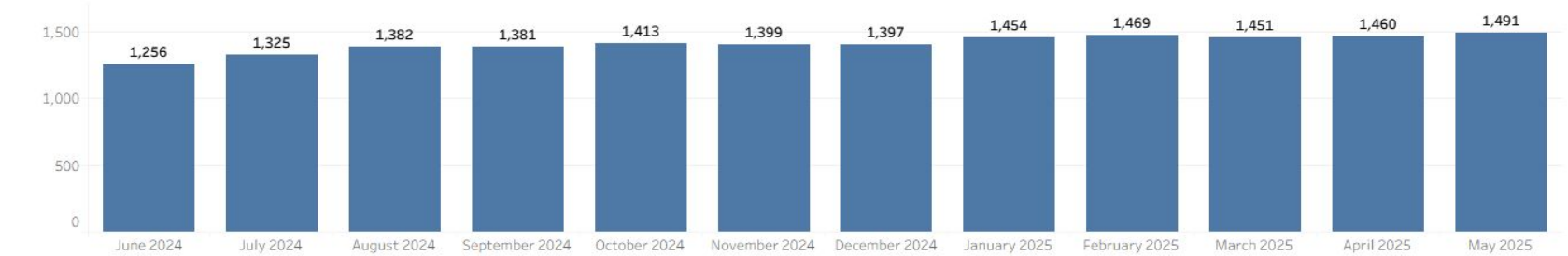
Measure Performance (each month is a 12-month report period)

TI JUSTICE



Measure Denominator

TI JUSTICE



Target Setting

- An AHCCCS Committee, in consultation with ASU TIPQIC, established tiers and targets for each measure.
- The committee considered National Medicaid Performance, AHCCCS Historical Performance, TIP Historical Performance, AHCCCS Minimum Performance Standards (MPS), and previous TI Fiscal Year performances to determine TI tiers and targets.
- The identity of the TI participants was blinded.
- Tiers and targets may differ across AOCs for the same measure.
- These differences accommodate variation in attribution methodologies.

Attribution

Attribution is re-evaluated each month for all report periods displayed on the dashboard. The attribution method used is specific to each AOC. Review the attribution method specific to the TI AOC you are enrolled in:

TI Area of Concentration	Attribution Method
Justice	Attribution is done using member referral lists (i.e., Justice Referral Lists). Members will be included in a TI provider's denominator if they meet all measure denominator criteria and were referred to a TI-participating organization within the two years prior to the end of the report period. For more details on this and the other Justice measures, see the TI 1.0 Justice Measure Evaluation & Attribution video (slides). **Please note:** although providers will not receive incentives for the measures in this video, they serve as the foundation for understanding TI Justice attribution.

Measure Details

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Engagement of SUD Treatment Definition

The percentage of new SUD episodes among justice-involved adults referred to a TI Justice clinic with evidence of treatment engagement within 34 days of initiation.

Quality Alignment

JUSTICE AOC									
Performance Measure	Measure Description	TI AOC Performance*	Quality Alignment						
			2026 ACOM 306 Measure	MAC 2024 Scorecard Measure	2025 CMS Core Set Measure	2024 UDS Quality of Care Measure	2024 SAMHSA CCBHC Quality Measure	NCQA HEDIS Stratified Measure	MAC QRS Measure
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Engagement (IET-E) ✻ ✾ + ✪ ❋	The percentage of patients 18 years and older with any substance use disorder event who initiated treatment and engaged in ongoing treatment within 34 days of the initiation visit.	48.4%		✻	✾		+	✪	❋

Importance

Early intervention improves outcomes: SUD is a chronic, relapsing condition, and timely engagement in treatment greatly increases the chances of sustained recovery.

Reduces avoidable crises: Consistent engagement lowers the likelihood of overdose, emergency department visits, hospitalizations, and criminal justice involvement.

Supports whole-person health: Effective SUD treatment improves mental, physical, and social well-being, helping individuals stabilize employment, housing, and relationships.

Addresses high public health burden: With rising overdose rates and co-occurring conditions, ensuring people enter and stay in treatment is critical to reducing mortality and community impacts.

Indicator of system effectiveness: Engagement reflects how well health systems and providers reduce barriers, connect patients to care, and sustain ongoing treatment relationships.

Aligns with value-based care and equity goals: Measuring engagement encourages health plans to design systems that are accessible, culturally responsive, and supportive of long-term recovery.

Initiation and Engagement of Substance Use Disorder Treatment (IET-E)

Your performance is reported as a percentage calculated as the = numerator/denominator

TI Area of Concentration	Measure	Denominator Definition	Numerator Definition
Justice	Initiation and Engagement of Substance Use Disorder Treatment: Engagement of Substance Use Disorder Treatment (IET-E)	Justice-involved members aged 18 years and older who are referred to a TI Justice clinic and who have an inpatient or outpatient visit with an AOD diagnosis and qualifying service (e.g., IET stand-alone visit or detoxification). Note: If a member has multiple denominator-qualifying episodes in the reporting period, only the first episode is considered for the measure. Note: To qualify for the denominator, members must be enrolled on the episode end date through 34 days after the episode end date with no breaks in enrollment.	Members in the denominator who have at least one follow-up visit within 14 days (initiation of treatment) **and** at least two follow-up visits within 34 days of treatment initiation (engagement of treatment).

Which Members Are in My Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (above), as well as the AHCCCS member population assessed, and the attribution method used.

Member Population Assessed (Justice AOC)

- Members referred to a TI Justice Clinic in the two years prior to the end of the reporting period who are enrolled in one of the six AHCCCS Complete Care (ACC) health plans. Members with SMI who meet the referral and health plan enrollment stated above are included.
- TI Justice Clinics and AHCCCS health plans provide the ASU TIP team with monthly referral lists. Instructions on Justice Referral Lists are on the TIPQIC website.
- Members who utilized hospice services or died during the report period are excluded from performance calculations.

Target Setting

- Two tiers were set for the IET-E measure
  - AHCCCS will email each provider organization with individual target setting information
- For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.
- TI Justice providers need to exceed their target to achieve the incentives associated with this performance measure.

What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Year 4 use HEDIS® Measurement Year 2023 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
    - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
        - United Healthcare - HEDIS® MY 2023 Reference Guide
    - For more information on HEDIS measures or to get your own license, see the NCQA HEDIS® site.
    - Value sets and codes used in HEDIS 2024 (Measurement Year 2023) measure calculations are available at no cost. Download the 2023 Quality Rating System (QRS) HEDIS Value Set Directory from the NCQA store.
- In addition to the billing codes listed in the guides linked, the following accommodations have been made for TI performance measurement:
    - The measure's numerator-qualifying telehealth services will get credit if they follow AHCCCS's telehealth billing guidelines allowed on the date of service.
    - Psychiatric Collaborative Care Model (CoCM) services (i.e., codes 99492, 99493, and 99494) will count as a numerator-qualifying visit for all servicing provider types (licensed and non-licensed).
        - CoCM is an approach to behavioral health integration recognized by CMS. Please see TIPQIC.org for billing guidance to maximize CoCM services for IET compliance and a list of TIP Providers who deliver CoCM services.

What Services Do Not Qualify for the Numerator?

What Services Do Not Qualify for the Numerator?

Reach-in (i.e., non-billable) services do not qualify for the numerator. Any procedure code not listed in the previous section does not qualify.

How Do I Document Services to Get Credit on the Measure?

TI performance measurement relies on claims data. Hybrid chart review does not apply.

Common Barriers & Best Practices

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Common Barriers for IET-E

1. Patient-Level Barriers

- **Stigma and denial**: Fear of being labeled with a substance use disorder or not perceiving a need for treatment.
- **Co-occurring conditions**: Mental health disorders, unstable housing, or physical health issues that interfere with engagement.
- **Logistical challenges**: Transportation, childcare, job demands, financial insecurity, or lack of phone/internet for telehealth.
- **Fear of legal or employment consequences**: Worries about confidentiality, especially in sensitive populations.
- **Motivational factors**: Ambivalence about changing substance use behaviors, particularly if initial symptoms are not perceived as severe.

2. System-Level Barriers

- **Limited availability of timely services**: Long wait times for specialty treatment, limited hours, and fragmented referral pathways reduce follow-up.
- **Workforce shortages**: Few addiction specialists and high turnover in behavioral health settings.
- **Fragmentation of care**: Separation of medical and behavioral health records leads to missed opportunities for coordination.
- **Insurance and coverage restrictions**: Prior authorization or limited network availability can delay access.
- **Inconsistent use of evidence-based treatment**: Underuse of medication for opioid use disorder (MOUD) or motivational interviewing in some systems.

3. Clinician-Related Barriers

- **Knowledge gaps**: Lack of training in addiction medicine or updated treatment guidelines.
- **Competing priorities in primary care visits**: Chronic conditions may take precedence over substance use discussions.
- **Discomfort discussing AOD**: Some clinicians feel unprepared to screen and counsel patients on sensitive topics.
- **Referral handoff issues**: Weak “warm handoff” processes increase no-show risk after initial diagnosis.

Best Practices for IET-E

1. Care Coordination & Patient Navigation

- **Patient navigation and case management** increase engagement by reducing logistical and psychosocial barriers (transport, childcare, insurance navigation).
- Studies show **navigators who provide active follow-up** (calls, appointment reminders, peer support) significantly improve treatment initiation and continuation.
- *Evidence*: Randomized trials and systematic reviews highlight navigation as a critical strategy for SUD engagement.

2. Integration of Care Services

- Integrating behavioral health clinicians or addiction specialists with primary care allows **same-day initiation and follow-up**.
- Improves coordination, reduces stigma, and minimizes delays caused by external referrals.
- *Evidence*: Models like Collaborative Care and integrated MAT programs show increased treatment engagement and retention.

3. Use of Medication-Assisted Treatment (MAT/MOUD/MAUD)

- Initiating evidence-based pharmacotherapy (e.g., buprenorphine, methadone, naltrexone) in emergency departments, inpatient, or primary care settings is strongly associated with higher engagement and retention.
- *Evidence*: RCTs demonstrate ED-initiated buprenorphine doubles treatment engagement at 30 days compared with referral alone.

Best Practices for IET-E Cont.

4. Motivational Interviewing and Brief Interventions

- Using **SBIRT (Screening, Brief Intervention, and Referral to Treatment)** with motivational interviewing improves readiness for change and treatment follow-through.
- Can be delivered in primary care, behavioral healthcare, ED, or telehealth settings.
- *Evidence*: Consistently shown to improve short-term engagement in care and reduce risky use patterns.

5. Telehealth

- Telehealth increases accessibility, reduces stigma, and overcomes geographic barriers.
- Evidence shows tele-SUD visits are associated with higher rates of treatment engagement, especially during COVID-19 policy expansions.
- *Evidence*: Observational studies and systematic reviews support telehealth as a facilitator of SUD treatment engagement.

6. Active Follow-Up and Rapid Appointments

- Engagement rates rise when **follow-up visits are scheduled within 7 days** of initiation and supported by reminders, transportation help, and peer support.
- **Warm handoffs** (direct introductions from diagnosing provider to treatment team) outperform passive referrals.
- *Evidence*: Implementation studies show rapid follow-up scheduling and reminder systems increase adherence to IET benchmarks.

Discussion

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Lightning Round

In one sentence, what is one takeaway or action step your organization will focus on before the next TIPQIC meeting?

Discussion Questions

What structural or social factors most impact engagement or follow-up rates for justice-involved patients in your setting?

How confident are you that the Justice Referral Lists and attribution methods reflect your true patient population?

What challenges have you encountered in identifying and tracking justice-referred members through your EHR or data systems?

Discussion Questions

For organizations performing above target on IET-E or FUA7, what practices or workflows seem most critical to your success?

How do you use peer support, case management, or navigators to maintain contact post-release or post-ED visit?

Are there opportunities for cross-system collaboration (e.g., with probation, jails, or community reentry programs) that could help sustain engagement?

Closing

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Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.