AHCCCS Targeted Investments Program

Peds Quality Improvement Collaborative

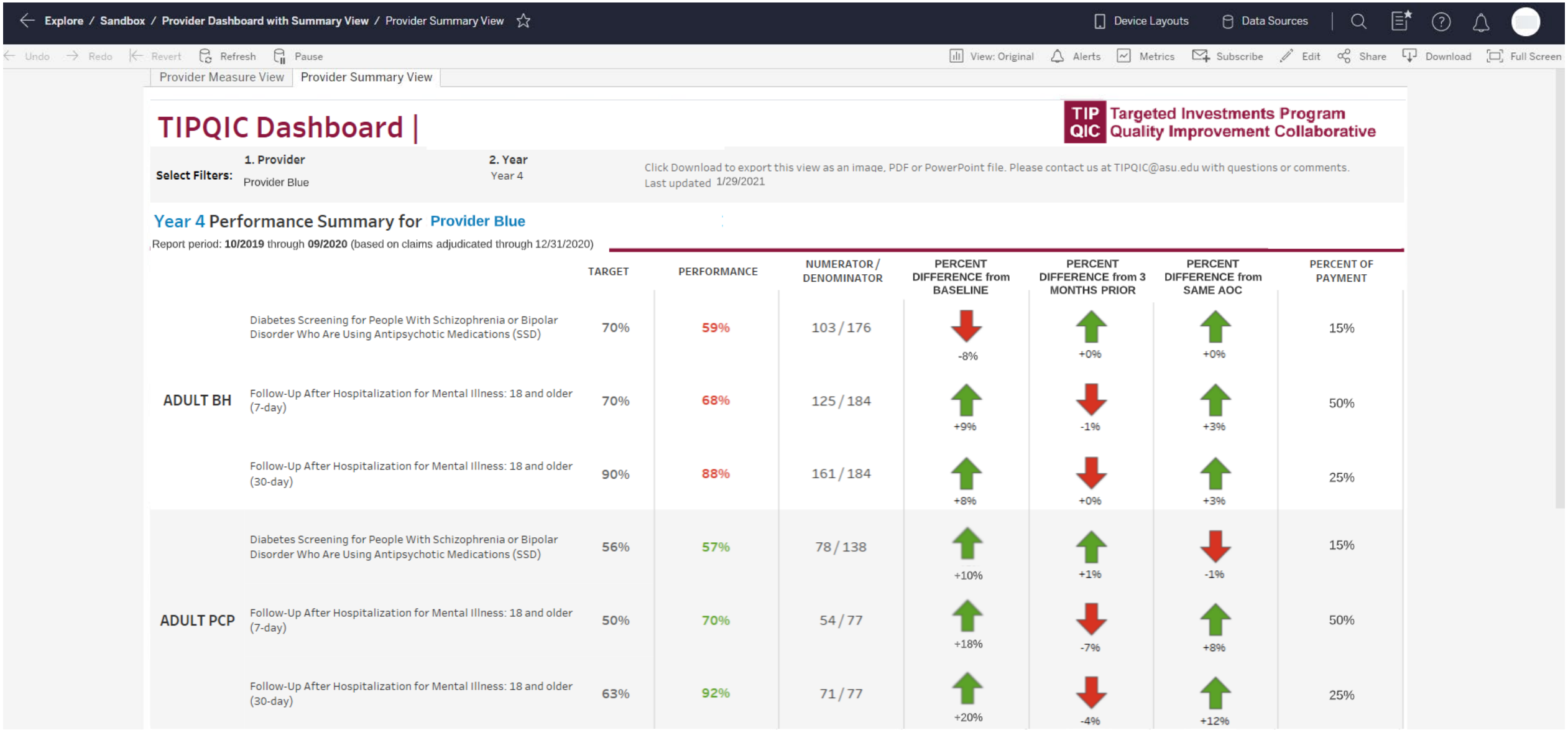
Dr. William Riley
Dr. Charlton Wilson

TIP Year 5: Session #4
February 2, 2021

Disclosures

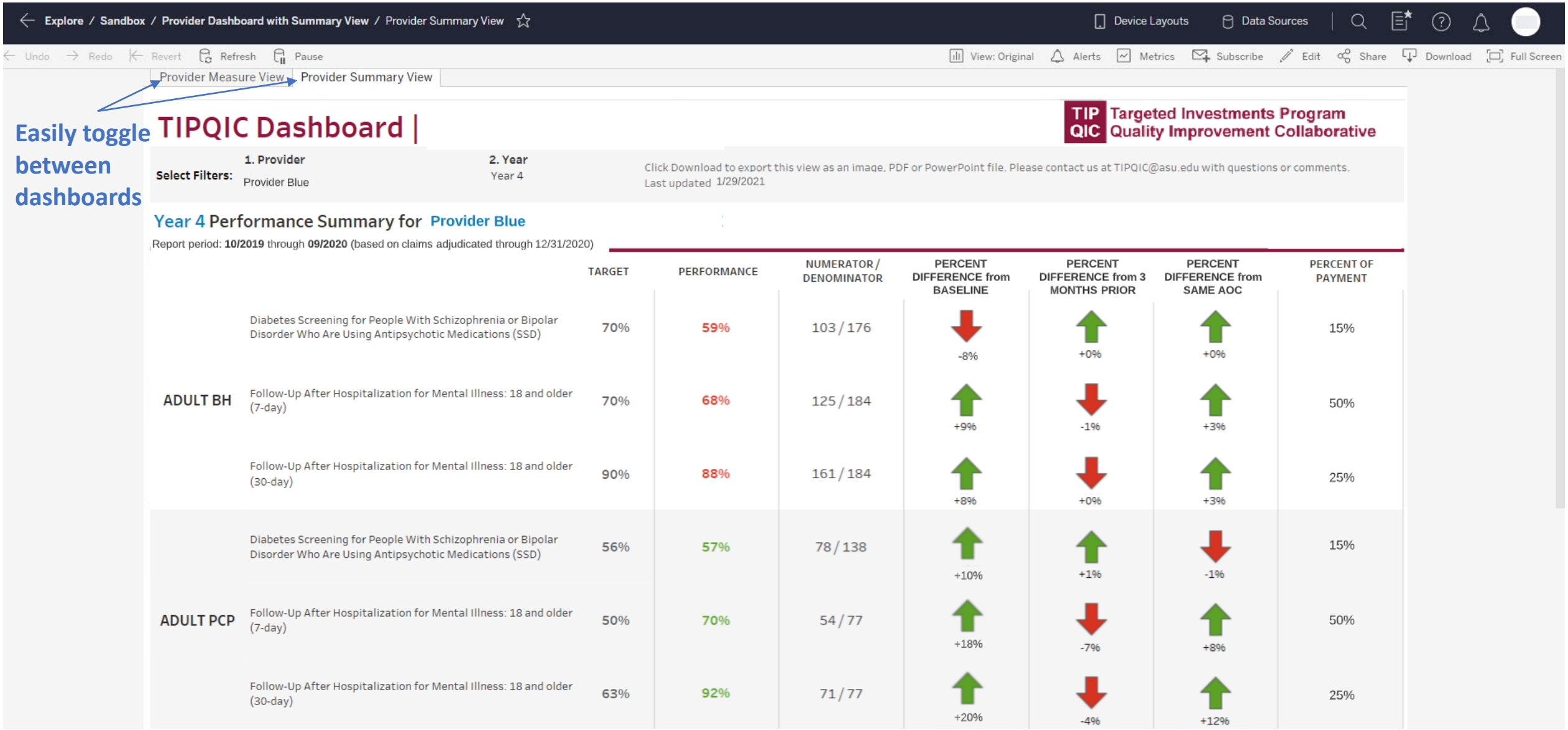
There are no disclosures for this presentation

New Summary View Available 2/12/2021



		TARGET	PERFORMANCE	NUMERATOR / DENOMINATOR	PERCENT DIFFERENCE from BASELINE	PERCENT DIFFERENCE from 3 MONTHS PRIOR	PERCENT DIFFERENCE from SAME AOC	PERCENT OF PAYMENT
ADULT BH	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	70%	59%	103 / 176	-8%	+0%	+0%	15%
	Follow-Up After Hospitalization for Mental Illness: 18 and older (7-day)	70%	68%	125 / 184	+9%	-1%	+3%	50%
	Follow-Up After Hospitalization for Mental Illness: 18 and older (30-day)	90%	88%	161 / 184	+8%	+0%	+3%	25%
ADULT PCP	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	56%	57%	78 / 138	+10%	+1%	-1%	15%
	Follow-Up After Hospitalization for Mental Illness: 18 and older (7-day)	50%	70%	54 / 77	+18%	-7%	+8%	50%
	Follow-Up After Hospitalization for Mental Illness: 18 and older (30-day)	63%	92%	71 / 77	+20%	-4%	+12%	25%

New Provider Summary View Available 2/12/2021



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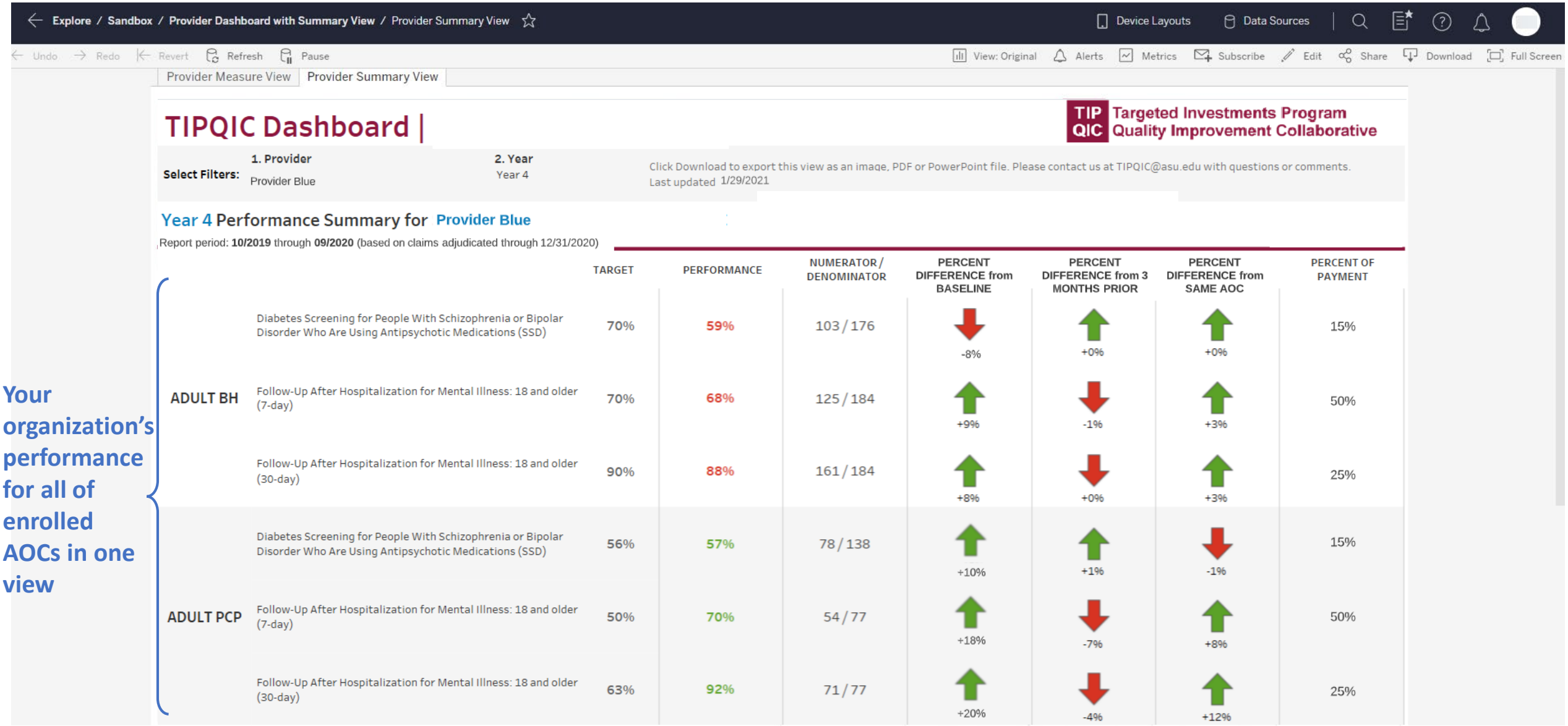

Your organization's performance for all of enrolled AOCs in one view

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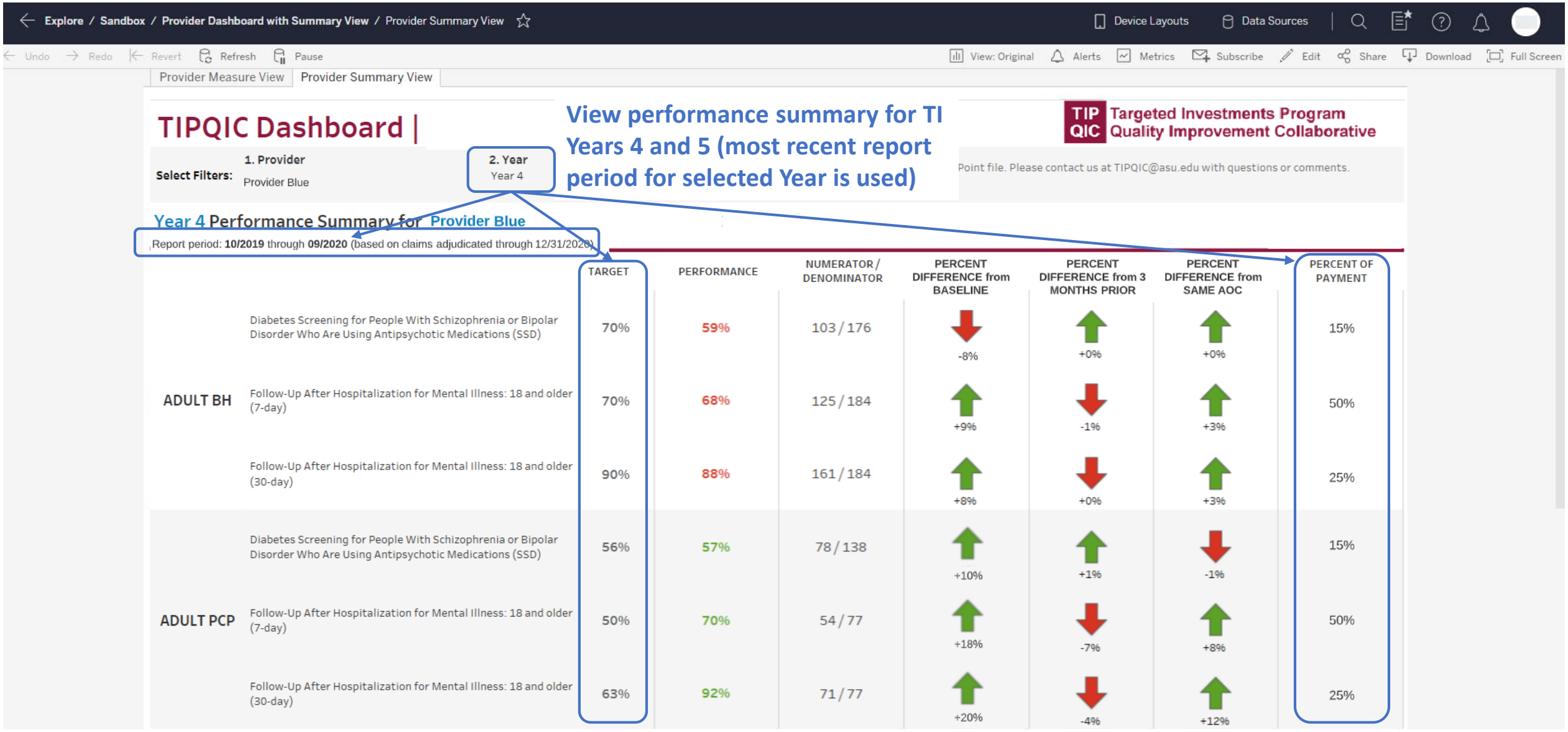

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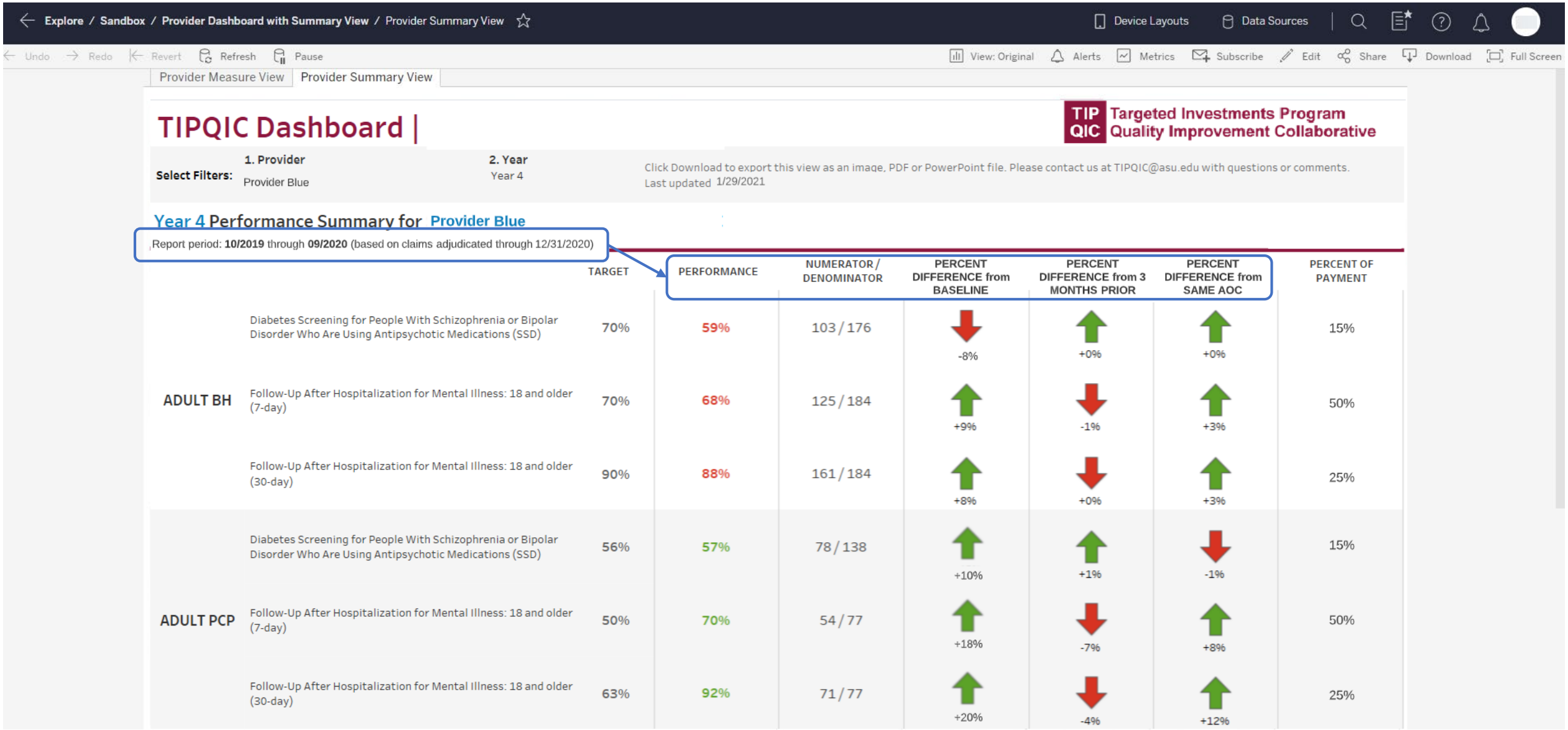

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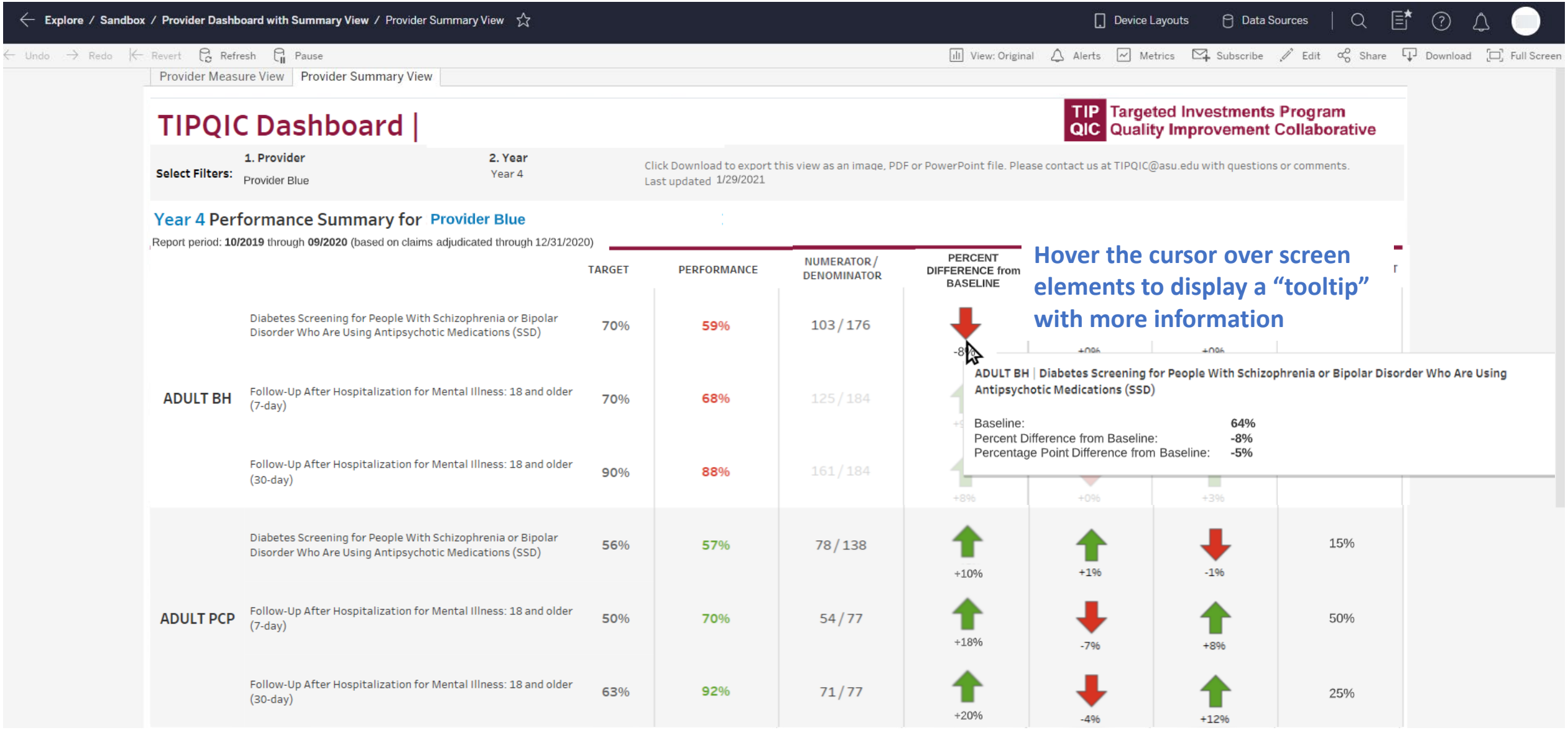

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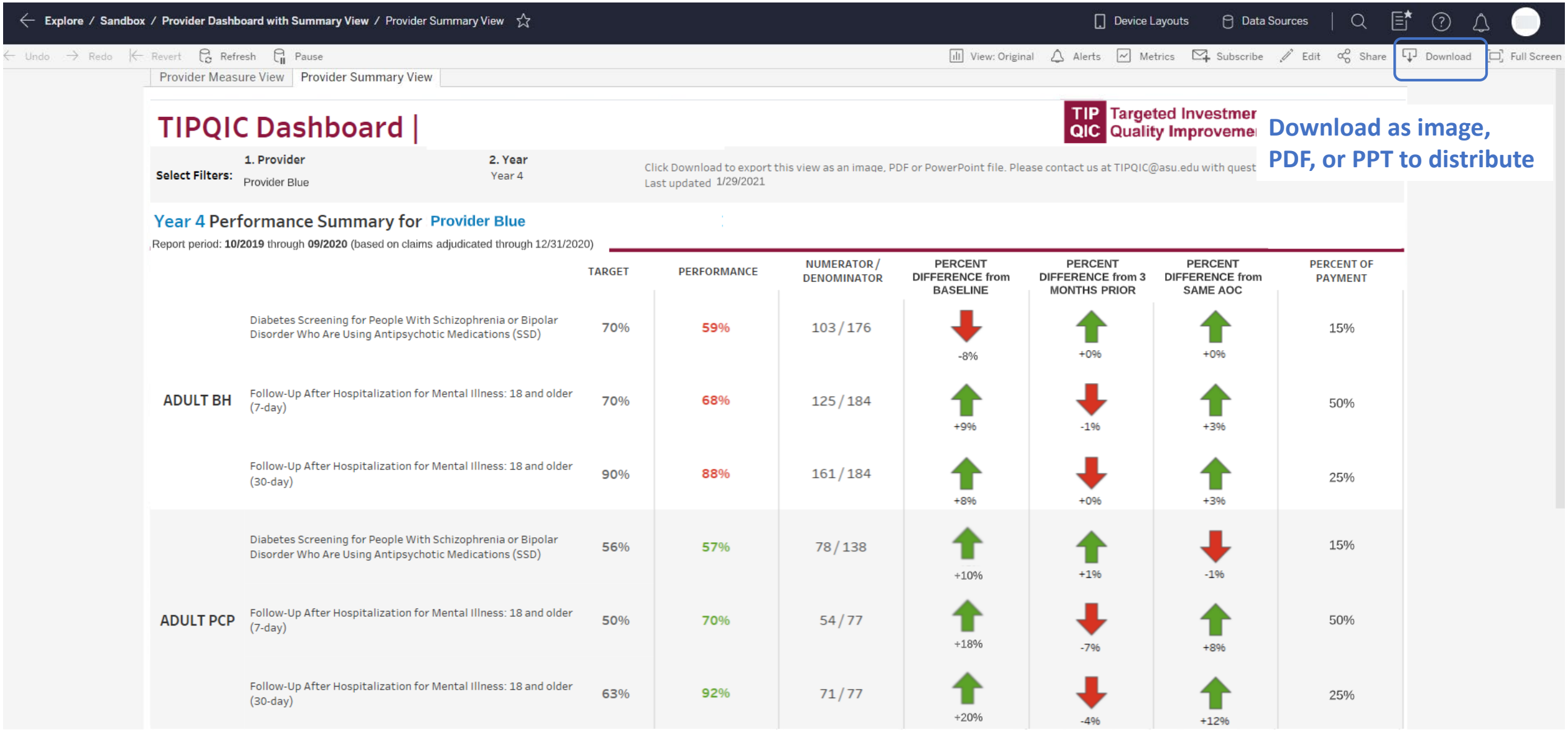


Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	Introduction & Updates	Kailey Love
11:35 AM – 11:40 AM	Brief Overview of Session	William Riley
11:40 AM – 11:50 AM	Peer Presentation #1: 7 Day & 30 Day FUH	Child Family & Support Services Troy Bailey Emily Luechtefeld
11:50 AM – 12:00 PM	Peer Presentation #2: Metabolic Monitoring	Jewish Family & Children's Services Megan Lipman Brian Rosenstein
12:00 PM – 12:10 PM	Peer Presentation #3: Well-Child Visits	North Valley Pediatrics JoAnn Kolnick Dr. Luis Trunzo
12:10 PM – 12:50 PM	Round Table Discussion	Facilitator: Charlton Wilson Respondent: Assurance Sarah Germain Courtney Broome
12:55 PM – 1:00 PM	Next Steps	Kailey Love

Learning Objectives

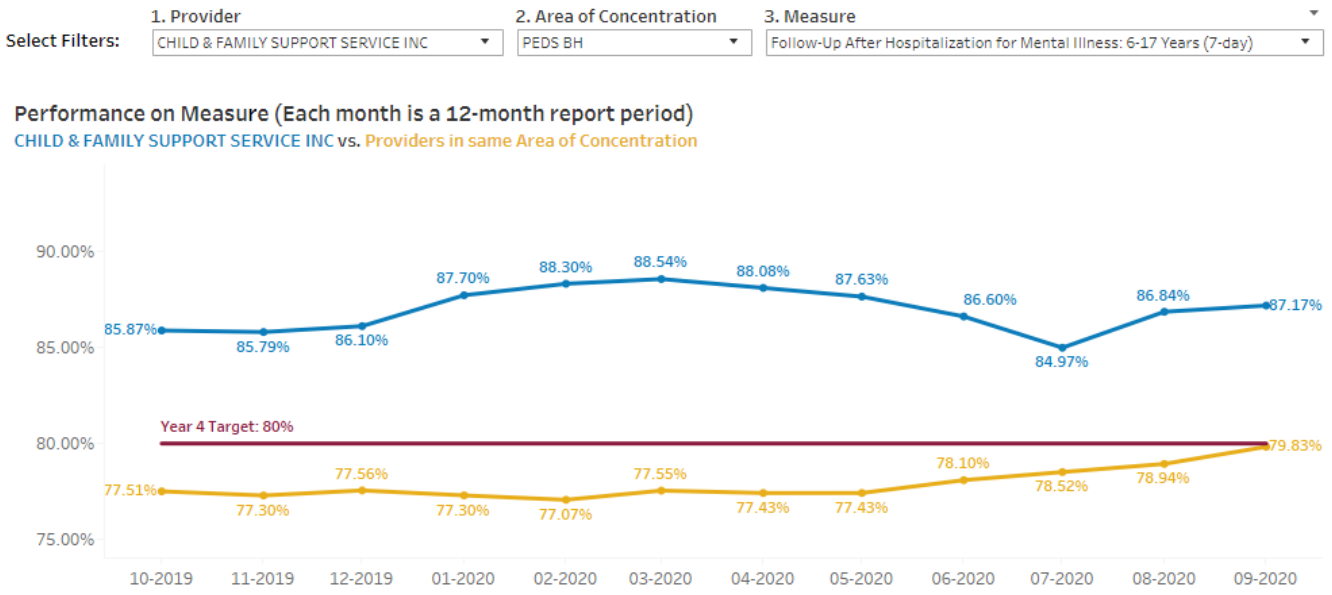
1. Analyze alternative strategies to improve patient compliance with metrics for ambulatory visits.
2. Identify two changes that can be done at your organization to increase patient compliance to improve performance.
3. Develop a plan to achieve those two changes.

Performance Comparisons

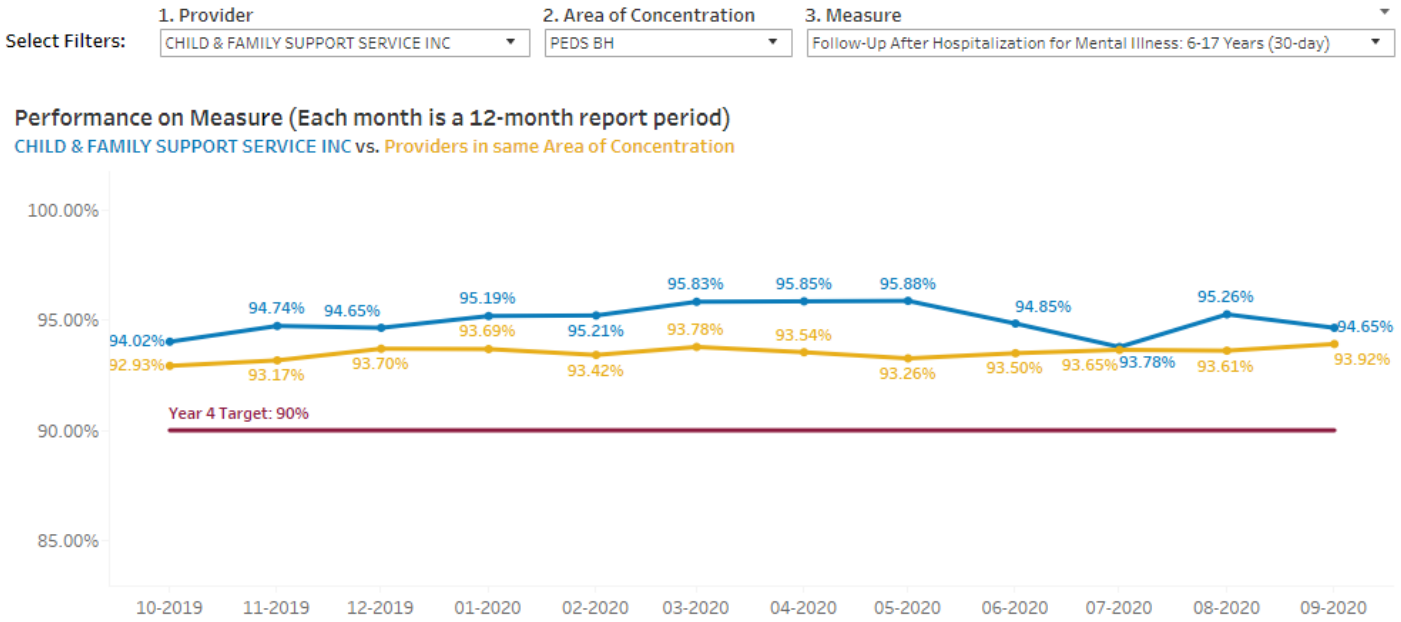
- 7-Day and 30-Day Follow-up After Hospitalization
- Metabolic Screening for Children on Antipsychotics
- Well Child Visits for Three Age Groups

Child Family & Support Services

7 Day FUH



30 Day FUH



CFSS | Child & Family Support Services

Child Family & Support Services

Troy Bailey
Emily Luechtefeld

CFSS | Child & Family Support Services

Overview

- Statewide comprehensive service provider contracted with all seven (7) health plans across all three (3) GSAs.
- Primarily work with children and transition age young adults.
- Typically work with complex, comprehensive individuals, at-risk or transitioning from out of home placement.
- Statewide enrollment of approx. 3000 affiliated members at any given point in time
- CFSS was *started and designed* precisely for this purpose: to provide support services to maintain youth in the community who were transitioning from, or at-risk of entering, out of home placements.

CFSS | Child & Family Support Services

CFSS Current Process

- CFSS is aware / notified that an assigned young person is in placement.
  - CFSS assigns a coordinator to meet with the family or conduct the intake same day or no later than 24 hours.
- The assigned coordinator attends the follow-up meeting *with the family*.
- As discussed in an earlier presentation, CFSS utilizes a centralized tracker which integrates with our nurse practitioner's schedules within our EHR.
  - CFSS reserves Five (5) hours each week for Program Directors to utilize for after care, follow-up and emergency needs.
- CFSS is unapologetic in the coordination
  - We do not assume we are responsible for a family or an outcome. We are their partners. We don’t chase a metric, we meet to make sure what was promised is being provided.

CFSS | Child & Family Support Services

Discussion Questions

1. What are the main reasons why individuals miss appointments for the 7-day and 30-day metrics?
2. How do you encourage patients to keep scheduled appointments?
3. Do you use different processes for the 7-day and 30-day metrics?
4. What would you describe as the main component of your process that explains the large difference in comparison with the overall TI Collaborative?

CFSS | Child & Family Support Services

Good intentions…

- We believe in taking action because it makes sense.
  - Do what is right and what is needed because it honors the member, not because it checks a compliance box.
- Our model of supports to maintain members in the community can create different levels of "energy".

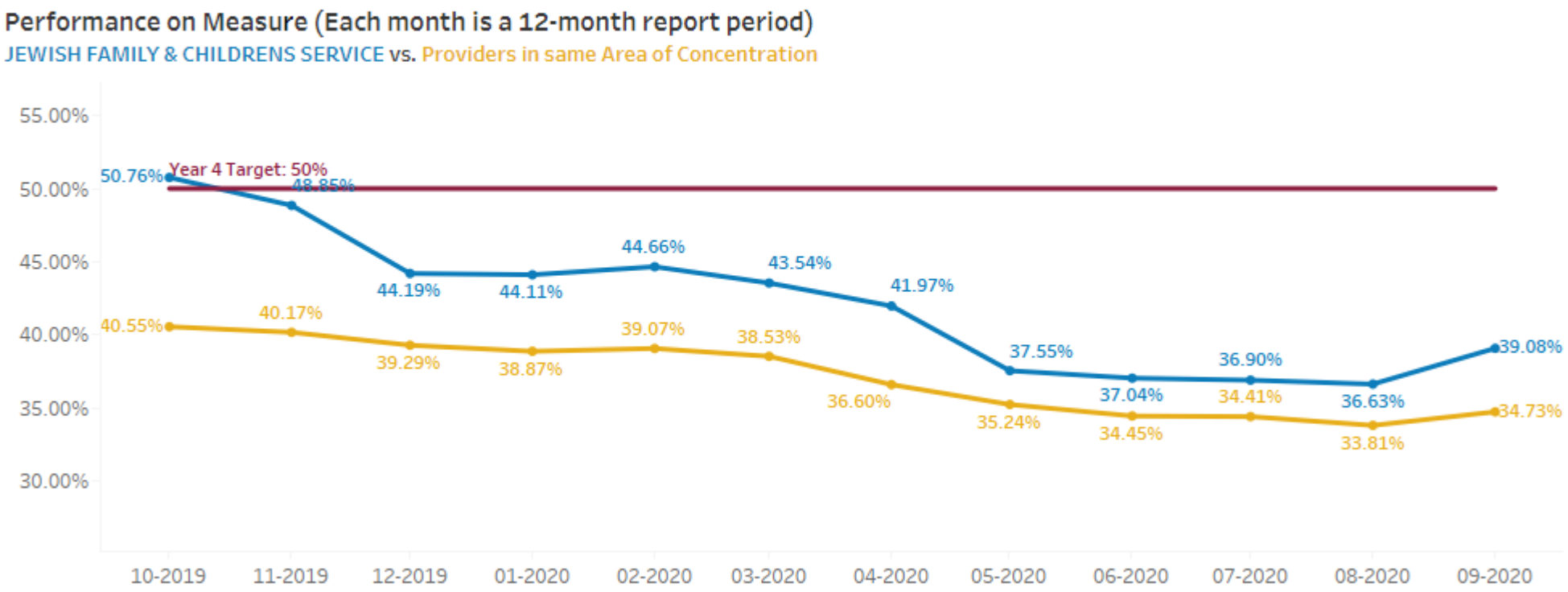
  -For every kudos we receive, we have an equal amount of utilization review from a health plan questioning the amount of service delivery. We do this it this way *because this is what we believe honors the individual / family; and it works*.

Jewish Family & Children's Services

Metabolic Screening for Children on Antipsychotics

Select Filters:

1. Provider: JEWISH FAMILY & CHILDRENS SERVICE
2. Area of Concentration: PEDS BH
3. Measure: Metabolic Monitoring for Children and Adolescents on Antipsychotics (AP...



Jewish Family & Children's Service

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Targeted Investment YEAR 4

Pediatric Core Component – Metabolic Monitoring for Children and Adolescents on Antipsychotics

Megan Lipman
Brian Rosenstein

About JFCS

- Jewish Family & Children's Service (JFCS) is a non-profit, non-sectarian 501(c)(3) organization dedicated to strengthening the community by providing behavioral health, healthcare and social services to all ages, faiths and backgrounds. JFCS was founded in 1935 and has been providing services to the community for 80+ years.

- JFCS programs and services include: primary care, counseling, mental health assessment and treatment, early childhood trauma assessment and treatment, child crisis intervention and rehabilitative services, support for victims of domestic violence, substance abuse, work force readiness & high school equivalency exams for teens in foster care.

Why Do Members Miss Appointments? (Metabolic Monitoring)

- Non-Emergency Blood Work
  - Members encounter a variety of challenges that cause interruptions in routine health maintenance

- Have to go to an outside lab for blood draws.
  - Transportation

- Timing & Scheduling
  - Parents and caregivers having challenges balancing an already busy schedule, also seen with group home settings.
  - Challenges with scheduling unique patients (those with difficulty have labs drawn)

- COVID-19

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Strategies to Increase Patient Compliance? (Metabolic Monitoring)

- REMINDERS - REMINDERS – REMINDERS

- Completing the lab work in house at time of appointment if possible.

- Assign a Health Navigator to see what barriers are in place and ensure members follow up on lab work.

- Population Health Reporting
  - Created an accurate real-time list of members who need labs completed.
  - Understanding your EHR and your data points

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Population Health – TIP Report (Metabolic Monitoring)

PatientName	AHCCCSID	Location	Compliant Y/N	Last metabolic test ordered	Result Received Y/N	Last Lab Completed date	Next Lab Due Date	Next BHMP Appt Date	BHMPProvider
John Doe	123456	Phoenix	y	1/5/2021	y	1/5/2021	1/5/2022	2/15/2021	
Jane Doe	123457	Phoenix	n	1/5/2021	n	1/8/2018	10/1/2020	2/28/2021	
Jake Doe	123458	Phoenix	n	7/10/2020	y	7/10/2020	7/10/2121	3/1/2021	

Goal: Develop an accurate tool that our clinics can use to identify what clients are eligible/complainant for this specific.

- Step One: From a data perspective, understanding what client's are eligible for this measure (denominator).
  - Age, Dx Codes, Medication

- Step Two: Understanding what criteria will close the measure for the member (numerator).
  - Test May have been ordered but the results may have not been received.

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Population Health – Reworking Report & Workflow (Metabolic Monitoring)

PatientName	AHCCCSID	Location	Compliant Y/N	Last metabolic test ordered	Result Received Y/N	Last Lab Completed date	Next Lab Due Date	Next BHMP Appt Date	BHMPProvider
John Doe	123456	Phoenix	y	1/5/2021	y	1/5/2021	1/5/2022	2/15/2021	
Jane Doe	123457	Phoenix	n	1/5/2021	n	1/8/2018	10/1/2020	2/28/2021	
Jake Doe	123458	Phoenix	n	7/10/2020	y	7/10/2020	7/10/2121	3/1/2021	

- Step Three: Present this information to the clinics and understand their workflow.

- Step Four: Listen to feedback from the clinics and make changes to the TIP report.
  - Accuracy, Ease of use, Continuing process
    - Members may not be compliant for the tip year but may not yet need labs.

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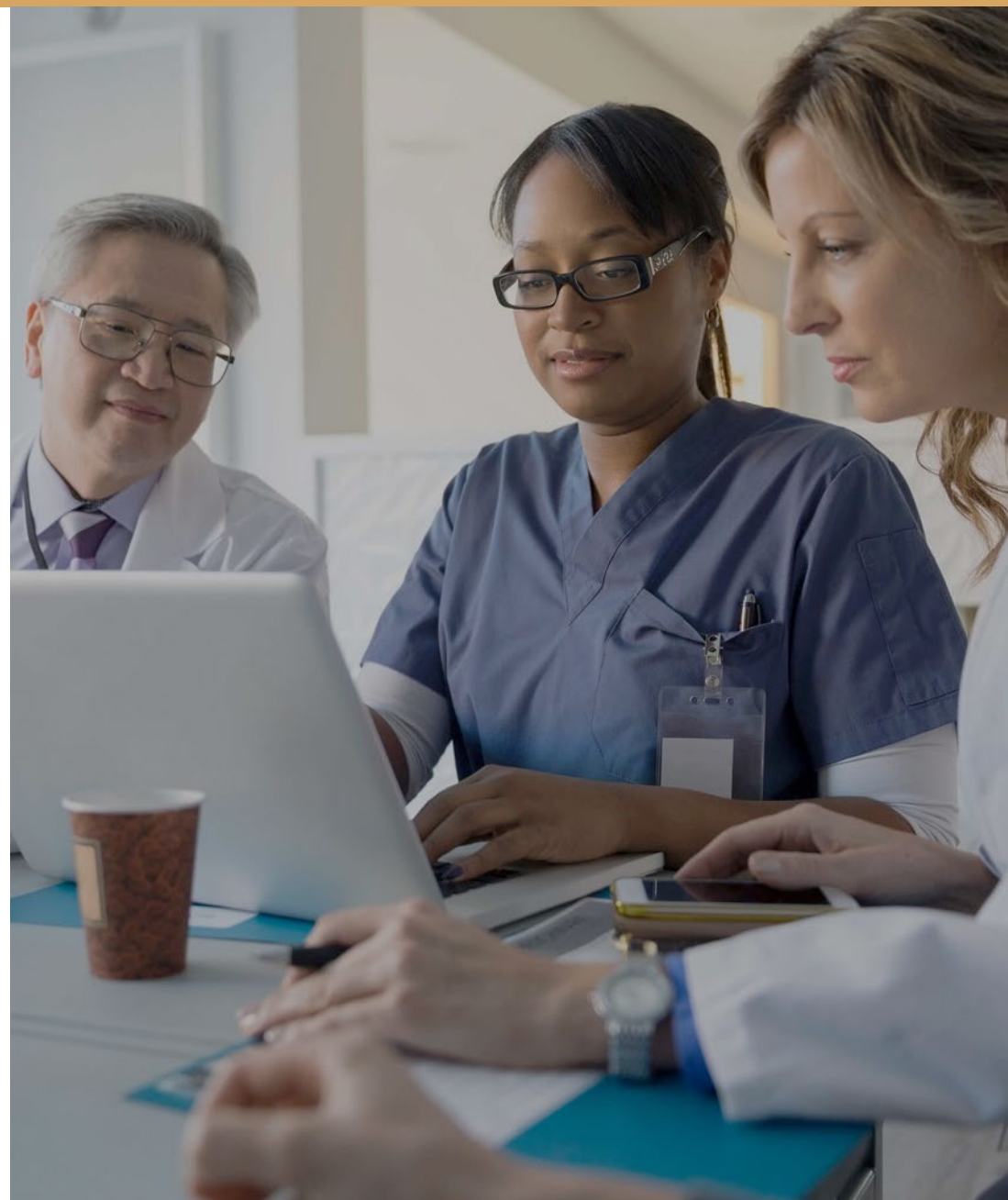
Lessons Learned & Future Improvements

- Onsite blood draw availability
- Health plan incentives
- Telehealth has improved overall appointment compliance
- In-home nursing visits
- Automation



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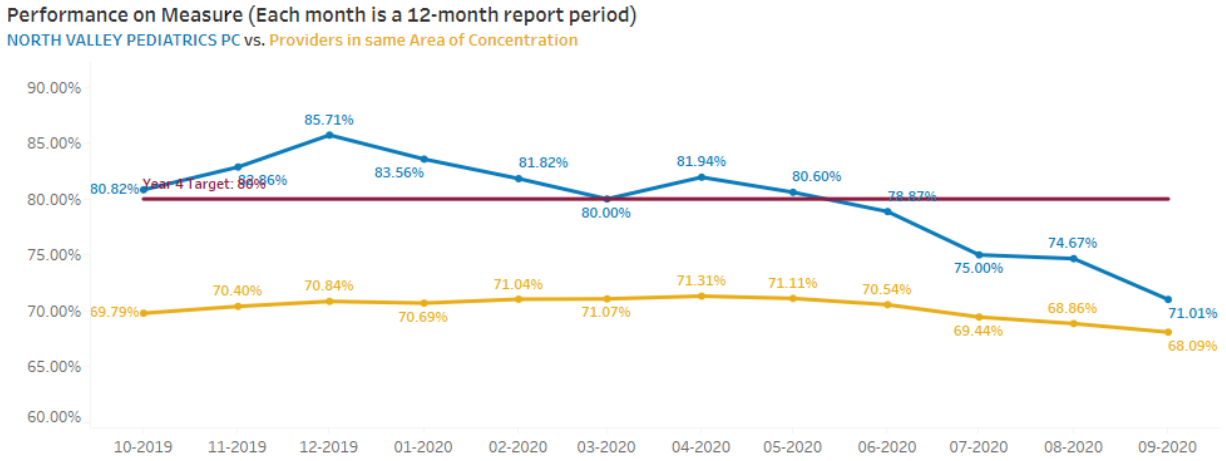
North Valley Pediatrics

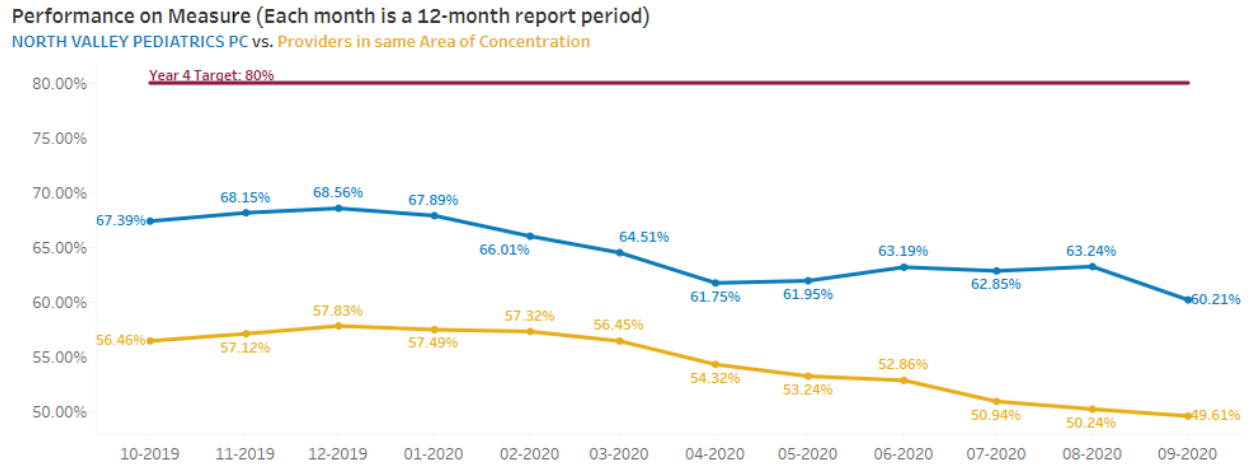
Well-Child Visits 0-15 Months

Select Filters: 1. Provider: NORTH VALLEY PEDIATRICS PC; 2. Area of Concentration: PEDS PCP; 3. Measure: Well-Child Visits (Ages 0-15 Months): 6 or More Well-Child Visits



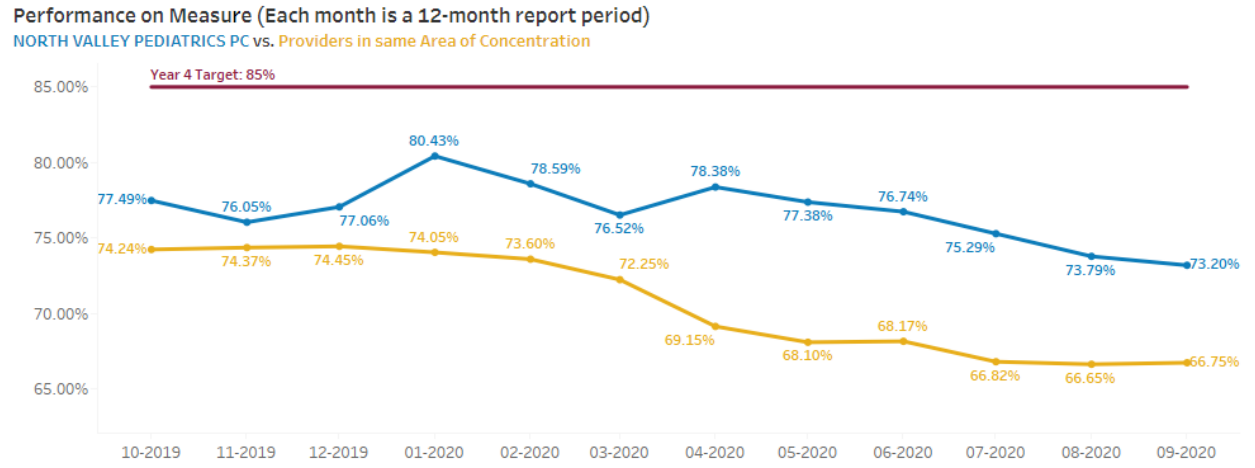
Adolescent Well Care

Select Filters: 1. Provider: NORTH VALLEY PEDIATRICS PC; 2. Area of Concentration: PEDS PCP; 3. Measure: Adolescent Well-Care Visits: At Least 1 Comprehensive Well-Care Visit



Well-Child Visits 3-6 Years

Select Filters: 1. Provider: NORTH VALLEY PEDIATRICS PC; 2. Area of Concentration: PEDS PCP; 3. Measure: Well-Child Visits (Ages 3-6 Years): 1 or More Well-Child Visits



North Valley Pediatrics

JoAnn Kolnick

Dr. Louis Trunzo

Questions

- Why do patient's miss appointments?
- How does NVP encourage patients to keep scheduled appointment?
- Does NVP use different processes for the three age groups.
- What are the main components of the workflow that explains the difference in our performance?
- Can you interpret why performance has dropped for the 0-15 months' well-child visits while it has stayed stable for the other two?

Missed Appointments

- Traffic
- Work
- School
- Lack of Reminder
- Slept In
- Car Broke Down

Tools for Appointment Follow Through

- Tele Vox, phone calls, refusal to do referrals or write meds w/o annual well care.
- Do well care with sick visits.
- All vitals for 0 – 24 month visit (head circumference, ect) so that well care is easy for provider to do if sick visit scheduled. All office staff believes in medical home concept.
- Office is flexible about late arrivals, routine forms include permission to treat for other family members and friends. (ie Grandma can bring in child with permission.)

Different Processes for Three Age Groups

- Calls for newborn well care appointments tied to vaccine reports, newborn screen reports and Hepatitis B office report.
- Call for 3 – 6 yr well care visits are pulled from vaccine reports and office well care report, but timed for summer vacation before school starts. Usually starting in May and ending in September.
- Adolescent calls are pulled from vaccine reports and office well care reports. School breaks, summer, holidays. Postcards are often used .
- Medical records from ER/urgent care and hospitals are also used to target visits. Patients are more receptive to come in for follow up after needing outside care.
- Asthma 6 month lists, telemed opportunities. Well care Saturdays.

Main Components of Workflow that Explains Difference in Performance

- The office value supports the medical home concept and all staff is tries to get patient well care completed when the opportunity appears.

Why did NVP performance drop for 0 to 15-month Well-Child Visit?

- Some of the office procedures necessitated by COVID made the office environment less friendly. Less visitors allowed at patient visits, decreased sitting in the waiting room. Less available staff when personal exposures and quarantine episodes occurred. We were fortunate that are two MAs were both exposed (by family) in different two-week time periods. Parents are reluctant to expose newborns to infectious diseases. We did resume well care Saturdays, which are successful, but difficult for the provider to do weekly. We did need to let our senior provider retire to protect him from exposure (85 years old.)
- Office reluctance to schedule many patients at a time when the case rate was high. We sent more patients to the ER and urgent care because of need to get COVID testing, and desire to keeps patients and staff safe from infection.

Round Table Discussion

Q&A

- Please insert any questions in the Q&A box

Next Steps

- Post-Event Survey: 2 Parts
  - General Feedback Questions
  - Continuing Education Evaluation

- Continuing Education for 2021 will be awarded post all 2021 QIC sessions (December 2021)

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

Thank you!

TIPQIC@asu.edu