

AHCCCS Targeted Investments Program

# Quality Improvement Workgroup #1

## Adult PCP/BH 7 & 30 Day FUH

William Riley, PhD

TIP Year 6: Quality Improvement Workgroup Series  
February 7, 2022

# **Disclosures (for CEUs)**

There are no disclosures

# Learning Objectives (for CEUs)

1. Understand the importance of Quality Improvement frameworks to improving performance on HEDIS measures
  - Lean Six Sigma, and DMAIC
  - Model for Improvement
2. Introduce intervention to improve internal processes

# Agenda

| TIME                 | TOPIC                                                                                                                                                                                              |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12:00 to 12:02 PM    | Overview                                                                                                                                                                                           |
| 12:02 PM to 12:10 PM | Case Study Organization <ul style="list-style-type: none"><li>• Introductions</li><li>• Overview</li><li>• Performance Review</li></ul>                                                            |
| 12:10 PM to 12:40 PM | Root Cause Analysis: <ul style="list-style-type: none"><li>• Develop Aim Statement</li><li>• Identify and Prioritize Obstacles</li><li>• Identify Interventions</li><li>• Create Metrics</li></ul> |
| 12:40 PM to 12:50 PM | Discussion and Q&A                                                                                                                                                                                 |
| 12:50 PM to 1:00 PM  | Homework and Next Steps                                                                                                                                                                            |

# Quality Improvement Workgroup #1

## Case Study Organization

Aurora Behavioral Health

Contact Information:

- Valerie Purdie, Community Liaison,  
[Valerie.Purdie@aurorabehavioral.com](mailto:Valerie.Purdie@aurorabehavioral.com)
- Jordan L. Peterson, Director of Business Development,  
[Jordan.Peterson@aurorabehavioral.com](mailto:Jordan.Peterson@aurorabehavioral.com)

# Aurora Overview

- Aurora Behavioral Health System is Arizona's largest free-standing psychiatric healthcare system with 238 inpatient beds across two locations in Glendale and Tempe, serving adolescents and adults 13 years and older.
- Both hospitals offer a full continuum of care with integrated outpatient centers offering Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) to meet mental health and addiction treatment needs at each level of care.

# Aurora Performance

Select Filters:

1. Provider

AURORA BEHAVIORAL HEALTHCARE - TEMPE LLC

2. Area of Concentration

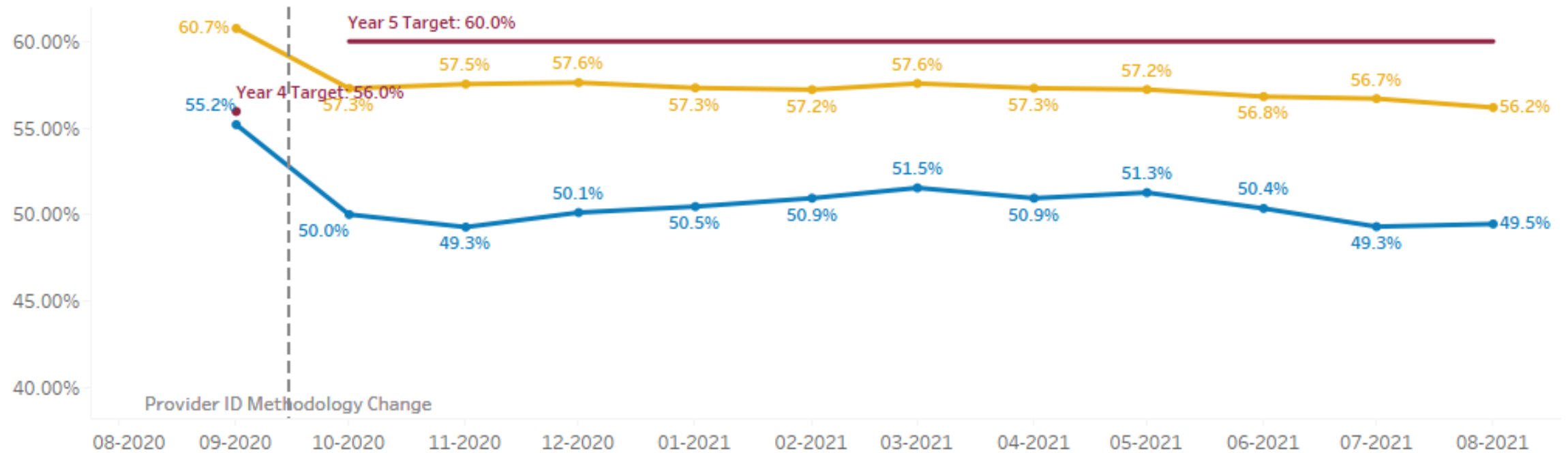
HOSPITAL

3. Measure

Follow-Up After Hospitalization for Mental Illness: 18 and older (7-day)

Performance on Measure (Each month is a 12-month report period)

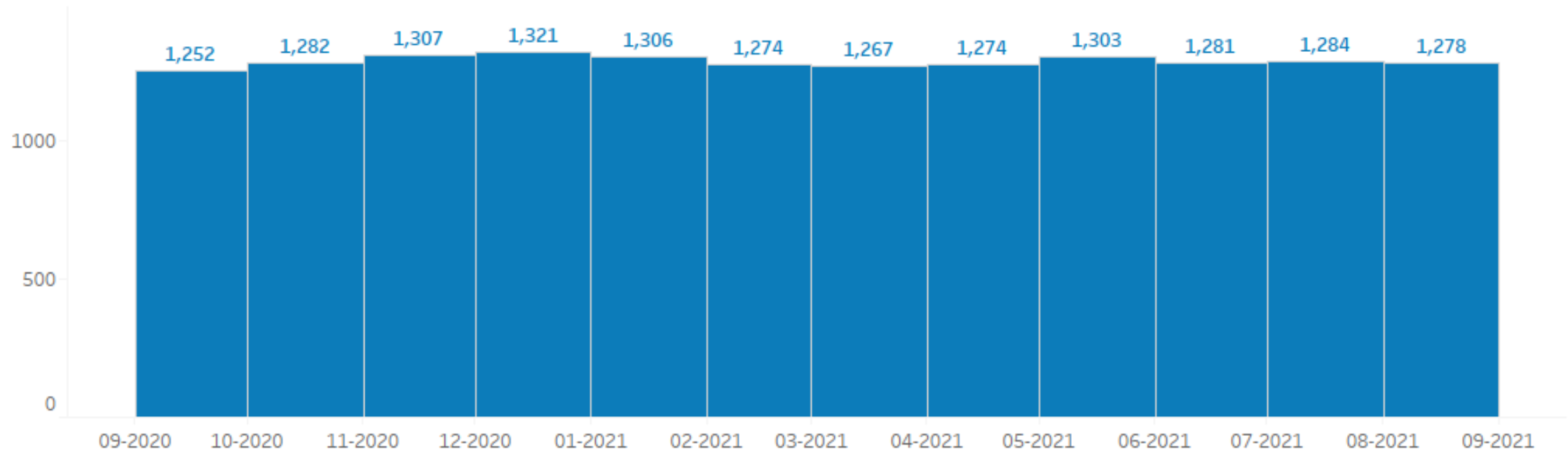
AURORA BEHAVIORAL HEALTHCARE - TEMPE LLC vs. Providers in same Area of Concentration



# Aurora Denominator

## Denominator

AURORA BEHAVIORAL HEALTHCARE - TEMPE LLC





# Today's Goal

1. Develop Aim Statement
2. Identify and Prioritize Obstacles
3. Identify Interventions
4. Establish Measures

# Component 1: The Aim Statement

- Create an aim statement
  - What are we trying to accomplish?
  - Include specific terms to define success and time period

# Component 1: **Aurora's** Aim Statement

- Aim Statement:

- Increase the **7-day** follow-up after hospitalization (FUH) rate 10 percentage points (50% to 60%) from February 7, 2022 to August 30, 2022
- Increase the **30-day** follow-up after hospitalization (FUH) rate 19 percentage points (66% to 85%) from February 7, 2022 to August 30, 2022

# Component 2: Identify and Prioritize Obstacles

- Part A: Identify obstacles
  - What are key barriers to obtaining the aim statement?
- Part B: Prioritize the obstacles identified
  - Which obstacles make the biggest impact upon the aim statement and are achievable?

# Component 2: **Aurora's** Obstacles

## Part A. Identifying Key Obstacles

### Key Obstacles:

1. Limited appointment availability
  - Staffing shortages
2. Discharge day of the week for patients
3. Appointment compliance
  - Work and/or family obligations following discharge
4. Lack of patient and family education
  - Engagement in the continuum of care
5. Address the social determinants of health
  - Transportation
  - Housing
6. Poor patient hand-offs
  - Undeveloped partnerships with community organizations
  - Stalled and delayed vendor credentialing process
  - Inconsistent standards across health plans on provider notification of patient hospitalization/discharge
  - Inability of case managers from SMI clinics to go into hospitals
7. Poor utilization of referral options for specific patient
  - Lack of awareness of pain management resources for the substance use populations

# Obstacles Discussion

- To the audience:
  - From your experience, are there other obstacles that you have found impeding your performance on FUH 7 and 30 day?

# Component 2: **Aurora's** Obstacles

## Part B: Prioritization

| Priorities | Obstacles                                    |
|------------|----------------------------------------------|
| 1          | Poor patient hand-offs                       |
| 2          | Discharge day of the week for patients       |
| 3          | Lack of patient and family education         |
| 4          | Addressing the social determinants of health |

# Component 3: **Aurora's** Interventions

| Priorities                                   | Interventions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Poor patient hand-offs                       | <ul style="list-style-type: none"> <li>• Assigning an internal liaison to work with preferred providers (position description, recruitment, training, orientation)</li> <li>• Admitting privileges for the navigator (keys and badging)</li> <li>• Expanding list of preferred providers (identify and select partners, approach partner, explain expectations, execute MOU)</li> <li>• Ensure 100% warm hand-offs with SMI clinics (trouble-shooting with MCOs to coordinate with clinics)</li> </ul> |
| Discharge day of the week for patients       | <ul style="list-style-type: none"> <li>• Treatment teams reviews late day and weekend discharges</li> <li>• Work with health plans for LOS authorization</li> <li>• Avoid weekend or late day discharges</li> </ul>                                                                                                                                                                                                                                                                                    |
| Lack of patient and family education         | <ul style="list-style-type: none"> <li>• Assigning internal liaison to coordinate with discharge central to build awareness of continuum of care</li> <li>• Connecting with outpatient services</li> <li>• Schedule family education session within 72 hours of admission</li> <li>• Signage, interventions, competencies to build awareness</li> <li>• Provider type 77</li> </ul>                                                                                                                    |
| Addressing the social determinants of health | <ul style="list-style-type: none"> <li>• Work with preferred provider list to better address transportation and housing</li> <li>• Have community liaison teams researching and gathering information regarding preferred providers and detailing their specialties (to be reviewed and update quarterly)</li> </ul>                                                                                                                                                                                   |



# Interventions Discussion

- To the audience:
  - From your experience, are there other interventions that you have found effective?

# Component 4: Establishing Measures

- Measures are metrics to learn whether interventions are making a difference
  - Seek usefulness not perfection
  - Use qualitative and quantitative data
- Keep data collection simple
- Integrate measurement into daily routines whenever possible
- Plot and post data to track progress

# Component 4: Aurora's Measures

| Priorities                                   | Intervention                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Metrics                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Poor patient hand-offs                       | <ul style="list-style-type: none"> <li>Assigning an internal liaison to work with preferred providers (position description, recruitment, training, orientation)</li> <li>Admitting privileges for the navigator (keys and badging)</li> <li>Expanding list of preferred providers (identify and select partners, approach partner, explain expectations, execute MOU)</li> <li>Ensure 100% warm hand-offs with SMI clinics (trouble-shooting with MCOs to coordinate with clinics)</li> </ul> | <ul style="list-style-type: none"> <li># of liaison contacts per week</li> <li># of contacts not completed per week</li> <li>% of navigators keyed and badged</li> <li># of pending and completed MOUs</li> <li>% of discharges that do not go to preferred providers</li> <li>% of warm hand-offs</li> </ul> |
| Discharge day of the week for patients       | <ul style="list-style-type: none"> <li>Treatment team reviews late-in-day and weekend discharges</li> <li>Work with health plans for length of stay authorization</li> <li>Avoid weekend or late-in-day discharges</li> </ul>                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>Identify late-in-day and weekend discharges; contact all late-in-day and weekend discharges next day</li> <li># of health plans contacted; # of health plans agree</li> <li>% reduction of late-in-day and weekend discharges</li> </ul>                               |
| Lack of patient and family education         | <ul style="list-style-type: none"> <li>Assigning internal liaison to coordinate with discharge central to build awareness of continuum of care</li> <li>Connecting with outpatient services</li> <li>Schedule family education session within 72 hours of admission</li> <li>Signage, interventions, competencies to build awareness</li> <li>Provider type 77 does not qualify</li> </ul>                                                                                                     | <ul style="list-style-type: none"> <li># of internal liaison connections made</li> <li># and % of connections made with outpatient services</li> <li># of family education sessions made within 72 hrs of admission</li> <li>All provide type 77's are corrected</li> </ul>                                   |
| Addressing the social determinants of health | <ul style="list-style-type: none"> <li>Work with preferred provider list to better address transportation and housing</li> <li>Have community liaison teams researching and gathering information regarding preferred providers and detailing their specialties (to be reviewed and update quarterly)</li> </ul>                                                                                                                                                                               | <ul style="list-style-type: none"> <li>% of clinic visits missed because of transportation</li> <li>% of clinic visits missed because of homelessness</li> </ul>                                                                                                                                              |

# Metrics Discussion

- To the audience:
  - From your experience, are there other metrics that you have found effective?

# **QIW #1 Session 1: “Homework”**

1. Develop Aim Statement
2. Identify and Prioritize Obstacles (what to change)
3. Identify Intervention (how to change)
4. Establish Measures (measuring progress of change)

# “Homework”

## Component 1: Develop Aim Statement

1. **Develop Aim Statement**
2. Identify and Prioritize Obstacles (what to change)
3. Identify Intervention (how to change)
4. Establish Measures (measuring progress of change)

### Aim Statement:

- Increase the **7-day** follow-up after hospitalization (FUH) rate \_\_\_\_\_ percentage points (\_\_\_\_% to \_\_\_\_%) from February 1, 2022 to August 30, 2022
- Increase the **30-day** follow-up after hospitalization (FUH) rate \_\_\_\_\_ percentage points (\_\_\_\_% to \_\_\_\_%) from February 1, 2022 to August 30, 2022

# “Homework”

## Components 2-4

1. Develop Aim Statement
- 2. Identify and Prioritize Obstacles (what to change)**
- 3. Identify Intervention (how to change)**
- 4. Establish Measures (measuring progress of change)**

| Priorities | Obstacles | Intervention | Metrics |
|------------|-----------|--------------|---------|
|            |           |              |         |
|            |           |              |         |
|            |           |              |         |
|            |           |              |         |

# **QIW #1 Session 2: Focus**

- Develop Plan-Do-Study Act (PDSA) Cycle #1



# Next Steps

- Continuing Education Units (CEU): Post Event Survey
  - Once session has ended, CEU survey will appear in browser
  - If issues accessing, please email [TIPQIC@asu.edu](mailto:TIPQIC@asu.edu)
  - All CEU's for 2022 will be awarded following all 2022 QIC sessions (ETA November 2022)
- Attendees to complete recommended 'homework' prior to session #2
- Questions or concerns?
  - Please contact ASU QIC team at [TIPQIC@asu.edu](mailto:TIPQIC@asu.edu) if questions or concerns

# Thank you!

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