AHCCCS Targeted Investments Program

Diabetes Screening (SSD)/Metabolic Monitoring (APM) Quality Improvement Workgroup #4

William Riley, PhD

TIP Year 6: Quality Improvement Workgroup Series
May 25, 2022: QIW #4 Session #4

College of Health Solutions Arizona State University

AHCCCS Arizona Health Care Cost Containment System | Targeted Investments

College of Health Solutions Arizona State University

Center for Health Information and Research

Disclosures

CEU Disclosures:

There are no disclosures.

Recording:

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All templates, slides, and session materials can be found: https://tipqic.org/QIWorkgroups.html

Learning Objectives (for CEUs)

1. Describe Plan-Do-Study-Act (PDSA) cycle interventions to achieve key metrics
2. Debrief pros and cons of applying the PDSA cycle to diabetes screening and metabolic monitoring measures

Agenda

TIME	TOPIC
12:00 to 12:02 PM	Overview
12:02 to 12:20 PM	PDSA Cycle Updates
12:20 PM to 12:50 PM	PDSA Cycle Discussion
12:50 PM to 1:00 PM	Next Steps

Additional Case Study

KRMC- Kingman Regional Medical Center

Naomi Brown PMHNP, BC, Behavioral Health Integration: Naomi.Brown@azkrmc.com

Grant Benson, Director of Primary Care: GBenson@azkrmc.com

Jeanette Garcia, Behavioral Health Care Coordinator: JGarcia@azkrmc.com

Dr. Anthony Santarelli, Clinical Research Administrator: Anthony.Santarelli@azkrmc.com

Dr. Efren Cano, Residency Director Family Medicine Clinic: ECano@azkrmc.com

Ashley Schmitz, Office Manager Primary Care: Ashley.Schmitz@azkrmc.com

Michelle Callicoat, Office Manager Primary Care: Michelle.Calicoat@azkrmc.com

Margaret Libertini, Business Application Analyst: Mlibertini@azkrmc.com

KRMC

Aims Statements

Aim 1: To decrease the risk of diabetic and metabolic complications for patients prescribed atypical antipsychotics.

By Increasing the Adult PCP/BH SSD rate 20.3 percentage points (34.7% to 55.0%) and 20 from 34 to 54 patients from October 01, 2021 to August 30, 2022

KRMC

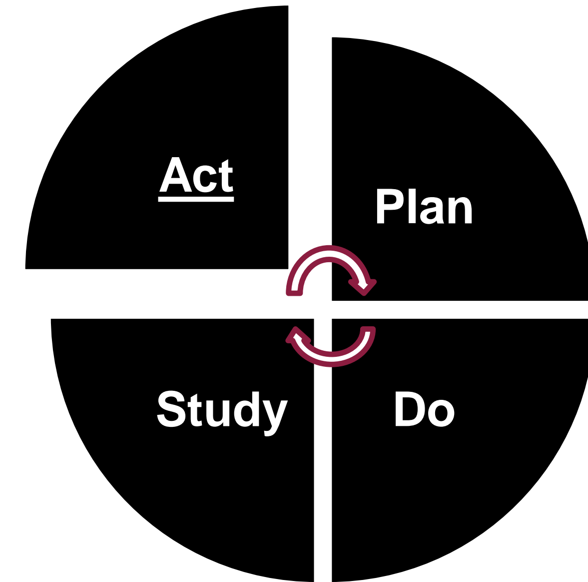
Prioritize Obstacles, Identify Interventions & Establish Measures

Priorities	Obstacles	Intervention	Metrics
Education	• A Large Residency Contributes to a high portion of our PCPs. • Lack of patient knowledge of the health benefits of routine screening.	• Educational presentation targeted toward PCPs and residents at their clinics • Evidence-Based practice clinical guideline made institutionally available	• Attendance of educational events • Public folder access frequency
Collaboration	• Gap in communication channels between community mental health partners and KRMC PCPs. • Receive mentoring from others	• Monthly rounding meeting between CHPs and BH Staff and PCPS • Established relationships with other AZ TI and CoCM participants	• Frequency of meetings • # of Participants
Identification	• Patients receive Atypical prescriptions by external behavioral health partners.	• Creation of a Surveillance Registry that collates HbG-A1c, and Atypical Medications by Provider.	• Registry Roll out Date (anticipated July 1) • Number of Patients/provider on registry
Access	• Limited transportation availability in Mohave County • Patient Care avoidance during COVID and Reliance on Telehealth Services	• HbG-A1c Point of Care testing units at PCP offices.	• % of PCPs with Units Installed • # of HbG-A1c POC orders from PCP offices

KRMC

Plan-Do-Study-Act

Aim: To decrease the risk of diabetic and metabolic complications for patients prescribed atypical antipsychotics.		
Goal: To increase the **Adult PCP/BH SSD** rate 20.3 percentage points (34.7% to 55.0%) and 20 from 34 to 54 patients from October 01, 2021 to August 30, 2022		
		Cycle 1: Identify Billing codes and Educate Providers
Plan: To Educate	Who?	Primary Care Providers
	What?	Best Practices
	Where?	In the Clinics
	When?	Quarterly Seminars and Updates
Do	How?	Behavioral health integration team in person discussions and emails
Study	Evaluate	At Least 80% of PCPs will attend an In-person Discussion
Act	Lock-in or Revise & Re-do	In March, 2022 attendance was > 80%. Re-administration to Occur In July, 2022. - If attendance <80%: Institute individualized visits.



KRMC

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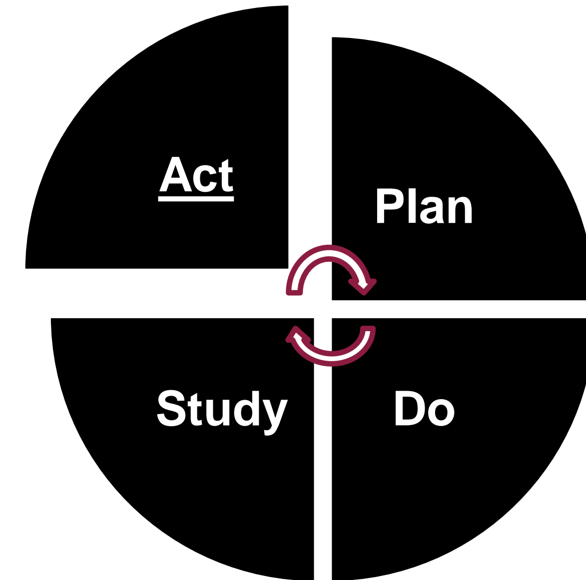
		Cycle 2: Develop Communication Channels Between CHPs and PCPS
Plan: Collaborate	Who?	Community Health Partners, Primary Care Providers, Behavioral Health Staff
	What?	Monthly rounding Meetings
	Where?	Virtually
	When?	Local first Tuesday of the month, Collaborative; second Friday of the month
Do	How?	Discuss PDSA cycles
Study	Evaluate	Continued participation of all sites, # of evidence based practice protocols and Information transfer materials developed.
Act	Lock-in or Revise & Re-do	Determined successful if > 80% of patients have a completed Information transfer form. If less than 80% at 3 months then address barriers to utilization. Collaborative- ongoing meetings with 75 % system participation if successful. If less then address need and or barriers



KRMC

Plan-Do-Study-Act

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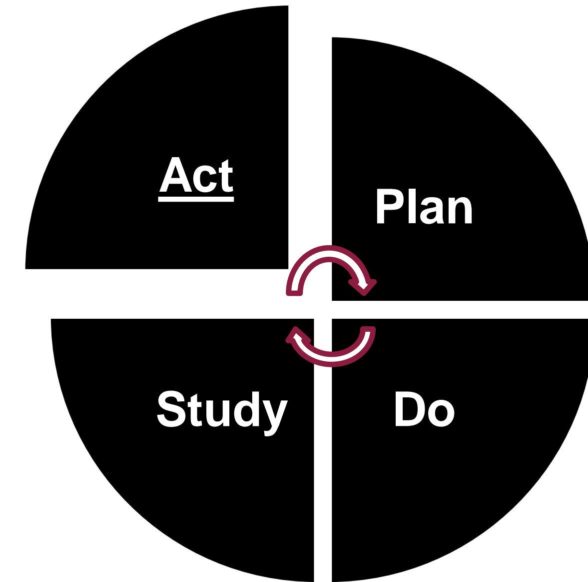
		Cycle 3: Identify Patients in Need of Services
Plan: Identify Patients	Who?	Those on Atypical Antipsychotics Prescribed by Community Health Partners
	What?	Creation of a surveillance registry
	Where?	KRMC Electronic Medical Record
	When?	To be completed July 1
Do	How?	Formed an IT team for the build
Study	Evaluate	Patient Capture Rate
Act	Lock-in or Revise & Re-do	Considered a success If > 75% capture rate is attained. If < 75% capture rate revise the data capture in the registry.



KRMC

Plan-Do-Study-Act

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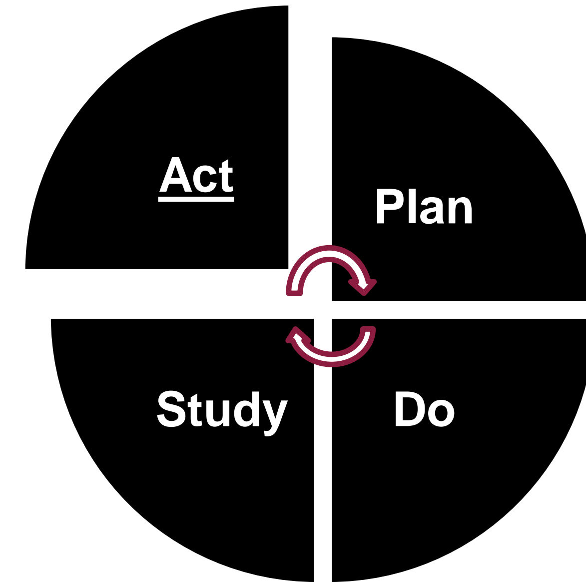
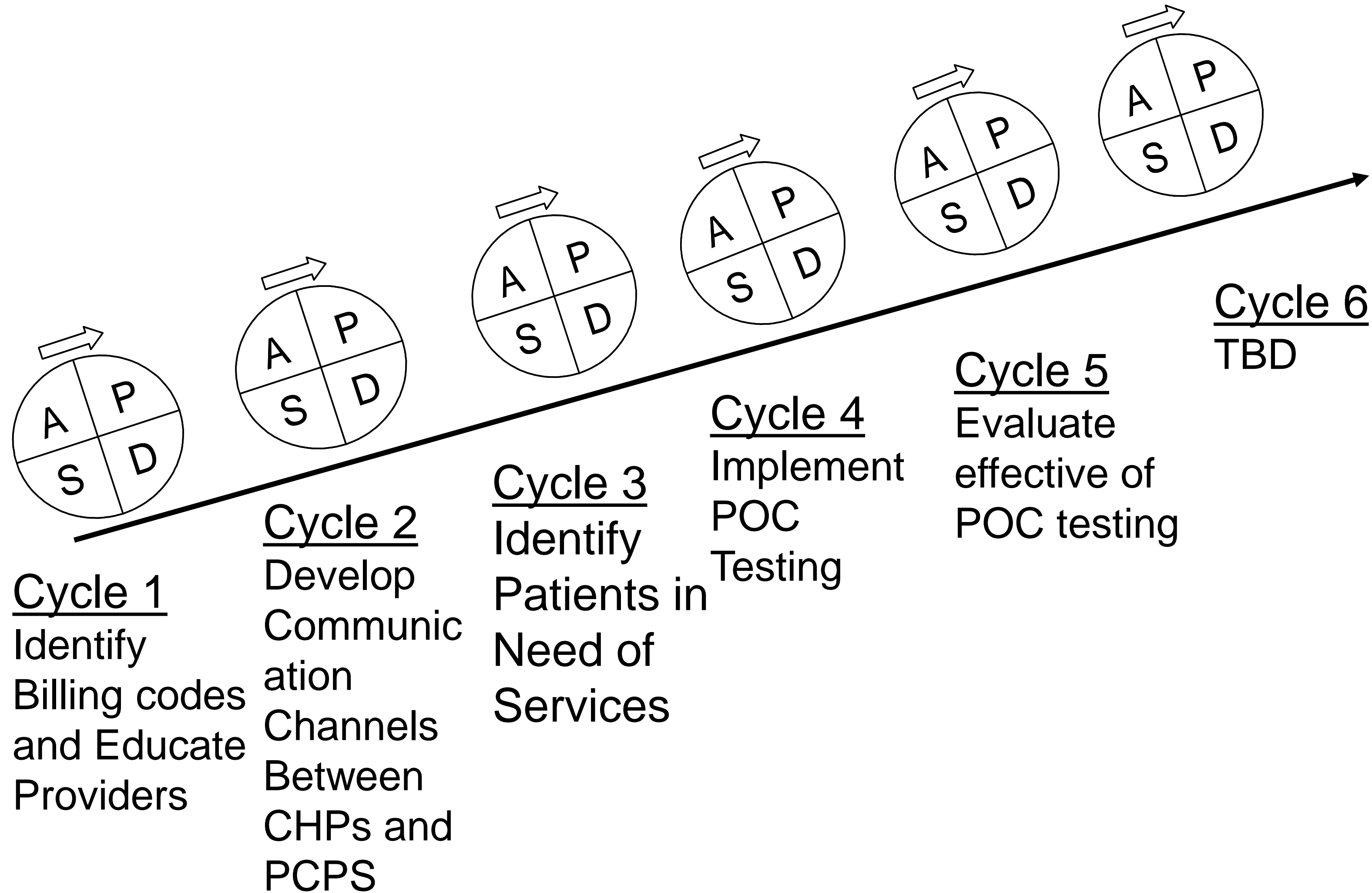
Goal: To increase the **Adult PCP/BH SSD** rate 20.3 percentage points (34.7% to 55.0%) and 20 from 34 to 54 patients from October 01, 2021 to August 30, 2022		
		Cycle 4: Implement POC Testing
Plan: Access	Who?	Patients
	What?	Lack of reliable transportation to the Lab
	Where?	Addressed at the Point of Care
	When?	By July 1
Do	How?	Provide ABBOTT POC HgB-A1c Machine to each clinic
Study	Evaluate	% of PCP office coverage, # of tests administered on site
Act	Lock-in or Revise & Re-do	Considered a success if 3 are installed and 20 tests administered/month through those machines. If < 20 tests administered then reeducate on POC testing



KRMC PDSA Ramp



KRMC Metrics

Metrics												
Cycle #1	**Achievement**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Week 9**	**Week 10**	**Future**
Identify Billing codes and Educate Providers	Identify Codes (Unidentified/Identified)			X	X							
	Provided Seminars (Clinics/4)	X (2/4)	X (3/4)	X (4/4)								X
Cycle 2:												
Develop Communication Channels Between CHPs and PCPS	Meetings Held (Groups Attended/Total partners (N=4))			X (2/4)				X (4/4)				x
	EBP Materials Developed (#)			X (1)			X (2)				X (3)	X (4-j)
Cycle #3:												
Identify Patients in Need of Services	Form IT Workgroup (binary)				X							
	Define Discrete Variables for Registry (binary)					X						
	Test Registry (binary)								X			
	Complete Build (binary)										X	
	Educate For Use (binary)											X
	Go Live (binary)											X
Cycle #4:												
Implement POC Testing	Identify Machine (binary)					X						
	Obtain Approval for Purchase								X			
	Install Machines (#/4)										X (1/4)	X (4/4)
	Educate Staff (binary)									X	X	X
	Go Live										X	X

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Discussion

- Any questions?

Quality Improvement Workgroup Case Study Organization

COPE Community Services, Inc.

Siobhan O'Boyle, *Chief Compliance and Operations Officer*

soboyle@copecommunityservices.org

Laura Santa Cruz, *Director of Integrated Clinics*

lsantacruz@copecommunityservices.org

Rachel Vega, *QM/TIP Specialist*

rvega@copecommunityservices.org

TIPQIC Dashboard | Rachel Vega

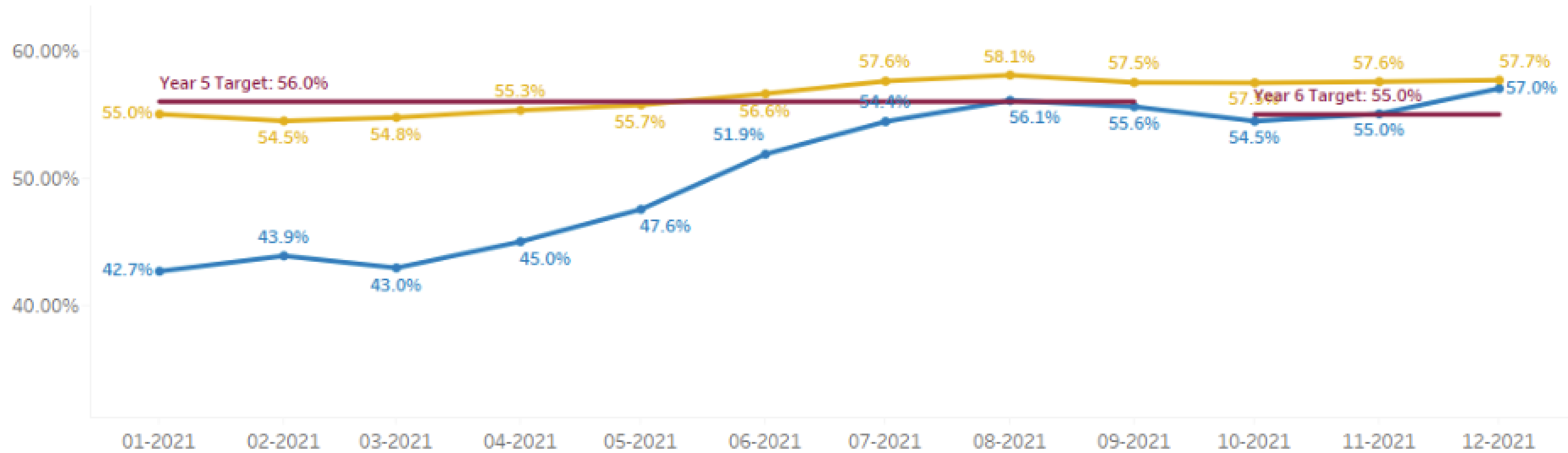
TIP QIC Targeted Investments Program Quality Improvement Collaborative

Use the filters to see your performance on each measure. Click Download to export this view as an image, PDF or PowerPoint file. Please contact us at TIPQIC@asu.edu with questions or comments. Dashboard last updated 5/12/2022. Analysis performed with encounter data adjudicated through 3/31/2022.

Select Filters: 1. Provider: COPE COMMUNITY SERVICES INC | 2. Area of Concentration: ADULT PCP | 3. Measure: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are...

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

COPE COMMUNITY SERVICES INC vs. Providers in same Area of Concentration



Denominator

COPE COMMUNITY SERVICES INC

TIPQIC Dashboard | Rachel Vega

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Select Filters:

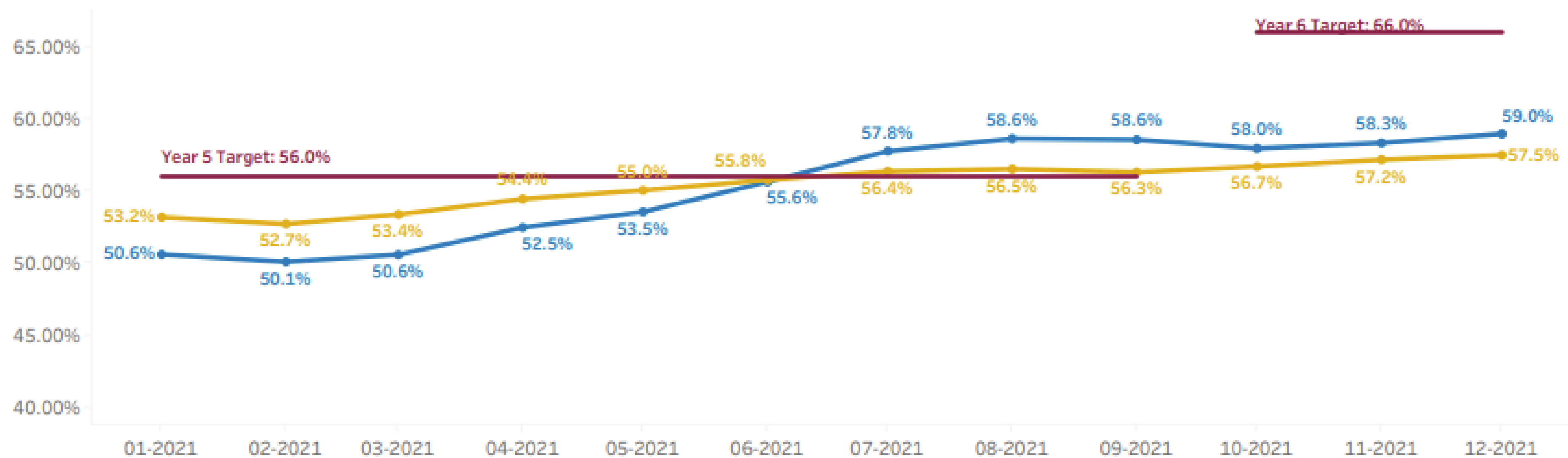
1. Provider COPE COMMUNITY SERVICES INC

2. Area of Concentration ADULT BH

3. Measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who ..

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

COPE COMMUNITY SERVICES INC vs. Providers in same Area of Concentration



Denominator

COPE COMMUNITY SERVICES INC

COPE Develop Aim Statement

Template statements for FUH measure

- Increase the Adult PCP SSD rate 3 percentage points (57% to 60%) from April 13, 2022 to August 30, 2022
- TIP Target 55% Pop 663. Current dashboard score 57%
- Increase the BH SSD rate 8 percentage points (59% to 67%) from April 13, 2022 to August 30, 2022
- TIP Target 66% Pop 1167. Current dashboard score 59%

Prioritize Obstacles, Identify Interventions & Establish Measures

Priorities	Obstacles	Intervention	Metrics
1	Inconsistent workflow/triage processes at the integrated clinics	• Establish collaboration workgroup including MA/LPN, front office, directors, administrative staff, and TIP specialist to develop MA/triage workflow • Troubleshoot and formalize MA workflow • Implementation and training of workflow • Auditing screenings are being completed	• Monitoring completion of tests via audit of completed appointments. • Reviewing internal scores and Tableau dashboard
2	Active migration of EMR to new platform-not yet able to flag when A1C is due		
3	Continued use of telehealth limiting us to lab orders/outside lab testing thereby often being unable to close the loop		

Plan-Do-Study-Act

Aim: Increase score for completed screening/SSD		
Goal: A1C screenings completed for all patients on an anti-psychotic medication at provider appointment		
		Cycle 1
Plan	Who?	Laura Santa Cruz, IC Directors, EMR workgroup, QM/TIP Specialist
	What?	MA workflow developed, training of staff, audit/evaluate/adjust
	Where?	COPE integrated clinics
	When?	TBD
Do	How?	Implementation of A1C screening for any patient qualifying for SSD measure, based on prescribed medication
Study	Evaluate	Review of audit scores resulting in discussion/adjustments based on common barriers (ex: supplies-communication among clinics when one site is out of cartridges while order is pending)
Act	Lock-in or Revise & Re-do	If Plan met = Monitor and fine tune If plan not met = explore and troubleshoot unexpected barriers / revise

Ramp #1: PDSA Cycles

Aim: Increase SSD rates

Goal: Development of MA workflow/triage which includes diabetes screening (A1C)

		Cycle 1: Develop workflow that includes A1C screening/testing	Cycle 2: Train on workflow	Cycle 3: Staff actively following MA workflow including A1C screen/test	Cycle 4: Evaluate and reinforce workflow process
Plan	Who?	Laura Santa Cruz IC Directors EMR workgroup QM/TIP Specialist	Laura Santa Cruz EMR workgroup QM/TIP Specialist	MA/LPN staff	Rachel Vega Laura Santa Cruz IC directors
	What?	MA workflow/screening developed	Staff trained on workflow/screening	MA/LPN staff actively using	QM team audits
	Where?	COPE	COPE	COPE	COPE
	When?	Workflow finalized by 4/1/22	Trainings scheduled at each integrated clinic by 4/15/22	Following cycle 2-Worklow implemented at all clinics 5/15/22	Monitor completion of diabetes screening/testing
Do	How?	Develop workflow	Complete trainings by 4/30/22	Implement workflow	Audit for completed screenings/test results
Study	Evaluate	Workflow implemented (y/n)? Reviewed/audit weekly (y/n)	Trainings completed (Y/N)	Review of completed appointments for screening/test results	Review and report Audit scores and trends
Act	Monitor or Revise	Plan met=monitor Plan not met+ explore and adjust	Plan met= monitor Plan not met= revise (overflow training)	Plan met=monitor Plan not met= explore and adjust	Plan met = monitor Plan not met = revise/adjust

PDSA Ramp #1

A P S D

Cycle 1
Develop MA workflow

Cycle 2
Train staff on workflow

Cycle 3
MA/LPN staff actively screen/test A1C

Cycle 4
Evaluate & reinforce the process

Cycle 5
TBD

Cycle 6
TBD

Monitor Metrics

Increase SSD scores							
Cycle #1: Develop Workflow including A1C screening	**Numerator/Denominator**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
Workflow outlined Workflow discussed with workgroup Workflow finalized	Yes/No						
Cycle 2: Train on workflow							
Training held for all medical staff and IC leadership	Yes/No						
Cycle #3: Workflow implemented							
	# of patients with A1C results on file in measurement year						
Cycle #4: Evaluate and reinforce workflow process							
Barriers discussed/explore solutions							

Discussion

- Any questions?

Next Steps

- Continuing Education Units (CEU): Post Event Survey
  - CEU survey available in chat
  - If issues accessing, please email TIPQIC@asu.edu
  - All CEU's for 2022 will be awarded following all 2022 QIC sessions (ETA November 2022)

- Attendees to complete recommended next steps

- Slides and template can be found on the TIPQIC website

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

Thank you!

TIPQIC@asu.edu

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