AHCCCS Targeted Investments Program

Pediatric Quality Improvement Collaborative

TIP Year 6: QIC Session #3
June 7, 2022: 11:30 AM to 1:00 PM

ASU College of Health Solutions
Arizona State University

AHCCCS Arizona Health Care Cost Containment System | Targeted Investments

ASU 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/

Learning Objectives (for CEUs)

1. Describe best practices to improving performance on key HEDIS measures

Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	Introduction	William Riley, PhD
11:35 AM – 11:40 AM	TIP Updates	Stephanie Furniss, PhD
11:40 AM – 12:00 PM	Case Study Presentation	Arizona Youth & Family Services
12:00 PM – 12:30 PM	Case Study Presentation	Callie Pediatrics
12:30 PM – 12:55 PM	Q&A	All
12:55 PM to 1:00 PM	Next Steps	William Riley, PhD

AHCCCS Telehealth billing updates & TIP performance measurement

- Updated AHCCCS telehealth billing guidelines effective 1/1/2022:
  - UD modifier no longer allowed for any service
  - FQ modifier added to approved codes

- The TI measures' numerator-qualifying telehealth services will get credit if they follow AHCCCS's telehealth billing guidelines allowed on the date of service

- Regarding telehealth claims denied in 2022, TIP performance measurement will accommodate to the extent allowed by AHCCCS for the transition period to the new codes

TIP Year 6: Lessons Learned

Arizona Youth & Family Services, Inc. (AYFS)

Jennifer Sander, MC, LPC, Clinical Director

Joey Zepeda, Director of Operations

A Little About AYFS…

- Outpatient behavioral health agency serving youth & families since 2005
- Assigned Behavioral Health Clinic (ABHC) services:
  - Counseling
  - Psychiatry
  - Family supports
  - School-based services
  - High Needs Case Management (HNCM)
- Direct Service Provider (DSP) services:
  - Meet Me Where I Am (MMWIA)
  - Stabilization Treatment and Regulatory Support Services (STARSS)

1. What throughout the TIP has been the most helpful? What has been the least helpful?

Most helpful

- Increasing collaboration with medical providers
- How others mitigated barriers
- Inspiring expanded perspectives of delivering services
- Root cause analyses

Least helpful

- Fewer ideas for smaller agencies who aren't able to fully integrate yet
- Attribution problems with Direct Service Program (DSP) skews our results negatively
- Metabolic monitoring measures are dependent upon factors often beyond our control

2. What progress have you made since the start of TIP? Have you implemented any specific interventions?

- Increased collaboration with medical providers
- Electronic Medical Record (EMR) tracking post-hospitalization visits and psychotropic medication management
- Revamped yearly assessment to integrate more medical and Social Determinants of Health (SDOH) areas
- Bilateral exchange of information with the Health Information Exchange (HIE)
- Referral processes streamlined with plans and medical providers

3. What do you plan to do in the next 4 months to finish out TIP year 6?

- Continued work to sustain progress with post hospitalization follow-up and metabolic monitoring
- Where applicable, integrating TIP-related ideas gleaned from participants

4. What has worked well for our organization?
5. What hasn't worked well for our organization?

Worked well

- Automating reporting to improve post-hospitalization follow-up & metabolic monitoring
- Chewing over ideas from the TIP and individualizing recommendations to meet our agency's unique needs
- Organizational support
- Agency size

Hasn't worked well

- Workforce shortages and financial impact of COVID make us wear many hats
- Time, effort, and expense of making changes in the EMR
- Agency size

6. If you could do one thing differently, what would it be?

- For the level of integration we are at, there really isn't anything that we would do differently because it appears to be working for us.
- If we had a magic wand, we would be a fully integrated practice where both the medical and mental health services for patients are provided within the same location /organization.

To reach us…

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Questions?

CALLIE PEDIATRICS

Caring for families since 1973

Dr. Mary Beth Callie, PhD
Integration,HealthySteps Program, Research/Policy/Communication
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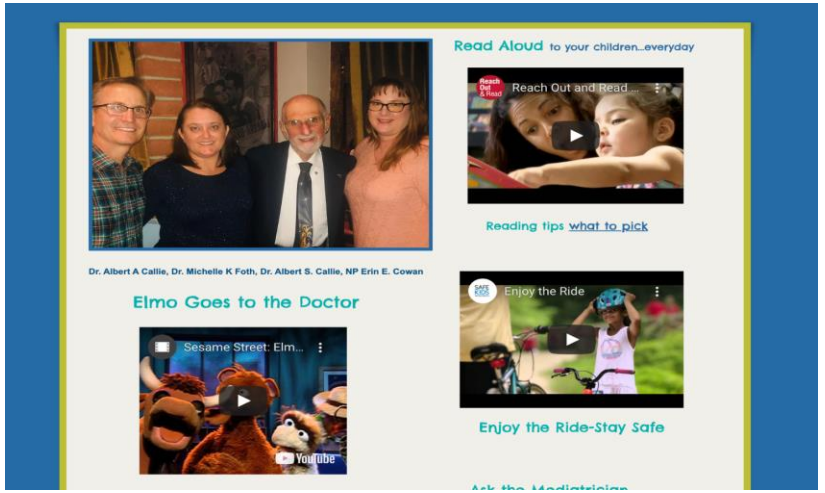
SINCLAIR
WASHING
LUBRICATION

Callie Pediatrics Background

- **Callie Pediatrics,east side of Tucson, near St. Joseph's Hospital.**
  - 6000 patients a year (1300 ages zero-to-three), many parents, grandparents, and great-grandparents were once patients.
  - 52% AHCCCS, on four different plans
  - 42% Hispanic/Latino, 8% African American, 3% Asian
  - Now owned by Albert A. Callie, MD with 4 pediatric providers (2 MDs, 2 CPNP), Office Manager/Billing, and staff (MAs, Front Office); I came aboard full-time in 2016, right in time for the TIP launch.
  - Since 2020: HealthySteps (0-3), HS Specialist, care coordination.
- **Callie Pediatrics, since 1973:** sick care; physicals for school, sports, and camp; state-mandated immunizations for day care and school.
- **Concurrent history**
  - Medicaid (1965) , EPSDT for children (1967), HMO/PCPs (1973)
  - AHCCCS (1982), vaccines programs, skyrocketing fee-for-service costs, misaligned incentives.
  - EHRs (2007), 2010 Affordable Care Act (2010)--preventive care



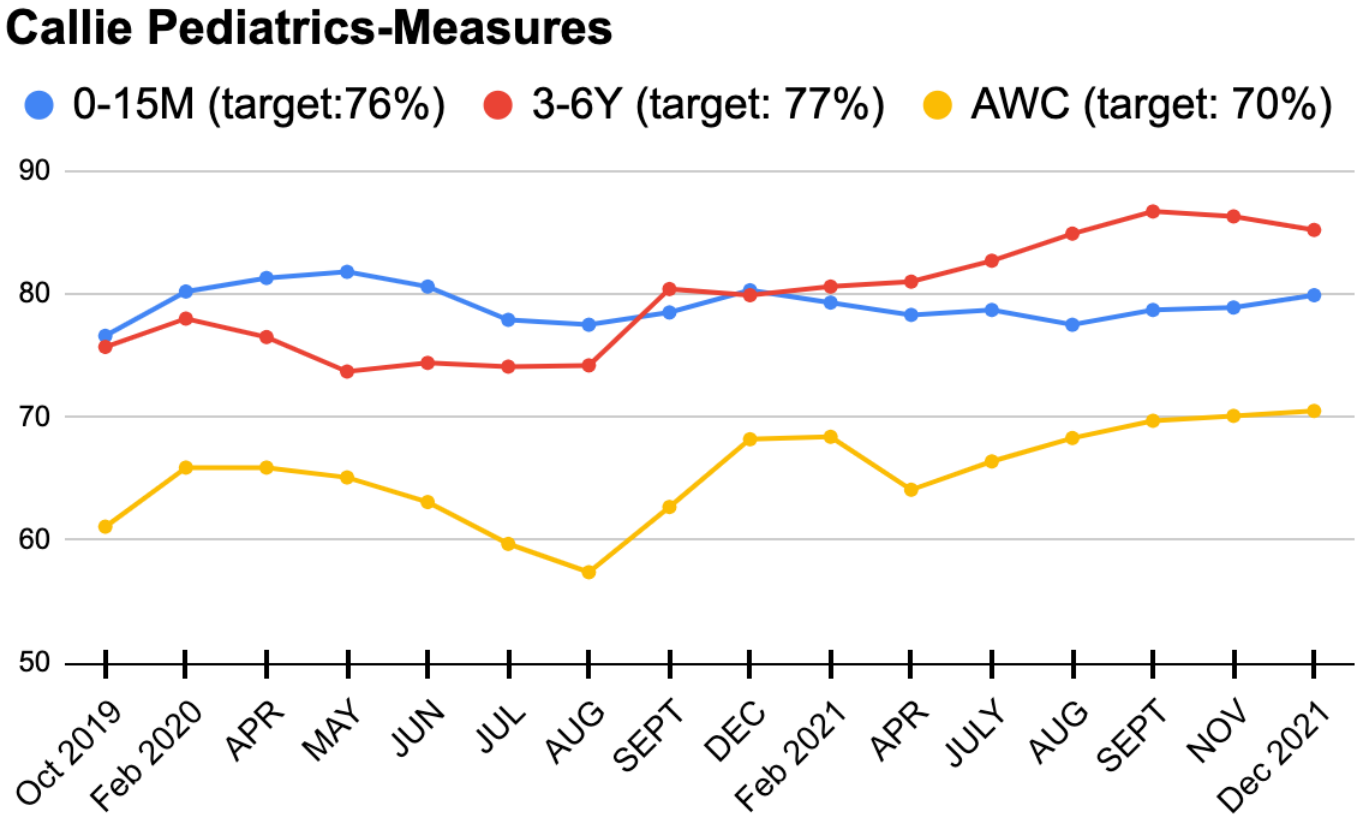
Enter the Targeted Investment Program (TIP)

- Most Helpful Components:

Overall design/scaffolding and bell curve rollout, aligned incentives, mandated training (ACE, MI) and the QIC have all helped us to…

  - find the **space, time, and labor** to make deep, substantial, and long-term changes.
  - see the **micro/macro** and **trees/forest**
  - build connections (warm handoffs)
  - be inspired (and equipped) to become an official **Healthy Steps site**, which supports early intervention and integrated care; incentive payments underwrite the cost.
  - Focus on **care coordination** and follow-up
  - Understand **quality** and **value-based** programs

Progress



Measure:	our T6 target		approx # patients	aggregate (approx)
0-15:	From 76.6 to about 79%	**+2%**	-8%, to 61%	76%
	188			
3-6:	From 75.7 to about 81%	**+5%**	-13% to 61%	77%,
	800			
AWC:	From 61.1 to about 65%	**+5%**	-12% to 45%	70%
	875			

Helpful Interventions

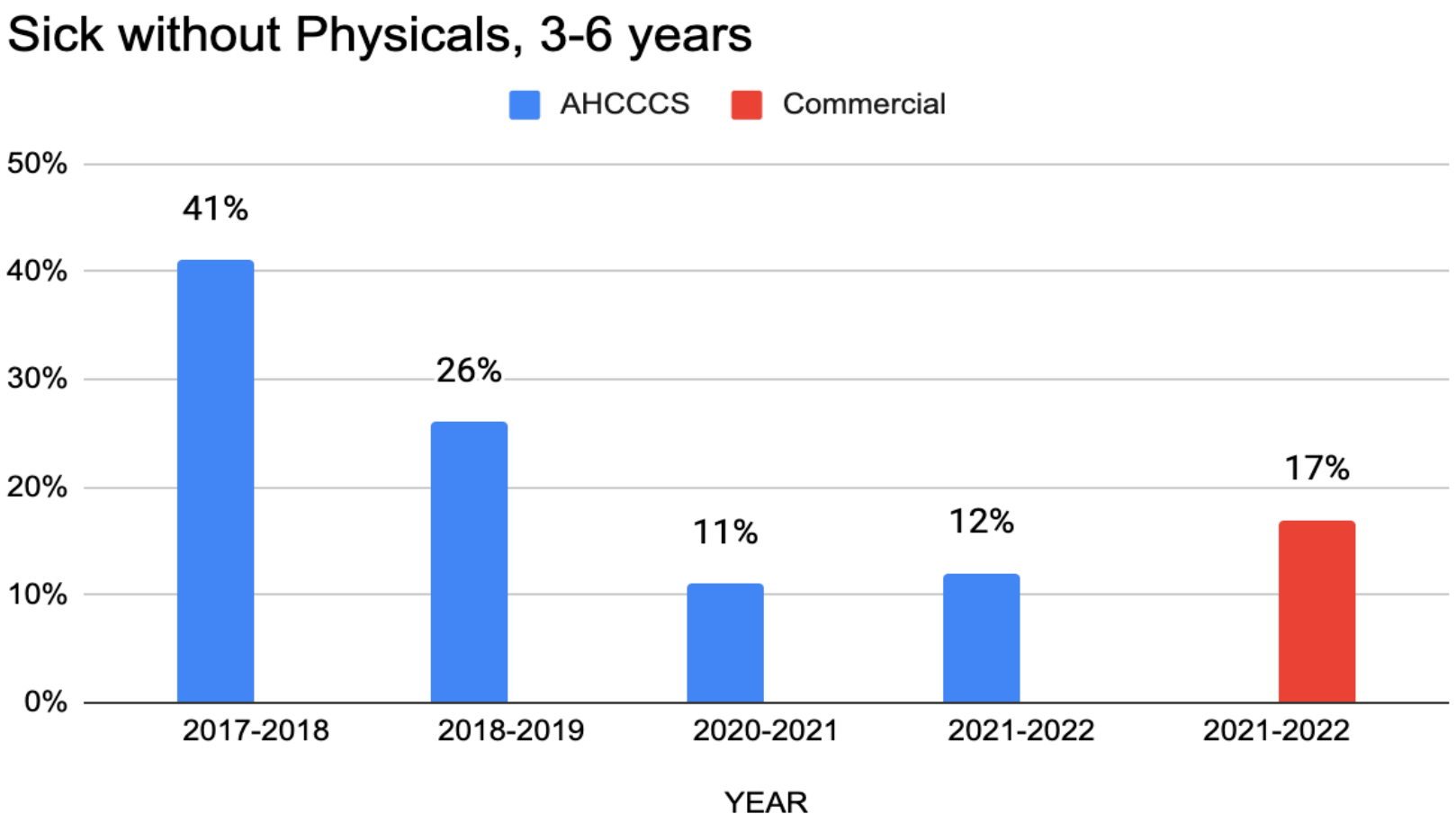
- **Messaging on website, newsletter, in-person:** about the importance of WELL VISITS(track/monitor growth and development, even during COVID; safety precautions in place)
- **Use EHR Registry to focus on and track established patients, given TIP attribution method.** Why? Plan rosters and MCO gaps or "opportunity" lists don't show us who has an upcoming scheduled appointment and include patients we've never seen.
  - Patients (3-21Y) who had **physical** previous year but none completed/scheduled for current AHCCCS year
  - Patients (3-21Y) who had **physical 2-3 years prior,** but none completed/scheduled for current AHCCCS year
  - **"High Risk"** patients (dx codes in-group) with no physical in the current or previous years
  - Patients with **sick and Immunizations visits** in the current program year, but none completed/scheduled for the current AHCCCS year
  - **No Shows and Cancels** during a two-week span
  - **"High Risk" patients each day,** for an e-huddle and spreadsheet list w/ notes for care coordinator/providers.
- **Long-term: Compare Rosters to our Active Patient lists** (by plan)t to identify 1) Established patients not assigned to us and 2) Patients assigned to us, never seen. Compared Never seen to ASIIS. Sent results to plans; Met for reconciliation, but ongoing issues due to "choice" assumptions, algorithms, etc.
- **Parent/patient engagement,** with awareness of SDOH, ACE, and Motivational Interviewing

PDSA Cycles

- **PDSA in 2021: Scheduling Annual well-visit at check-out** (PDSA cycle started with 3-6Y and being overwhelmed with the number of visits that needed to be scheduled)
  - Started with a goal to improve in the 3-6 year measure and a conversation with our Banner Quality Rep, who suggested we try a PDSA cycle.
  - Issue: children were on track for their wells until 3, but then their physicals stopped being on-time because siblings were often scheduled together, or, as kids got older, physicals were scheduled for summer camp or fall sports.
  - Analysis/Baseline: for Au 2020 - March 2021, **12% of 4 yr visits were scheduled at the 3-yr visit.**
  - **St. Paddy's week challenge--**For 03/16/21 - 03/19/21: What percent can we get?
    - Provided script: "Let's schedule ___ for well visit right now, to ensure she stays on track. We'll send you reminders and emails. If you need to cancel or re-schedule, just give us a call."
  - Results: In the following weeks, the percentage went up to 80%. Overall: 50%

- PDSA in 2022: Same Day Sick patients without annual well--get scheduled

PDSA example / outcomes



Next Four Months

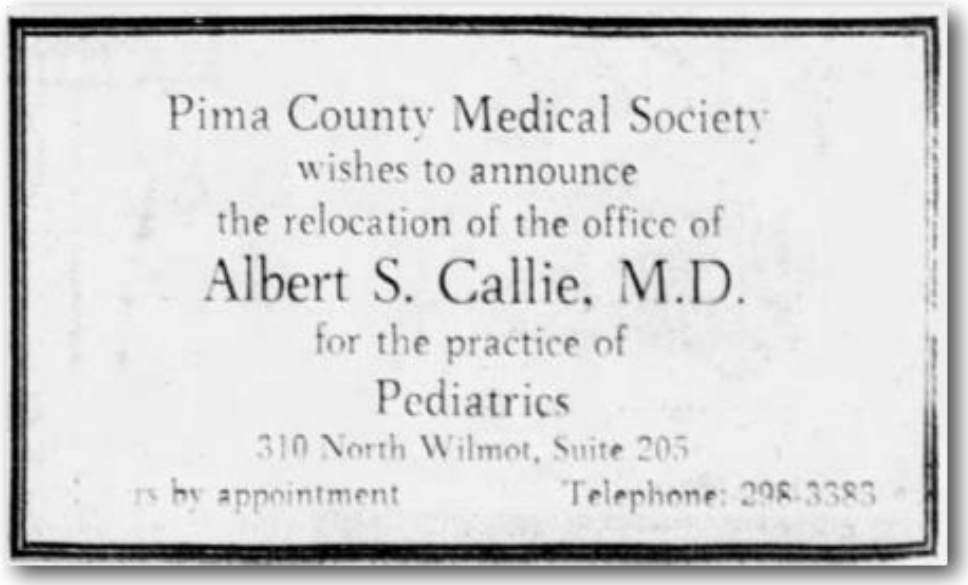
- **PCP Assignment:** Get PCPs changed *before* Sept 30, 2022 (snapshot date)
  - For NEW sick and well patients: stress that need to change their PCP BEFORE **(scheduler & verifier)** or DURING their visit (check-in/check-out, e.g., hand parents a slip of paper with the number to call, get reference number at check-out, or sign a PCP change form).
  - **Compare EHR Registry lists to Rosters/gaps reports:** Continue to compare our patient lists with Rosters (depending on the plan and the info they provide, sort and filter rosters for patients who recently assigned or who don't have a recently DOS. This helps us to identify the "never seen" or inactive patients on our lists.
  - Continue to **compare "Never seen" lists to ASIIS**, to see where they are probably established as a patient and get that list to each plan.
- **PDSA cycle: New Sick patients**--well exam within a month (need better tracking, follow-up)
- **PDSA cycle:** Clarify and improve tracking/follow-up/EHR documentation of no-shows and canceled well visits.
- **PDSA cycle**: Evaluate the usefulness of letters as outreach when calls, texts, and emails aren't working.
- **PDSA cycle:** Evaluate the usefulness of text blasts for patients who had physical the year before but need one in the upcoming 2-3 months; We have not been sending blasts because new staff was getting overwhelmed.

Where we need more help and collaboration…

- Customer “choice” model of managed care and “individualist” parenting (Reich, 2018)
  - Impact on PCP assignment
  - MCO attitudes and beliefs are needed for new algorithms, better communication, and provider rep/leadership understanding
  - support with non-compliant parents and families (excessive no-shows or non-responsiveness, no immunizations) and clear protocols.
    - E.g., Banner Child & Maternal Health team has been helpful, but there’s only so much they can do (due to choice) and contact info can be outdated. UHCCP sends letters based on the No-show /Cancel list we fax.

Conclusion

- Thanks again to the TIP and ASU teams for your support, and to QIC members for all your insights!
- Any questions?



Az Daily Star, 1973

2022

Our Mission: “Our mission is to provide quality, personalized pediatric health care to optimize the growth and development of children. Through our HealthySteps program and integrated care coordination we seek to support and guide parents/caregivers, in order to enhance the lives of children, their families, and our community.”

Next Steps

- All QI templates and QIW material can be found here: https://tipqic.org/QIWorkgroups.html

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

- Continuing Education for 2022 will be awarded post all 2022 QIC sessions

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

Thank you!

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