

AHCCCS Targeted Investments Program

Adult C Quality Improvement Collaborative

**William Riley, PhD
George Runger, PhD**

**Session #3
April 21, 2020**

Disclosures

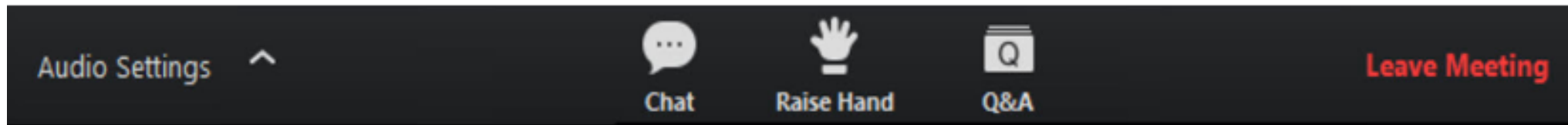
There are no disclosures for this presentation

Reminders & Updates

- Attendance
 - To track attendance, please ensure clinical and administrative representative log-in separately by computer via the link provided in the invite
- Dashboard
 - All Adult and Peds PCP providers have been provided access to the dashboard
 - BH providers will be provided access once the attribution process is finalized

QIC Participation

- All participants will be automatically muted when joining the Zoom webinar
- All questions should be directed to the Q&A box
- If a participant would like to speak or we are requesting verbal participation, select “raise hand” to be unmuted



ASU QIC Team



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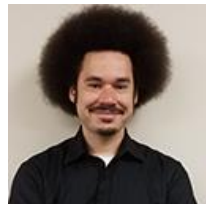
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Medical Director
Mercy Care



Neil Robbins, PhD
Data Scientist Specialist
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Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:40 AM	Overview <ul style="list-style-type: none">• Agenda• Objectives• Feedback	Bill Riley
11:40 – 12:30 PM	Peer Learning <ul style="list-style-type: none">• Diabetic Screening• 30 Day Follow-up	Presenter: Rajiv Parikh Respondent: Good Health Medical Presenter: Copa Health Respondent: Kingman Hospital
12:30 PM – 12:40 PM	Update on Target Setting	George Runger
12:40 PM – 12:50 PM	Q&A	All
12:50 PM – 1:00 PM	Next Steps <ul style="list-style-type: none">• Post Event Survey	Kailey Love

Feedback

Learning Objectives

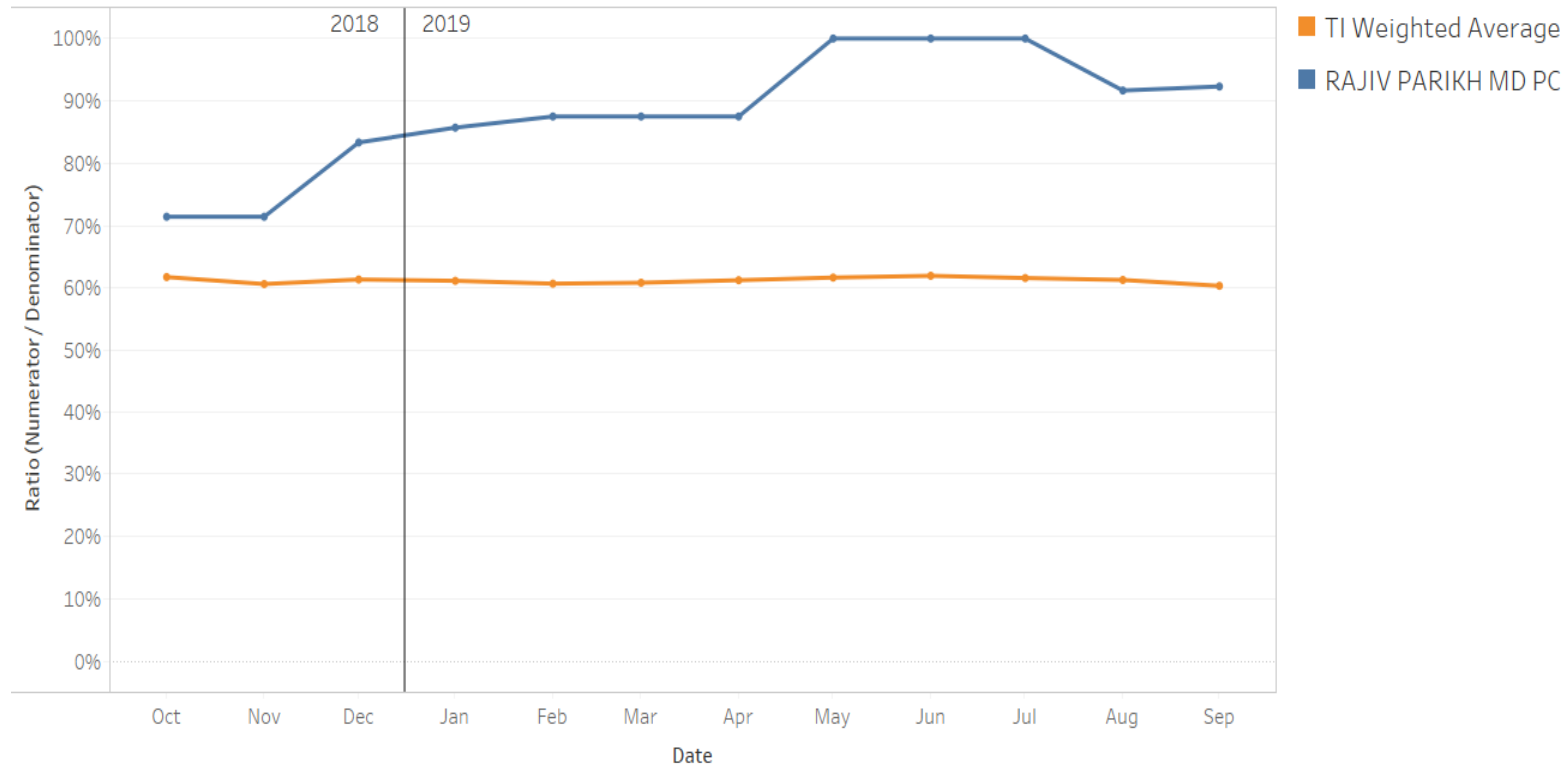
1. Evaluate milestone performance using trend analysis.
2. Identify failure modes in the milestone performance.
3. Critically apply improvements to milestone performance.

Diabetic Screening

Presenter: Rajiv Parikh, MD

Diabetes Screening for Patients on Antipsychotic Medication

Data were calculated using PCP attribution methodology, and represent a 12-month rolling average ending on the last day of the month of each data point



Performance Management Questions

- Process Stability
 - What type of variation is present?
 - Common Cause or Special Cause
- Process Capability
 - Performance of stable process
- Process Acceptability
 - Is milestone target met?

Metric: Diabetic Screening

Presenter: Rajiv Parikh, MD

- Please identify at least three features of your current process that have contributed to why your performance on this metric is strong.
- What led you to develop each of the steps to improve the performance for this metric?
- What obstacles did you overcome in order to develop the steps in #2?
- What do you feel are the top steps that you still need to improve? What needs to be done for you to make this improvement?

RAJIV PARIKH MEDICAL PRACTICE

April Adult C QIC
Session #3

Sunita Parikh
Rajiv Parikh, MD

1. Please identify at least three features of your current process that have contributed to why your performance on this metric is strong.
 - Proactively engage patients for annual physicals and chronic care follow-ups
 - Screen all adults for diabetes
 - Screen all Medicaid patients for behavioral health problems
 - Offer in office lab draws for each patient's convenience

2. What led you to develop each of the steps to improve the performance for this metric?

- Improve quality of patient health
- Improve community health
- Process to implement guidelines
- Proactively screen for chronic conditions

3. What obstacles did you overcome in order to develop the steps in #2?

- Developed robocalls for annual exams
- Daily chart prepping
- Having in-house phlebotomist

4. What do you feel are the top steps that you still need to improve? What needs to be done for you to make this improvement?

- Reaching out to patients and getting them educated and focus on preventive care
- Proactively do reminders for patients not being compliant
- Try complete gaps in care

Discussion Questions

Respondent: Good Health Medical

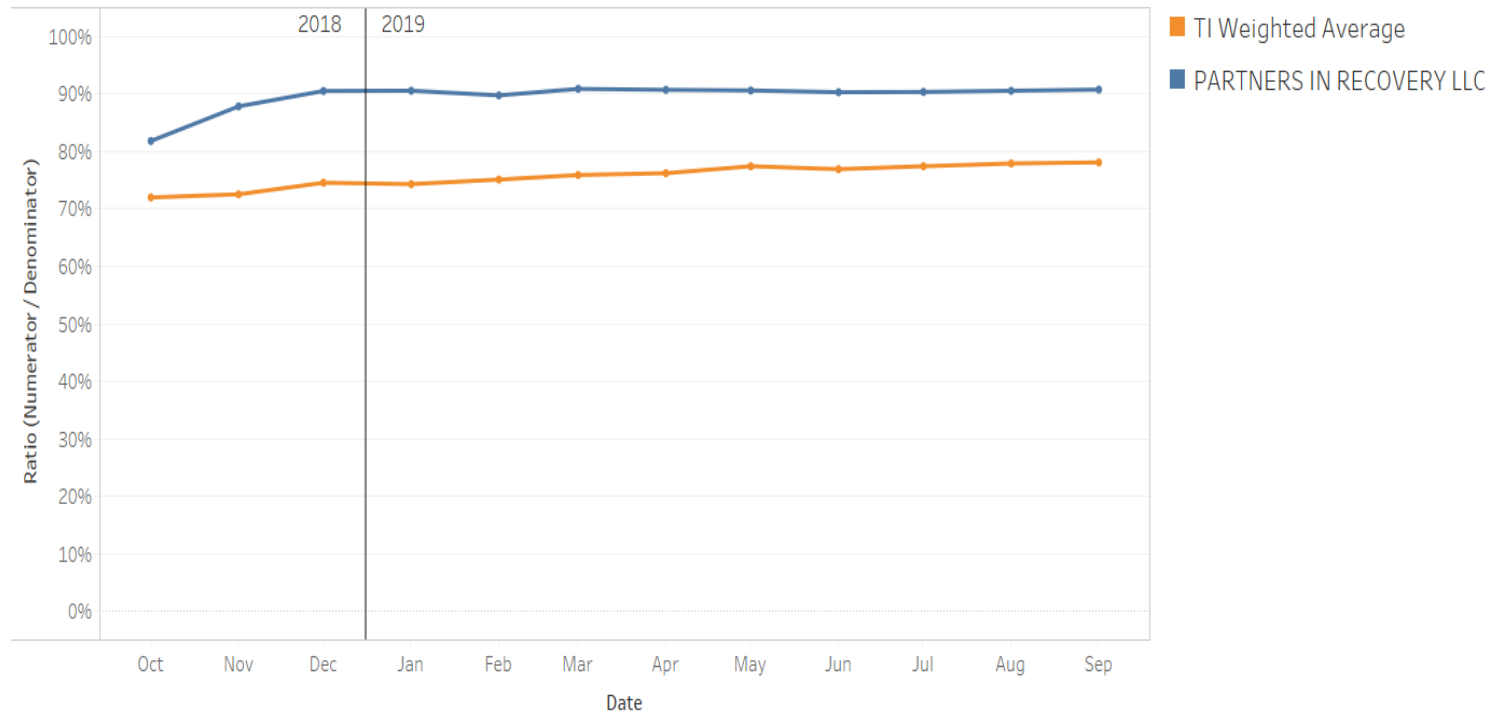
- Please give your response regarding what was helpful to you from the presentation for your organization.
- Please identify 2 or 3 challenges that you have had with this metric. Explain why each of these have been difficult.
- Ask if the presenter had a similar challenge and what they did to overcome the challenge.

Metric: 30 Day Follow-up

Presenter: Partners in Recover, COPA Health

30 Day Follow-up Visit for Patients Discharged from Mental Health Related Hospitalization

Data were calculated using PCP attribution methodology, and represent a 12-month rolling average ending on the last day of the month of each data point



Metric: 30 Day Follow-up

Presenter: COPA Health

- Please identify at least three features of your current process that have contributed to why your performance on this metric is strong.
- What led you to develop each of the steps to improve the performance for this metric?
- What obstacles did you overcome in order to develop the steps in #2?
- What do you feel are the top steps that you still need to improve? What needs to be done for you to make this improvement?

30 Day Follow Up after Psychiatric Hospitalization



April Adult C QIC
Session #3

Michael Franczak, Ph.D.
Michaela Statt, LMSW
Andrew Terech

Outcomes

- Individuals who are discharged need to be seen as quickly as possible to reconcile medications, follow-up on discharge instructions, identify the supports necessary to make a successful transition and establish relationships with their community team.
- Currently have several different outcomes we are tracking:
 - COPA-PIR expectation – Follow-up in 48 business hours.
 - Mercy Care - Follow-up in three days.
 - TIP – Follow-up in 7 days.
 - TIP – Follow-up in 30 days.

Structure

- The discharge planning, transition and follow-up has the following staffing structure and IT features:
 - Mercy Care Hospital Discharge Care Managers are assigned to most psychiatric hospitals.
 - COPA-PIR Discharge/Transition Specialists are assigned to each COPA-PIR Campus.
 - Ongoing communication between the Mercy Care and COPA-PIR discharge staff.
 - Data from various sources is correlated and tracked:
 - Data from MC Care Managers and COPA-PIR Discharge/Transition Specialists
 - Monthly ED report from Mercy Care
 - ADT Alerts and batch reports from the HIE
 - EMR data

Process

- Developed detailed policy and workflow regarding discharge planning, transitions and follow up.
- Workflows included everyone involved in the process from Discharge/Transition Specialist, Office Assistant, Case Manager, Medical Assistant, Medical Providers, etc.
- Key components include appointment accessibility, provider cross-coverage, and members being brought to discharge follow-up appointments by a member of their clinical team.
- Daily Integrated “Huddles” reviewing admissions and discharges
- Process steps are tracked via spreadsheet by the Discharge/Transition Specialist and reported bi-weekly to Population Health Data Specialist.
- Missing data points are returned for further information.
- Monthly data on performance is reported back to the campus.

Obstacles

- Individuals who are attributed to COPA-PIR however not engaged in active services.
- Individuals who leave the inpatient facility AMA.
- Individuals who are homeless upon admission and require housing resources....long delay in obtaining housing.
- Merging multiple data sources can be time consuming.
- Individuals who refuse to engage with services.

Discussion Questions

Respondent: Kingman Hospital

- Please give your response regarding what was helpful to you from the presentation for your organization.
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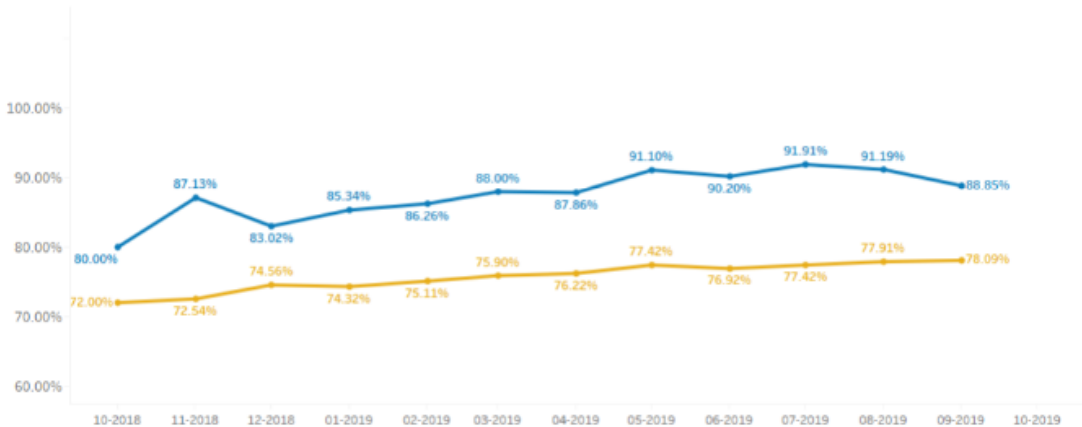
Dashboard Example

Use the filters to see your performance on each measure. Click Download to export this view as an image, PDF or PowerPoint file. If you have questions or comments, please contact us at TIPQIC@asu.edu.

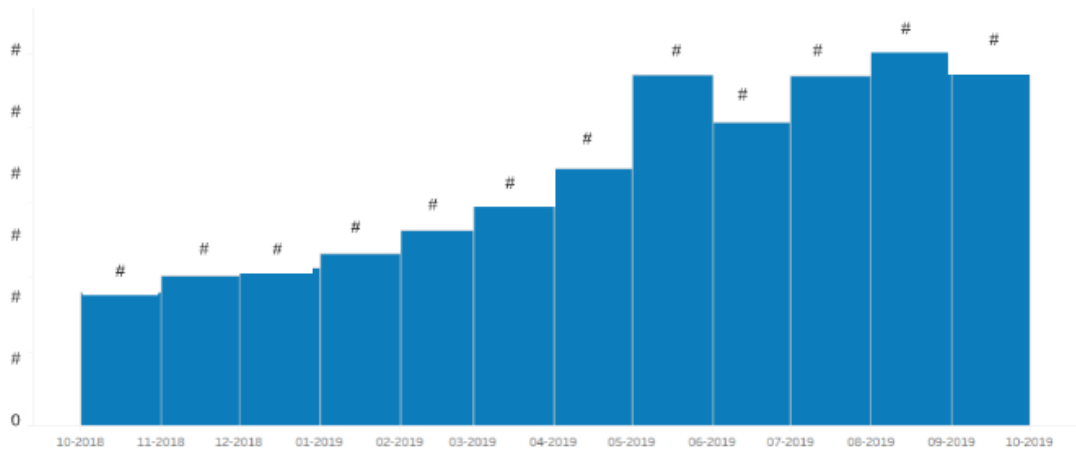
Provider Type
☒ ADULT PCP

Select Measure
☐ Patient(s) 18 years of age and older hospitalized for mental illness or intentional ...
☒ Patient(s) 18 years of age and older hospitalized for mental illness or intentional ...
☐ Patient(s) with schizophrenia, schizoaffective disorder or bipolar disorder taking...

Performance on Measure (Each month is a year-to-date performance on the measure)
Your Name vs. Providers in same Area of Concentration



Denominator
Your Name

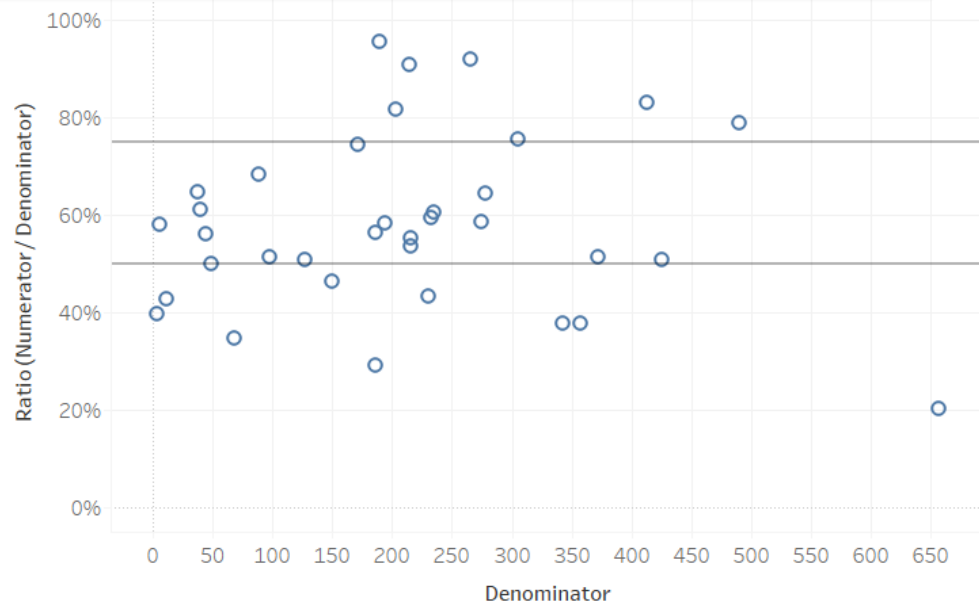


PCP Target Setting Methodology Update

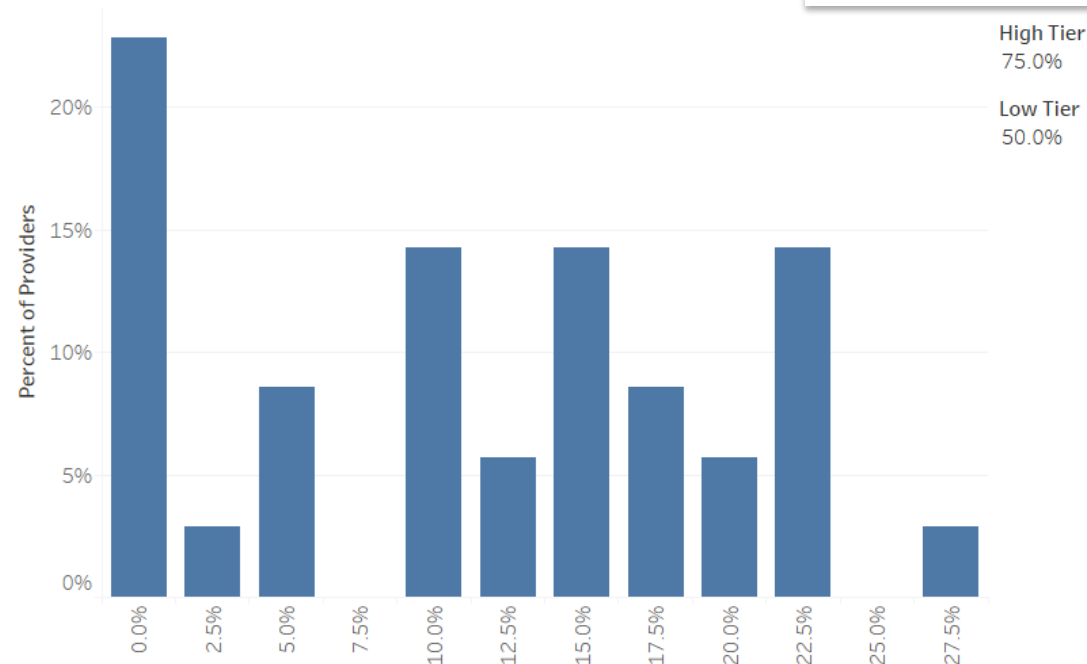
- Goal is to drive aggregate performance and encourage participants to achieve goals
- Reviewed
 - National Performance
 - AHCCCS Historical Performance
 - TIP Historical Performance
 - AHCCCS Minimal Performance Standards (MPS)
- Comprehensive analysis conducted
- Committee made recommendations based on blinded data

PCP Target Setting Visual

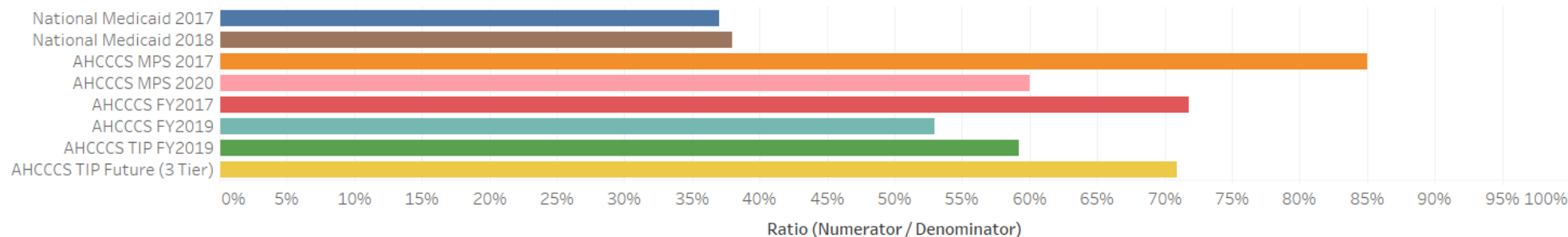
Example Data



Percentage-point change by provider



Aggregate Ratios



Decisions for Incorporating CoCM Codes:

- *PCP attribution*: CoCM codes will not be included among E&M codes or other qualifying visit in PCP attribution process.
- *PCP measure evaluation (i.e., 7/30-day follow up after hospitalization for mental illness measures)*: CoCM codes will count as a qualified visit for numerator.
- *BH evaluation (i.e., 7/30-day follow up after hospitalization for mental illness measures)*: In post-discharge period, CoCM codes will count as a qualified visit for numerator. In period prior to hospitalization (i.e., 90 days prior), CoCM codes will qualify the BH provider in denominator.

Q&A

- Please insert any questions in the Q&A box

Next Steps

- Next Steps
 - Post-Event Survey: 2 Parts
 - General Feedback Questions
 - Continuing Education Evaluation
 - Continuing Education will be awarded post all 2020 QIC sessions (November 2020)
- Questions or concerns?
 - Please contact ASU QIC team at TIPQIC@asu.edu if questions or concerns regarding performance data

Thank you!

TIPQIC@asu.edu