AHCCCS Targeted Investments Program

Adult Quality Improvement Collaborative

TIP Year 5: Session #10
September 14, 2021

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

There are no disclosures

Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:32 AM	Introduction	Kailey Love
11:32 AM – 11:45 AM	TIP Data Performance Review	George Runger, PhD
11:45 AM – 12:00 PM	QIC Topic Review • Best Practices Discussion	William Riley, PhD
12:00 PM – 12:55 PM	TIP Reflection • Top 5 Lessons Learned	Panel Discussion Community Health Associates Recovery Innovations GB Family Care
12:55 PM to 1:00 PM	Next Steps	Kailey

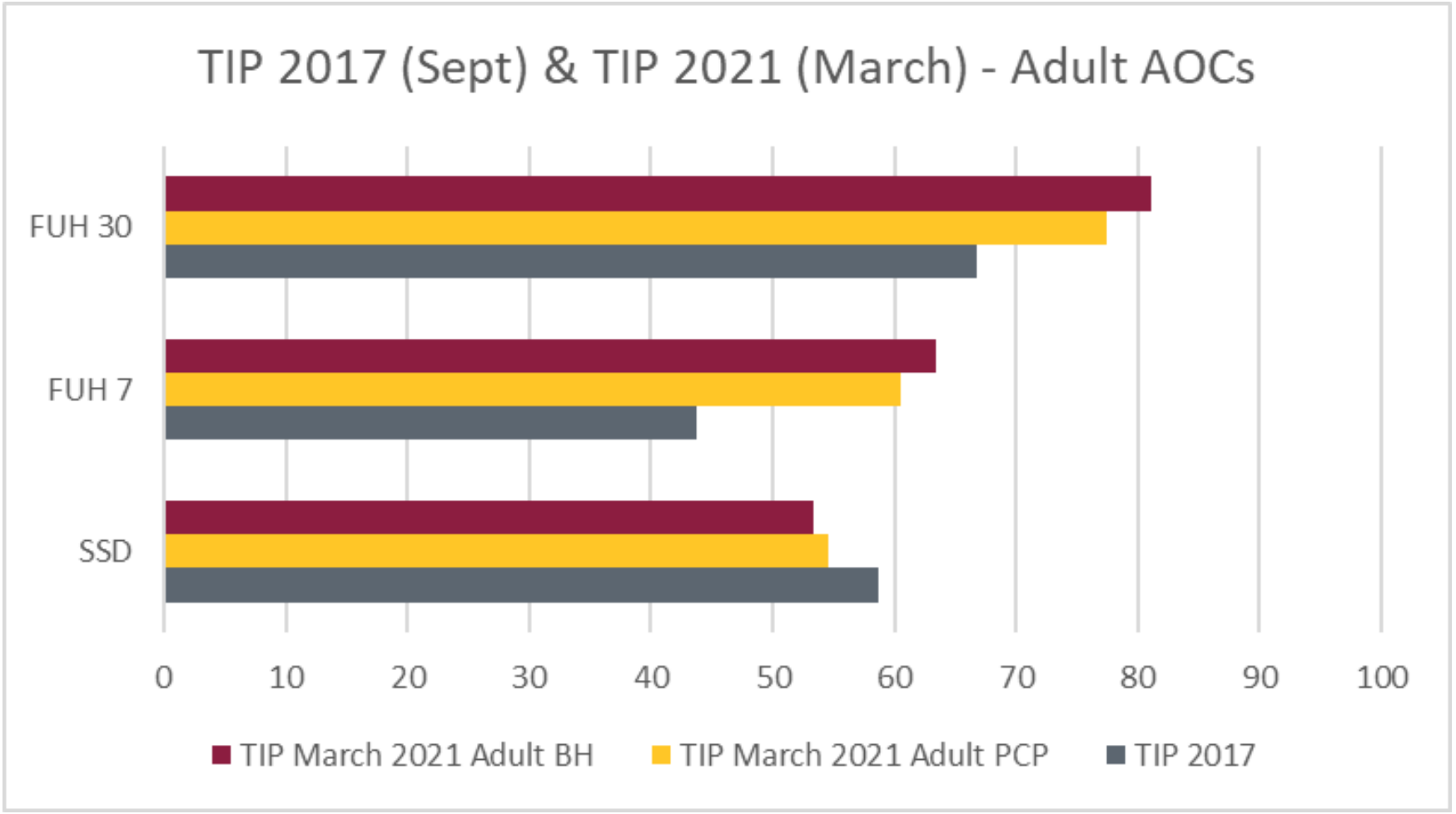
Learning Objectives

1. Critically analyze lessons learned for your organization
2. Describe the role of data and the barriers in the Targeted Investment Program

Overcoming Barriers

- COVID-19 Pandemic
- Modification to Allowed Telehealth Codes
- Inclusion of Collaborative of Care Model Codes
- Alternative Attribution Methodologies

Performance Measures



*Measures were increasing in 2019 before pandemic

Roles of Data in the Targeted Investment Program

- Dashboards for Performance Tracking (Providers and MCOs)
- Technical Assistance Based on the Data
- Data Harmonization to Improve Internal Monitoring of Members
- Aggregate Performance Measures
- Impact of Telehealth to TIP (new codes)
- Collaborative Care Model (new codes)
- Common Attribution Methodology
- Assignment File Coordination

QIC Topics Review

QIC Topic	Date
Attribution Methodologies	March 2020
Trend Chart Analysis	April 2020
Run Chart Analysis	May 2020
Cause & Effect Analysis	June 2020
Health Information Exchange	August 2020
Process Mapping	September 2020
Collaborative Care Model	October 2020
Internal Performance Reporting	November 2020
Follow-up After Hospitalization Round Table	January 2021
Appointment Compliance Round Table	February 2021
High Performing Organizations	March 2021
Soft Infrastructure Aspects of Telemedicine	April 2021
Integrated Care Coordination	May 2021
System Level Coordination for Follow-up After Hospitalization	June 2021
System Level Coordination for Metabolic Monitoring	August 2021
Targeted Investment Program Reflection	September 2021

TIP Process Improvement Gains (2016-2021)

- Peer organizations sharing best practices
- Improved use of HIE systems
- Enhanced use of data to improve performance
- Enriched understanding of performance measures used in value-based programs
- Proficiency in analyzing workflows
- Creative problem solving to improve delivery of care
- Strengthened integration and coordination across provider types and care continuum

TIP Reflection – Adult PCP CC for Yrs 2 & 3

CC	Milestone
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare
2	Identify members who are high-risk and develop electronic registry; Demonstrate use of identification criteria and document members in registry
3	Utilize care managers for members in high-risk registry; Demonstrate that care manager(s) are trained in integrated care
4	Implement integrated care plan
5	Screen all members to assess SDOH
6	Develop communication protocols with physical health and behavioral health providers for referring members
7	Screen all members for behavioral health disorders
8	Utilize the Arizona Opioid Prescribing Guidelines for acute and chronic pain
9	Participate in the health information exchange with Health Current
10	Identify community-based resources
11	Prioritize access to appointments for all individuals listed in high-risk registry
12	Participate in any TI program-offered training

TIP Reflection – Adult BH CC for Yrs 2 & 3

CC	Milestone
1	Utilize a behavioral health integration toolkit and action plan and determine level of integration
2	Implement the use of an integrated care plan
3	Screen members using SDOH and develop procedures for intervention
4	Develop communication protocols with MCO's and providers
5	Participate in the health information exchange with Health Current
6	Identify community based resources
7	Participate in relevant TI program-offered training

TIP Reflection:
Adult PCP & BH Yrs 4 & 5

Adult PCP and Adult BH Performance Measure
Follow-up after hospitalization for mental illness: 18 and older (30 Day)
Follow-up after hospitalization for mental illness: 18 and oldr (7 Day)
Diabetes Screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications

TIP Reflection: Discussion Questions

Please identify the 5 most important lessons you have learned:

- During the first three years (TI Years 1-3)
- During the last two years (TI Years 4 and 5)

- Community Health Associates
  - Matthew Lenertz
  - Stephanie Crawford
- GB Family Care
  - Dr. Maria Gonzalez Berlari
  - Joaquin Maza
- Recovery Innovations
  - Dr. Monika Weldon
  - Marleigh O'Meara

Community Health Associates

Strengthening Families, Empowering Communities

Adult QIC

Locations

Yuma

Casa Grande

Tucson


THE MOST
VALUABLE LESSONS
AREN'T TAUGHT.
THEY'RE
EXPERIENCED.
PictureQuotes.com

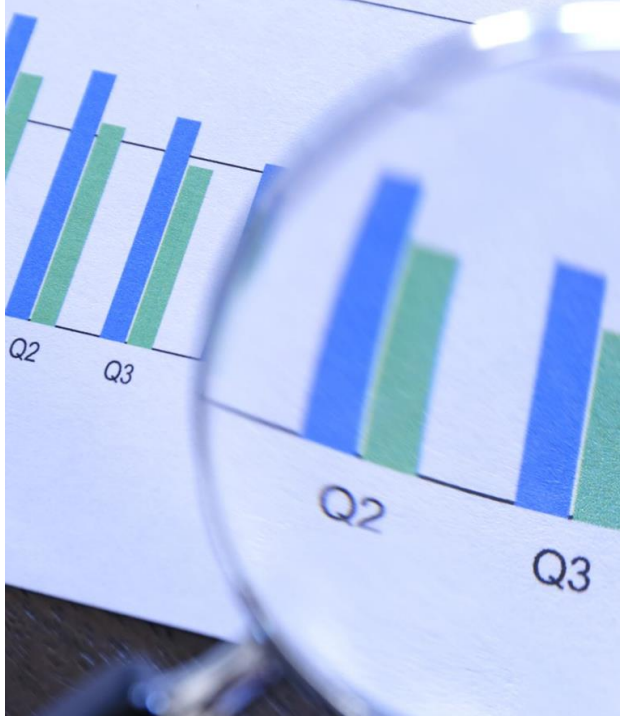

LESSONS
LEARNED.

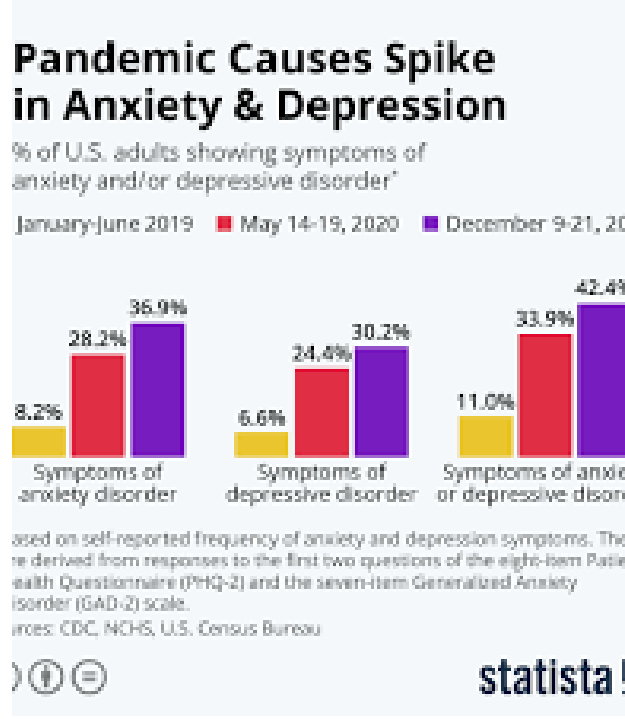
Years 1 - 3

- Culture and Cross Training
- Defining Teams and Processes
- Ongoing Communication
- Multidisciplinary teams
- Partnerships with shared and/or parallel goals
- High Risk Registry and STI’s

Years 4 & 5

- 7 & 30 day measures
- Remote engagement
- Metric tracking – EHR's ability to pull data
- Cost/Benefit of engaging without transportation
- Increases in Anxiety/Depression/substance abuse and co-occurring disorder presentations





Recovery Innovations

Please identify the 5 most important lessons you have learned:

- During the first three years (TI Years 1-3)
- During the last two years (TI Years 4 and 5)

Dr. Monika Weldon

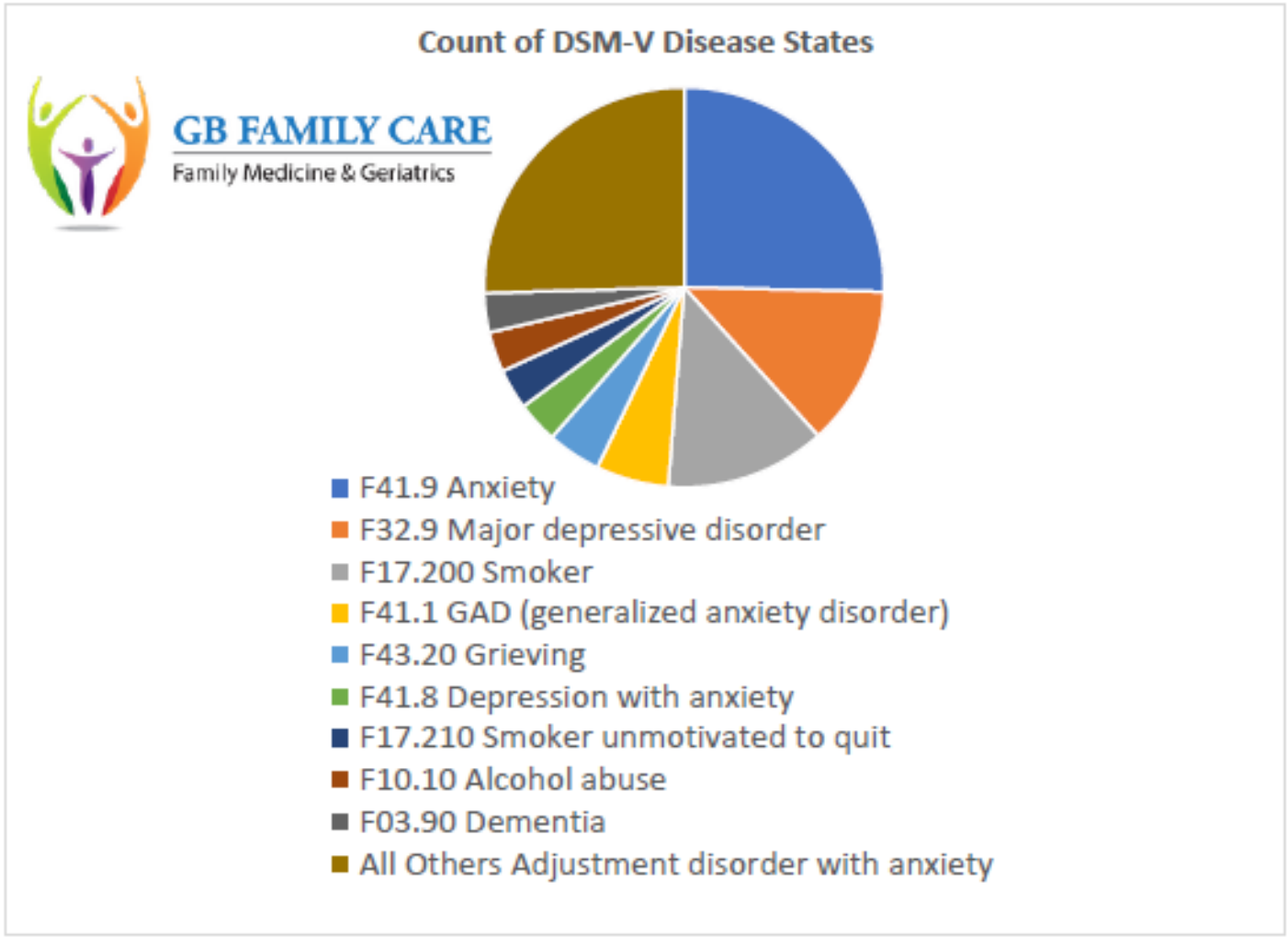
Marleigh O'Meara

GB Family Care

Please identify the 5 most important lessons you have learned:

During the first three years (TI Years 1-3)

During the last two years (TI Years 4 and 5)



Joaquin Maza
Dr. Maria Gonzalez Berlari

GB Family Care

*Evaluation for participation in TIP

*Review capabilities and looks for potential BH group partners

*Business Agreement with BH group next and connecting to one of our facilities
Challenges on the practices and execution of the team effort between us and group

- IT MIS related
- EHR integration and compliance. Why it didn't work
- Scheduling and referrals in site. Challenges and frustrations
- Provider relations. Challenges of constant turn overs
- Corporate culture vs. small PCP dynamics

*Outsourced in house BH services

-Initial success and patient response
-Its success and Covid 19 impact with program
-Evaluation and comparison with patient compliance and continuity before, during Covid 19

*Current situation

- Facility ready and hiring process
- Learning curve will set us for success.
- Cultural and language barriers of demographics understood
- PC Provider engagement

Joaquin Maza
Dr. Maria Gonzalez Berlari

Best Practices Process Audit: Metabolic Monitoring

Measure: Diabetic Screening/Metabolic Monitoring	
Category	Process Audit
Awareness of Assigned Members	• Continuously verify assigned patient panel with all health plans
Integrated primary care and behavioral health clinic(s)	• Implement a practice specific action plan to integrate primary care and behavioral health based on an integrated toolkit (such as Organizational Assessment Toolkit, Massachusetts Behavioral Health Integration Toolkit, or Primary Care Behavioral Health Implementation Kit) ◦ Behavioral health and primary care fully integrated; located within the same site ◦ A primary care practice that uses the Collaborative Care Model (CoCM) ◦ Contractual relationships with primary care or behavioral health clinics
Policies	• Create a policy to screen all patients who are on antipsychotic medications for diabetes • Create no-show policies and re-engagement protocols ◦ Examples: ▪ Limit prescription renewals to two-weeks until appointment compliance occurs ▪ Create a regular appointment compliance report for tracking purposes • Create outreach policy for out of compliant patients

Measure: Diabetic Screening/Metabolic Monitoring	
Category	Process Audit

Provider/Staff Education	• Staff orientation and education includes importance of metabolic monitoring/diabetes screening and their role in assisting with providing the best patient care and improving performance
	  ○ Educate MA's on the importance of their role in ensuring lab draws are completed
	  ○ Staff education regarding ICD codes for metabolic monitoring/diabetes screening

Patient/Family Education	• Educate patients and family members on reasoning for and importance of frequent metabolic monitoring for patients on antipsychotic medications

Monitoring and Reporting	• Develop registry of all patients on antipsychotic medications
	  ○ Create a report from EHR of all members who have a documented (active) antipsychotic medication
	• If registry is not available then:
	  ○ Staff monitors patients on antipsychotic medications monthly. Puts flag/note on chart if no glucose lab in last
	• Utilize an automated appointment reminder system to disseminate text, email, and/or phone appointment reminders
	  ○ Capable of both reminding patients to schedule appointments and/or reminding patients of already scheduled appointments
	  ○ Build care gap alerts into EMR/EHR
	  ○ Configure alert to "pop up" during the patient look-up process.
	• Monitor screening for all patients on antipsychotic medications (Apply to all patients because specifying best practice to a specific population (e.g., Medicaid members only) complicates messaging to staff and goes against mission of prioritizing best patient care for all patients)
	• If screening targets are not met, form a QI group to explore the cause and develop an action plan to improve patient care and meet targets.
	• Frequently update physicians and staff on performance and progress towards care/performance goals

Measure: Diabetic Screening/Metabolic Monitoring	
Category	Process Audit

Phlebotomy	• In-house phlebotomy capability
	  ○ Conduct lab draw at time of appointment
	  ○ Medical Assistants (MAs) are trained to perform lab draws or contract with lab
	  ▪ Hire MA's certified for phlebotomy or provide MA phlebotomy training and certification
	• When indicated, provide mobile lab draw
	• If not able to complete lab draw in house or at home, staff provide the patient/family with "road map" (i.e., personalized information) on where to get labs drawn – a location close to patient's home and that is open at times that work for the patient

Whole Person Care Organizational Culture	• Embrace a culture of whole person care organization-wide, advocating for the "no wrong door approach" ○ Example: Coordinate with child's dental provider to obtain labs while child is receiving dental work under sedation (ideal for children afraid of lab draws and/or with sensory concerns)
Social Determinants of Health (SDoH)	• Conduct risk stratification based on SDoH screening • Provide case manager when indicated

Discussion

- Q&A

Next Steps

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

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

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

Thank you!

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