AHCCCS Targeted Investments Program

Peds Quality Improvement Collaborative

TIP Year 5: Session #10
September 7, 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 North Valley Pediatrics Southwest Network Bayless
12:55 PM to 1:00 PM	Next Steps	Kailey

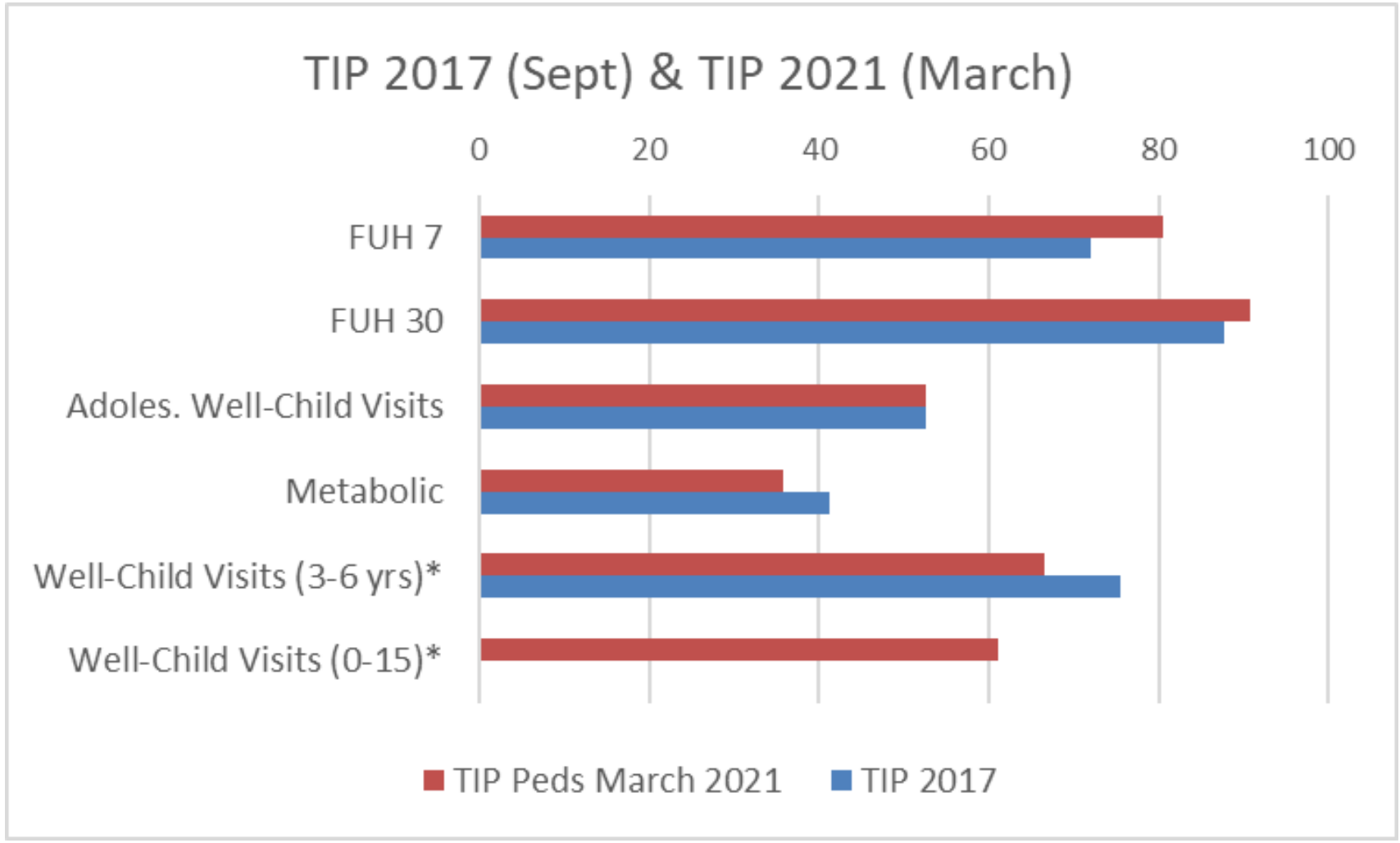
Learning Objectives

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 of 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 - Peds PCP Core Component for Yrs 2 & 3

CC #8 Removed

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 high-risk members and develop an electronic registry; Identify criteria is being used and recorded
3	Utilize practice care manager(s)for members included in the high-risk registry; Demonstrate the care manager(s)have been trained to use integrated care plans
4	Implement the use of an integrated care plan and develop communication protocols with MCO's and providers
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
9	Participate in the health information exchange with Health Current
10	Identify community-based resources, at a minimum through use lists managed by MCO's
11	Prioritize access to appointments for all individuals listed in the high-risk registry
12	Develop protocols for using Trauma-Informed Care for those in the high-risk registry
13	Develop communication protocols in agreement with ASD
14	Ensure medical staff complete ASD training program
15	Develop procedures to provide parent support
16	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers
17	Develop a protocol for obtaining records for those in the foster care system and their medication needs
18	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy
19	Participate in relevant TI program-offered training

TIP Reflection – Peds BH Core Component 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	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	Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII)
6	Participate in the health information exchange with Health Current
7	Identify community-based resources
8	Develop protocols for Trauma-Informed Care
9	Develop communication protocols in agreement with ASD
10	Develop procedures to provide information to families with children/youth with ASD
11	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers
12	Develop a protocol for obtaining records for those in the foster care system and medication needs
13	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy
14	Participate in relevant TI program-offered training

TIP Reflection:
Peds PCP & BH Yrs 4 & 5

Peds PCP Performance Measure	Peds BH Performance Measure
Well child visits in third, fourth, fifth, and sixth years of life	Pediatric follow-up after hospitalization for mental illness ages 6-17 (30 Day)
Adolescent well-care	Pediatric follow-up after hospitalization for mental illness ages 6-17 (7 Day)
Well-child visits in the first 15 months of life	Metabolic monitoring for children and adolescents on antipsychotics

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)

- North Valley Pediatrics
  - Dr. JoAnn Kolnick, MD
  - Dr. Louis Trunzo, MD
- Southwest Network
  - Crystal Domblisky-Klein
  - Kim Drexel
  - Katrina Noyes
- Bayless Healthcare
  - Dr. Gyann Phillips, LPC, DBH
  - Dr. Kristen Ray, LPC, DBH

North Valley Pediatrics

- JoAnn Kolnick
- Dr. Louis Trunzo, MD

TIP Most Important Lessons

- First, without the LEADERSHIP of the TIP Team, none of this would have been possible.
  - The Team provided us with the Structure, the Vision, and lastly, but importantly, the funding to take this journey into the unknown of integrative care.

- Year 1, 2 and 3 were composed of the Herculean task of learning the reasons and tools for Behavioral Health Integration with Clinical Medicine.

TIP Most Important Lessons

Behavioral Health Integration:

- Firstly, I learned that our patients needed integrated care. I learned that as a group, there were many more children affected by risks that were lost to complete care during most visits, including well care visits than were recognized. Children in foster care, enduring poverty, and families with drug and substance abuse were routine. We only saw the most critical, or impaired. It was so much of our daily life that we only saw the need when the child was in crisis.
- Second, without recognition of the of the risks/traumas our patients were enduring we did not follow up the counseling and therapy for the mild and moderately affected children.
- Third, practicing as pediatrics, our communication with the Behavioral Health and other therapies, was almost nonexistent. For all of us, BH and Clinicians, the concept of Care Coordination was lacking.
- Fourth, we were taught the tools for care coordination between BH and Primary Care. Shared Care Plans, excel spread sheets, web sites, surveys for social determinants of health, depression, drug use, alcoholism and education for trauma were all provided to us. These were essential lessons to achieving the care we wanted for our patients.
- Most importantly, in the process of meeting our measures, we learned that there was a real purpose, for the patient and quality of our care, in integrating clinical and behavioral care. I have become convinced that Behavioral and Clinical Integration is the highest quality of care we can provide for all of our patients.

TIP Most Important Lessons

- Year 4 and 5 started out as a numbers game.
  - Run a report, call patients in for appointments, and make sure all patients got there well care.
  - Our system worked well, and we saw the proof of it in our reports. I thought we knew it all.
- Covid took care of that.
  - The easy lessons that worked to get the kids in for well care didn't work.
  - We learned where we were weak.
  - Doing well care exams with minor sick visits, running reports and making calls, doing well care with vaccine visits, and Saturday visits were more difficult than before Covid.
  - Scheduling limits and masks decreased our ability to see patients for well care.
  - Telehealth helped, but we were not able to move our numbers forward.
  - We did poorly with our adolescents, who had no reason to come in for sports and school physicals, vaccines or even the usual illnesses of pre-Covid days.

TIP Most Important Lessons

- We learned how to compensate.
  - We were more flexible with same day appointments, tele-med appointments for medication visits, minor injuries and rashes.
  - We prioritized younger children during the Covid epidemic. Saturdays helped.
  - Communication was more important than ever for patients who needed care coordination.
  - Use of our EMR to tract compliance with scheduled referrals, labs and coordination of care helped.
  - The new tools of communication, HIE, and BH communication letters helped.
  - The new communication letters from the insurance plans notifying us of BH hospital admissions and discharges was a great new tool.
- The most important lesson learned from year 4 & 5 was the importance of teamwork.
  - Having a team, providers, front, back and management, who were all educated to the needs of total care and with the same mission, to provide the best care possible for our patients, allowed us to weather the storm.

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CREATING PARTNERSHIPS ▪ INSPIRING HOPE ▪ CHANGING LIVES

Targeted Investment – Lessons Learned

Creating Partnerships

Inspiring Hope

Changing Lives

Years 1-3

- A project manager is necessary
- Be planful and start right away
- Engaging community partners on the benefits of referral processes and working relationships as they relate to member care/ATC worked better than focusing the need to “check off” a TI metric
- Enhance already existing processes, if possible, versus reinventing the wheel

Years 4 and 5

- Internal data collection methods must be used because the lag of claims data
- Teamwork and strategy is a must.
  - Involve those who are doing the work in process improvement
- Use of RCA when you don’t see desired outcomes to ensure interventions are targeting the true root of the problem

Thank you

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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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