Provider and Health Plan Relationships on the Path to Accountable Care – Az HFMA One Day Event

February 24, 2017
Background:

• The Practice Innovation Institute is part of CMS’ Transforming Clinical Practices Initiative (TCPI) designed to help practices prepare for value based care (14.6M in grant funding over 4 years)
  • Achieve large scale health transformation and prepare for Value Based Care (VBC)
  • Develop comprehensive quality improvement strategies through peer based learning networks
  • Reduce costs and eliminate unnecessary tests and procedures
• Arizona Health-e Connection (AzHeC) with the support of Mercy Care Plan (MCP) applied for and received 3.6M in Year 1 grant funding which started October 2015
• Practice assessments are performed in tandem with local QIN/QIO participant (HSAG)
• Practice Transformation Consultants as well as Health Information Technology staff collaborate with data analysts and clinical champions to create a business plan for each practice
• Highlights of key elements from CMS’ TCPI change package are presented for practice approval and to establish transformation plan
Highlights

• What is a Practice Innovation Institute?
• Practice communications
  • Assessment and results communications
• Population health tools
• Vision and goals of transformation
• Resources:
  • Support and Alignment Networks (SANs)
  • Quality Innovation Network – Quality Improvement Organizations (QIN – QIO)
  • Affinity Groups
  • Learning Opportunities (Pii Academy and beyond)
Welcome to the Practice Innovation Institute!

By deciding to participate in Pii, you have given yourself access to a resource which will allow you to:

• Prepare your practice for success under the Quality Payment Program (formerly MACRA) and future value-based payment contracts
• Avoid penalties and payment reductions
• Improved reimbursement
• Get better member information with one connection
• Improve communication and care coordination with other providers
• Spend more time caring for your members and increase clinician joy in practice
• Get assistance with required reporting
• Take advantage of one-on-one consulting valued at more than $50k per practice
• Be a leader in state and national practice transformation efforts

_Ultimately, this process will help you improve health outcomes for your members_
### Scoring standard: 2017 performance period for the 2019 payment adjustment

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Percentage of Overall MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set*</td>
<td>60 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>0 percent</td>
</tr>
</tbody>
</table>

Note:  
*For a finalized list of quality measures, for primary care providers see Table A: Finalized Individual Quality Measures Available for MIPS Reporting in 2017 in the Quality Payment Program (QPP) Final Rule (pages 1,902 – 2,017). For a list of quality measures for reporting by specialty practices, see Table E: Finalized MIPS Specialty Measure Sets in the QPP Final Rule (pages 2,028 – 2,113)  
**For a finalized list of eligible activities, see Table 8: Improvement Activities eligible for Advancing Care Information Performance Category Bonus in the QPP Final Rule (p707 – 713)  
^For a finalized list of eligible improvement activities, see Table H: Finalized Improvement Activities Inventory in the QPP Final Rule (pages 2,157 – 2,171)
## Practice Innovation Institute Aims and Activities

<table>
<thead>
<tr>
<th>Aim</th>
<th>How Pii will help your practice</th>
</tr>
</thead>
</table>
| **Quality**                | • Assist practices in tracking and reporting on TCPI required process measures leading to improved outcomes (e.g., controlling high blood pressure, breast cancer screenings)  
                              • Work with practices to define additional measures that are important to their quality improvement goals for the specific populations being served. |
| **Advancing Care Information** | • Increase communication among members of the care team by connecting providers to the CareUnify tool, which will allow clinicians to assign specific tasks within care paths to providers in other practices  
                              • Increase interoperability and data sharing by connecting practices to the statewide Health Information Exchange (HIE) |
| **Clinical Practice Improvement** | • Work 1:1 with practice facilitators to build processes and capabilities within practices to successfully implement transformation objectives  
                              • Train practices on use of tools and demonstrate how to analyze and interpret new sets of data about their members |
| **Cost Reduction**         | • Give practices the tools and knowledge they will need to make meaningful progress towards identifying and mitigating major cost drivers, including high ED utilizers and frequent hospital admissions  
                              • Through facilitation of increased provider communication via CareUnify and the HIE, reduce delivery of redundant services and coordinate care more effectively |
Phase One of Transformation

1. Practice has developed and shared a vision and detailed plan that addresses goals of transformation with specific clinical outcomes and utilization aims along with the detail on how each of the aims will be addressed.
Demographic Data Collected

Member Demographics
Percent of total members

- Other: 6%
- Black/African Amer: 1%
- American Indian or Alaska Native: 39%
- White: 1%
- Hispanic or Latino: 0%

Member Payer Mix
Percent of total members

- Other: 77%
- Duals: 30%
- Medicare: 33%
- Medicaid: 0%
PTC to pull pictorial from Care Unify Implementation workbook in Sharepoint

(Name of organization) includes (#of) clinicians across (# of) sites

Name of Organization
TIN:

Campus
NPI:

Campus
NPI:

Campus
NPI:

Campus
NPI:

Campus
NPI:

Campus
NPI:

Orange: FQHC/FQHC LA
Yellow: FACT Team
Teal: Primary Care
Blue: Behavioral Health only
Red: SMI Clinic
Black: Integrated Health Home
Purple: ACT Team
White: MACT Team
Initial Practice Assessment Summary - Primary Care

Initial practice assessment summary –

**Pii business plan**

<table>
<thead>
<tr>
<th>PAT date:</th>
<th>3/28/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next assessment date:</td>
<td>9/28/2016</td>
</tr>
</tbody>
</table>

**Practice information**

- Assessment date: 3/28/2016
- Taxpayer Identification Number (TIN): 26-4681471
- Pathway: TBD

**Summary of practice assessment results**

**Grouped by primary driver**

<table>
<thead>
<tr>
<th>Group</th>
<th>Primary driver</th>
<th>Driver abbreviation</th>
<th>Summary score</th>
<th>Max score</th>
<th>Provider level</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Person and Family-Centered Care Design</td>
<td>PFCCD</td>
<td>25</td>
<td>42</td>
<td>Intermediate</td>
</tr>
<tr>
<td>B</td>
<td>Continuous, Data-Driven Quality Improvement</td>
<td>CDDQI</td>
<td>8</td>
<td>18</td>
<td>Intermediate</td>
</tr>
<tr>
<td>C</td>
<td>Sustainable Business Operations</td>
<td>SBO</td>
<td>7</td>
<td>15</td>
<td>Intermediate</td>
</tr>
<tr>
<td>D</td>
<td>TCPI Aims</td>
<td>TCPI Aims</td>
<td>4</td>
<td>6</td>
<td>Intermediate</td>
</tr>
</tbody>
</table>

**Grouped by phase of transformation**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Phase description</th>
<th>% of phase complete in last assessment</th>
<th>% of phase complete</th>
<th>Provider level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Setting aims</td>
<td>N/A</td>
<td>66.7%</td>
<td>In-progress</td>
</tr>
<tr>
<td>2</td>
<td>Using data to drive care</td>
<td>N/A</td>
<td>61.5%</td>
<td>In-progress</td>
</tr>
<tr>
<td>3</td>
<td>Achieve progress on aims</td>
<td>N/A</td>
<td>53.3%</td>
<td>In-progress</td>
</tr>
<tr>
<td>4</td>
<td>Achieve benchmark status</td>
<td>N/A</td>
<td>16.7%</td>
<td>In-progress</td>
</tr>
<tr>
<td>5</td>
<td>Thrive as a business via pay for value approaches</td>
<td>N/A</td>
<td>-</td>
<td>In-progress</td>
</tr>
</tbody>
</table>

Based on the self reported scores and the results of an initial assessment, (Name of organization) is currently in Phase 1 of transformation.

Does this accurately reflect internal views on ability to succeed under new contract models?
<table>
<thead>
<tr>
<th>TCPI</th>
<th>HRSA</th>
<th>HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILDHOOD IMMUNIZATIONS NQF 38</td>
<td>CHILDHOOD IMMUNIZATIONS IID-8</td>
<td>CHILDHOOD IMMUNIZATION STATUS</td>
</tr>
<tr>
<td>CERVICAL CANCER SCREENING NQF 32</td>
<td>CERVICAL CANCER SCREENING C-15</td>
<td>CERVICAL CANCER SCREENING</td>
</tr>
<tr>
<td>COLORECTAL CANCER SCREENING NQF 34</td>
<td>COLORECTAL CANCER SCREENING C-16</td>
<td>COLORECTAL CANCER SCREENING</td>
</tr>
<tr>
<td>CONTROL HIGH BLOOD PRESSURE NQF18</td>
<td>HYPERTENSION BP CONTROL HDS-12</td>
<td>CONTROLLING HIGH BLOOD PRESSURE</td>
</tr>
<tr>
<td>DIABETES HbA1c POOR CONTROL &gt;9% NQF59</td>
<td>DIABETES CONTROL HbA1c &gt;9% D-5.1</td>
<td>COMPREHENSIVE DIABETES CARE</td>
</tr>
<tr>
<td>INFLUENZA IMMUNIZATION NQF 41</td>
<td>OLDER ADULT INFLUENZA VACCINE</td>
<td>FLU VACCINATIONS FOR ADULTS 65+</td>
</tr>
<tr>
<td>INFLUENZA IMMUNIZATION NQF 41</td>
<td>ADULT INFLUENZA VACCINE</td>
<td>FLU VACCINATIONS FOR ADULTS 18-64</td>
</tr>
<tr>
<td>PNEUMOCOCCAL VACCINE STATUS NQF43</td>
<td>OLDER ADULT PNEUMOCOCCAL VACCINE</td>
<td>PNEUMOCOCCAL VACCINE FOR OLDER ADULTS</td>
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<tr>
<td>BREAST CANCER SCREENING NQF 2372</td>
<td>BREAST CANCER SCREENING</td>
<td>BREAST CANCER SCREENING</td>
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<tr>
<td>OPTIMAL ASTHMA CONTROL NQF N/A</td>
<td>MEDICATION MGT FOR PEOPLE W/ ASTHMA</td>
<td>FOLLOW UP AFTER MENTAL HEALTH HOSPITALIZATION NQF 576</td>
</tr>
<tr>
<td>FOLLOW UP AFTER MENTAL HEALTH HOSPITALIZATION NQF 576</td>
<td>EMERGENCY DEPARTMENT UTILIZATION</td>
<td></td>
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<tr>
<td>ANTI DEPRESSANT MEDICATION MANAGEMENT NQF 105</td>
<td>ANTI DEPRESSANT MEDICATION MANAGEMENT</td>
<td></td>
</tr>
<tr>
<td>TOBACCO USE: SCREENING &amp; CESSATION NQF28</td>
<td>MEDICAL ASSISTANCE WITH TOBACCO USE AND CESSATION</td>
<td></td>
</tr>
<tr>
<td>USE OF IMAGE STUDIES FOR LOW BACK PAIN NQF52</td>
<td>USE OF IMAGING STUDIES FOR LOW BACK PAIN</td>
<td></td>
</tr>
<tr>
<td>UNPLANNED HOSPITAL READMISSION WITHIN 30 DAYS</td>
<td>PLAN ALL-CAUSE READMISSIONS AND HOSPITALIZATION FOR PREVENTABLE COMPLICATIONS</td>
<td></td>
</tr>
<tr>
<td>DEPRESSION UTILIZATION OF PHQ-9 NQF 712</td>
<td>UTILIZATION OF THE PHQ-9 TO MONITOR DEPRESSION SYMPTOMS FOR ADULTS &amp; ADOLESCENTS</td>
<td></td>
</tr>
<tr>
<td>SCREENING FOR CLINICAL DEPRESSION AND FOLLOW UP NQF 418</td>
<td>UTILIZATION OF THE PHQ-9 TO MONITOR DEPRESSION SYMPTOMS</td>
<td></td>
</tr>
<tr>
<td>BMI SCREENING AND FOLLOW UP NQF 421</td>
<td>ADULT BMI ASSESSMENT</td>
<td></td>
</tr>
<tr>
<td>FALLS: SCREENING FOR FUTURE FALL RISK NQF101</td>
<td>FALL RISK MANAGEMENT</td>
<td></td>
</tr>
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</table>
(Name of organization’s) Contract Information: Integrated Health Home (IHH) and SMI Clinic (1 of 3)

**Incentives for measurement period 1/1/17 – 9/30/17**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Agency of measure</th>
<th>Performance indicators</th>
<th>Incentives Included in contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization: # of psychiatric hospital admissions</td>
<td>XXX</td>
<td>20% reduction</td>
<td>Claims</td>
</tr>
<tr>
<td>Hospitalization: # of medical hospital admissions</td>
<td>XXX</td>
<td>20% reduction</td>
<td>Claims</td>
</tr>
<tr>
<td>Emergency Room Utilization: utilization of ED</td>
<td>XXX</td>
<td>20% reduction</td>
<td>Claims</td>
</tr>
<tr>
<td>Employment: # of members who are competitively employed</td>
<td>XXX</td>
<td>5% increase</td>
<td></td>
</tr>
<tr>
<td>Homelessness: # of members who are homeless</td>
<td>XXX</td>
<td>15% reduction</td>
<td></td>
</tr>
</tbody>
</table>

Source: Mercy Maricopa
Pii – Clinical Outcome and Utilization Measures

Pii Performance Scorecard – Adults
Reporting period 10/1/14 – 9/30/15**

ED visits / 1,000
IP admits / 1,000

- 350
- 300
- 100
- 50
- 2

Practice baseline  Pii member average  Arizona Averages

Note: *Timeframe 2014 calendar year; **Most current full year of data available; full year used to account for seasonality
Source: MCP claims data; Kaiser Family Foundation; AHA Annual Survey
Population Health Tools
Health Information Exchange (HIE) activities are supported by (name of group) participation in the Statewide Health Integration Project (SHIP)

Process for connecting to the AzHeC health information exchange (HIE):

- Workflow completed
- Provider portal and secure email set up
- Alerts and notifications of ER visits, lab results, etc. enabled
- HIE interface established

<table>
<thead>
<tr>
<th>Estimated completion date</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X/XXXX</td>
<td>X/XXXX</td>
<td>X/XXXX</td>
<td>X/XXXX</td>
</tr>
</tbody>
</table>

By connecting with the HIE, your practice will improve its ability to identify gaps in care and target members for intervention; for example:

- Alerts and notifications can help facilitate following up with members after ED visits
- Access to lab results can help prevent unnecessary duplicate testing
- The population health reporting tool can help your practice track progress on key quality and cost measures

As the HIE tools are implemented in the coming months, the Pii team will be available to help you incorporate these tools into your practice
Vision and Goals of Transformation
TCPI AIMS, GOALS AND DRIVERS

TCPI AIMs/Goals

(1) Support more than 140,000 clinicians in their practice transformation work.

(2) Build the evidence based on practice transformation so that effective solutions can be scaled.

(3) Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.

(4) Reduce unnecessary hospitalizations for 5 million patients.

(5) Sustain efficient care delivery by reducing unnecessary testing and procedures.

(6) Generate $1 to $4 billion in savings to the federal government and commercial payers.

(7) Transition 75% of practices completing the program to participate in Alternative Payment Models

Primary Drivers

- Patient and Family-Centered Care Design
  - 1.1 Patient & family engagement
  - 1.2 Team-based relationships
  - 1.3 Population management
  - 1.4 Practice as a community partner
  - 1.5 Coordinated care delivery
  - 1.6 Organized, evidence based care
  - 1.7 Enhanced Access

- Continuous, Data-Driven Quality Improvement
  - 2.1 Engaged and committed leadership
  - 2.2 Quality improvement strategy supporting a culture of quality and safety
  - 2.3 Transparent measurement and monitoring
  - 2.4 Optimal use of HIT

- Sustainable Business Operations
  - 3.1 Strategic use of practice revenue
  - 3.2 Staff vitality and joy in work
  - 3.3 Capability to analyze and document value
  - 3.4 Efficiency of operation
## Sample Change Package

<table>
<thead>
<tr>
<th>PRACTICEAIMS</th>
<th>QUALITY MEASURES</th>
<th>PRIMARY DRIVER</th>
<th>CHANGE PACKAGE ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population management</td>
<td>• Preventative Care &amp; Screening: BMI Screening &amp; Follow Up Plan</td>
<td>Patient &amp; Family Centered Care Design</td>
<td>• Assign to Panels</td>
</tr>
<tr>
<td></td>
<td>• Weight Assessment &amp; Counseling for Children &amp; Adolescents</td>
<td></td>
<td>• Assign Accountability</td>
</tr>
<tr>
<td></td>
<td>• Tobacco Use &amp; Cessation Intervention</td>
<td></td>
<td>• Stratify Risk</td>
</tr>
<tr>
<td></td>
<td>• Tobacco Use and help with Quitting Among Adolescents</td>
<td></td>
<td>• Develop Registries</td>
</tr>
<tr>
<td></td>
<td>• Clinical Depression Screening &amp; Follow Up Plan</td>
<td></td>
<td>• Identify Care gaps</td>
</tr>
<tr>
<td></td>
<td>• Immunizations for Adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Childhood Immunization Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinated Care Delivery</td>
<td>• Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Patient &amp; Family Centered Care Design</td>
<td>• Manage Care Transitions</td>
</tr>
<tr>
<td></td>
<td>• Anti-Depressant Medication Management</td>
<td></td>
<td>• Establish Medical Neighborhoods</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Coordinate Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ensure Quality referrals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Manage Medication Reconciliation</td>
</tr>
<tr>
<td>Organized, Evidence Based Care</td>
<td>• ADHD Follow Up Care for Children on ADHD Medication</td>
<td>Patient &amp; Family Centered Care Design</td>
<td>• Consider the Whole Person</td>
</tr>
<tr>
<td></td>
<td>• Anti-Depressant Medication Management</td>
<td></td>
<td>• Plan Care</td>
</tr>
<tr>
<td></td>
<td>• Child &amp; Adolescent Major Depressive Disorder (MDD) – Suicide Risk Assessment</td>
<td></td>
<td>• Implement Evidence - Based Protocols</td>
</tr>
<tr>
<td></td>
<td>• Depression Utilization of PHQ-9 Tool</td>
<td></td>
<td>• Decrease Care Gaps</td>
</tr>
<tr>
<td></td>
<td>• Bipolar Disorder &amp; MDD: Appraisal for Alcohol / Substance Use</td>
<td></td>
<td>• Reduce Unnecessary Tests</td>
</tr>
</tbody>
</table>
Office Visit Process with Measures

Member
- Member arrives for appointment
- Demographic and insurance updates collected and entered
- Co-pay / Co-insurance Collected
- Member given PHQ-9 to complete in waiting room
- PHQ-9 Complete, Member checked in
- ACL_PEA_1
- Discharge Member
- Provide member with educational materials and schedule next appointment

Administrative Support Staff
- Give member portal instructions and username and temp password

Clinical Support Staff
- Record Member feedback on medication and treatment therapy
- Chief complaint for visit entered, add chief complaint for positive depression screening
- Views EHR schedule & member checked in status
- Greets member and moves to exam room
- Record vitals including height, weight and blood pressure in EHR
- Updates immunization history and tobacco use history and checks BMI %
- Record Medications, allergies, social, family and substance use history
- NQF 105
- NQF 712
- Follow up visit?
- Yes
  - Chief Complaint for visit entered, add CC for BMI > 25
  - NQF 421
- No
- Positive Depression Screening?
- Yes
  - Scores PHQ.9
- No

Clinician
- Clinician reviews chart and enters room
- Enter history of present illness and complete review of systems
- Updates problem list
- Addresses chief complaint(s)
- Addresses depression screening results and/or follow up and/or BMI
- Referral Required?
- Yes
  - Document Referral in EMR and give to member
  - Enter Service Performed Codes (CPT – HCPCS)
- No
  - Enter orders for labs or other services if needed
  - NQF 108, 418, 421
  - ACL_EP_1
  - Enter Dx Code(s) E-Prescribe Rx & enter treatment and follow up plan

CMS50v5
1. Identify members most likely to benefit from empanelment.
2. Assess the risks and needs of each member
3. Develop a care plan together with the member/family
4. Teach the member/family about the disease and their management, including medication management
5. Coach the member/family how to respond to worsening symptoms in order to avoid the need for hospital admissions
6. Track how the member is doing over time
7. Revise the care plan as needed
Let’s talk BMI

Who can help your family eat right to stay at a healthy weight?

Face it. Helping kids maintain a healthy weight is not easy.

But you have more power than you know. You can provide nutritious foods, help your kids be more active and limit their screen time. Learn more about how to get started at http://wecan.niddk.nih.gov.
Child & Adolescent MDD, Suicide Risk Assessment and Use of PHQ-9 Tool

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself or that you are a bother to others or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite — being too flighty or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### COLUMBIA-SUICIDE SEVERITY RATING SCALE

#### SUICIDE IDEATION DEFINITIONS AND PROMPTS

**Ask questions that are bold and underlined**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
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<tr>
<td>2. Suicidal Thoughts: General non-specific thoughts of wanting to end one’s life due to suicide. <em>I’ve thought about killing myself</em> without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
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<tr>
<td><strong>Have you actually had any thoughts of killing yourself?</strong></td>
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<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</td>
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<tr>
<td>3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, method details worked out. <em>I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.</em></td>
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<tr>
<td><strong>Have you been thinking about how you might kill yourself?</strong></td>
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<tr>
<td>4. Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
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<tr>
<td><strong>Have you had these thoughts and had some intention of acting on them?</strong></td>
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<tr>
<td>5. Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.</td>
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<td></td>
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<tr>
<td><strong>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Suicide Behavior <strong>Have you done anything, started to do anything, or prepared to do anything to end your life?</strong></td>
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<td></td>
</tr>
</tbody>
</table>

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.
Pediatric & Adolescent Care Plan Tool

**Action Plan**

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Parents/Caregivers</th>
</tr>
</thead>
</table>

**Primary Diagnosis**

**Secondary Diagnosis**

**Secondary Diagnosis(s)**

<table>
<thead>
<tr>
<th>Original Date of Plan</th>
<th>Updated Last</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Caregiver Signature</th>
<th>Clinician Signature</th>
<th>Name of Care Coordinator</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Common Presenting Problems/Findings with Specific Suggested Managements</th>
</tr>
</thead>
<tbody>
<tr>
<td>- See specialist letter(s) attached</td>
</tr>
</tbody>
</table>

**Problem #1**

**Presenting Signs & Symptoms:**

**Suggested Diagnostic Studies:**

**Treatment Considerations:**

Adapted from the American Academy of Pediatrics and the National Association for Medical Home Implementation.
Learning Opportunities
### Behavioral Health Integration Module 4
Learning Module 4: Measuring and Improving Care for Depression

<table>
<thead>
<tr>
<th>When</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>The Integrating Behavioral Health into Primary Care series of modules offers a review of key concepts and tools that support the integration of physical and mental health care. Primary care practices are increasingly being called upon to address mental health needs as a part of treating the whole person. In this module, Tina Frontera, Chief Operating Officer, Minnesota Community Measurement*, will share her experience measuring and reporting all aspects of care for depression, including screening, follow-up, response and remission. The presenter will review the importance of universal screening, and share her story of statewide measurement, from selecting a measure and collecting data for performance comparison and improvement, to identifying variation between practices and aligning with other initiatives. This module is intended for PTN practice advisors and other staff, as well as clinics participating in a PTN; specifically, those interested in how Behavioral Health Integration can support Change Tactics related to Continuous, Data-Driven Quality (2.3.1).</td>
</tr>
</tbody>
</table>
| What you will learn | • Specific tools for measuring depression screening, follow-up, response, and remission  
• About a specific regional initiative on depression screening, and how it aligns with national initiatives  
• Strategies for collecting and reporting data for performance comparison  
• How measurement is essential to improving mental health  

*Minnesota Community Measurement is the measure steward for three National Quality Forum endorsed measures: Six and Twelve Months Remission + Utilization of PHQ-9 |

| Registration link | NRHI SAN: Behavioral Health Integration Module 4: Measuring and Improving Care for Depression |
Goals of the “Pii Academy” Roadmap to Transformation

1. Providing education to support practice transformation
   - Training modules: Use modules to deliver educational materials in a logical sequence based on the Practice Assessment Tool (PAT), practice need, and progress along the change drivers
   - Seminars: All enrolled practices will be offered webinars via the TCPI website
   - Conferences: Pii Academy will offer conferences in conjunctions with the SANs, local and regional universities and academic groups to address the learning needs of the practices, clinicians and member advisory groups

2. Creating a learning healthcare system (LHS)
   - A LHS is based on cycles which include using data and analytics to generate knowledge, using this knowledge to give feedback to all stakeholders, and basing continual behavioral change around the knowledge gained
   - Partnerships across the healthcare community (e.g., academic institutions, educators, member advisory groups) will help practices turn data from routine clinical care into knowledge and knowledge into guidance for physicians at the point of care
   - These partnerships will also help bring technology, applications, telemedicine and other innovative approaches to transform care, particularly for vulnerable populations.

3. Developing centers of learning and innovation
   - Our practices represent unique populations of members and clinical services that serve diverse member populations with various mental health and physical health needs.
   - We can use learnings from caring for these populations to drive regional centers of learning and innovation
In the next 6 months, PIR’s aims will be addressed by focusing on 5 key milestones:

<table>
<thead>
<tr>
<th>Area of focus / milestones</th>
<th>Driver</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice has an organized approach to improvement</td>
<td>Data Driven Quality Improvement</td>
<td>Continuous, Data-Driven Quality Improvement</td>
</tr>
<tr>
<td>Practice establishes clear roles for each member of the care team</td>
<td>Team Based Care</td>
<td>Person and Family-Centered Care Design</td>
</tr>
<tr>
<td>Practice assigns members to a provider panel</td>
<td>Population Health / Empanelment</td>
<td>Person and Family-Centered Care Design</td>
</tr>
<tr>
<td>Practice identifies member risk level</td>
<td>Population Health / Empanelment</td>
<td>Person and Family-Centered Care Design</td>
</tr>
<tr>
<td>Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.</td>
<td>Engaged Leadership and Joy in Work</td>
<td>TCPI Aims</td>
</tr>
</tbody>
</table>
**Milestone 1**

- **Milestone Description:** Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities

- **Relevant Learning materials:**
  - Steps Forward Modules
    - Quality Improvement module

- **Role of Technology:**
  - Practice management software can help standardize day-to-day operations and can provide a centralized way to schedule appointments, assign tasks to team members, generate reports, etc.

- **Next Steps:**
  - Assign an owner / practice champion for this change driver
  - Schedule a date to complete module training with your PTC – Pi Institute recommends that the entire team engaged in quality improvement activities train in this module
  - Debrief from Module with PTC and discuss concrete ways to incorporate learnings into practice operation

**Practice PAT score**
1
Transformation Timeline

Now

- Execute against this business plan
- Review A&Ns which will help you standardize your practice’s response to ED visits and hospital admissions
- Receive training on these tools so that you are able to effectively access and interpret member data

6 months

- Continue training on the tools and updating customized care paths to reflect your members’ needs
- Establish connectivity with the statewide HIE
- Pii will perform a new PAT to check in on progress and develop an updated business plan

12 months

- Gain access to and training on the population health analytics and reporting tool
- Pii will perform a new PAT to check in on progress and develop an updated business plan

24+ months

- Continue to engage with your PTC to integrate new tools and capabilities into your practice’s workflow
- Pii will perform a new PAT every 6 months to check in on progress and develop an updated business plan
Resources

Healthcare Communities

Practice Innovation Institute
http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/PTN/PracticeInnovationInstitute.aspx

ACP Practice Advisor
https://www.practiceadvisor.org/about

Steps Forward Modules
https://www.stepsforward.org
Next Steps

Join our network!

**It’s free 😊**
Practice Innovation Institute

www.piiiaz.org

Jenn Sommers
Director, Physician Organizations & Relations

Jenn.Sommers@piiiaz.org