TCPI Exemplary Practice Performance Summary, April 2019
Southwest Behavioral Health Services
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Delivering integrated care services while reducing hospital and ER use.

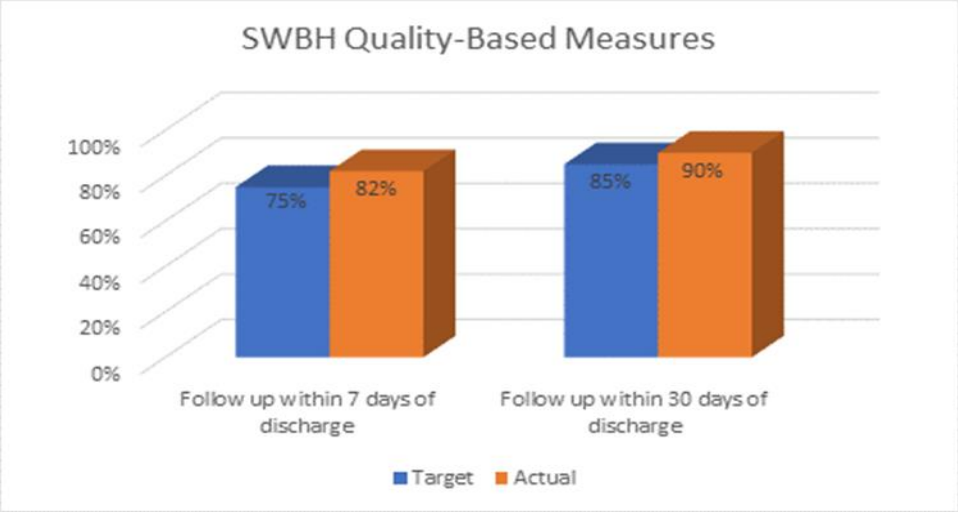
Southwest Behavioral & Health Services (SB&H) is an integrated care provider offering both physical and behavioral health services in Arizona in which 85% of the population served are Medicaid recipients. We have experience with Value Based contracts for the Mercy Care population. SB&H is a leader in development and delivery of services in the areas of crisis stabilization, inpatient recovery transition, residential care, housing, community living, evidence-based prevention services, school-based counseling services, outpatient services to adults, children, incarcerated persons, and dually diagnosed adults with serious mental illness/substance abuse (SMI/SA). As an innovative leader in integrated care, our services are client directed, outcome informed and evidence-based. We incorporate this model in the treatment of co-occurring disorders, the FAST (Family and Schools Together) model in prevention services, the Arizona Treatment Initiative for children and families, and the Recovery Model for persons with serious mental illness.

Arizona places a high value on integrated care and coordination efforts with acute care and the inpatient hospital systems. By focusing on the reduction of medically unnecessary hospital use and associated cost reduction, we involved our multidisciplinary teams in the review of admission and hospital use notices received from Health Current (Arizona's Health information Exchange), hospitals and health plans to identify patients for outreach while engaging patients and families in the process.

SB&H created a Hospital Navigator Team to track persons in the hospital and upon discharge. This team tracks and works directly with identified patients for a minimum of 6 months. The team contacts the post-discharged patients and schedules follow up visits with them. Outreach calls are made weekly during the first six months and bi-weekly contacts are made for the remaining three months. A primary aim for us was the reduction of medically unnecessary hospital use with a focus on reducing the associated costs. Our hospital navigator team was designed to assist our members who were admitted to the hospital and efforts to further engage them upon discharge. We routinely receive admission and hospital use notifications from Health Current, health plans, and hospital discharge teams. Our teams utilize these notifications by reaching out to our members and their families in an effort to provide support and resources during a hospital stay and post discharge. Hospital navigators work with our members in providing resources and assistance in scheduling time with their prescriber, counselor and/or nursing team.

Two of our targeted measures in our Value Based contract are related to follow-up after discharge from a hospitalization for mental illness. We were tasked with providing follow up within 7 days of discharge from the hospital at least 75% of the time. The detail was focused on the percentage of discharges for members 18 years of age and older who were hospitalized for treatment of selected mental health disorders. These members also had an outpatient visit, an intensive outpatient encounter or partial

hospitalization with a mental health practitioner with SB&H within the year. We exceeded the target by providing follow up within 7 days of discharge from the hospital 82% of the time. Our second target is to provide follow up after hospitalization for mental illness within 30 days of discharge to at least 85% of affected members. We exceeded this target with 90% of affected members receiving follow up within 30 days following hospitalization for mental illness.



The SB&H Hospital Navigator Team measures success by completing daily coordination, connecting to clinically indicated support services, and decreasing recidivism for each hospitalized member. When an individual is hospitalized for a medical or psychiatric emergency, an SB&H Hospital Navigator is notified; the key component in the navigation process is connecting the affected member's inpatient attending team with their outpatient clinical team. This connection serves to ensure successful coordination between inpatient attending prescriber and outpatient prescriber thereby aligning treatment efforts. The Hospital Navigation Team works to ensure the individual is not discharged from the hospital setting without a follow up appointment with their outpatient prescriber and their assigned clinician.

Our team members work with the individual in the hospital, while at the same time working closely with behavioral health and physical health practitioners. This practice allows us to identify individuals at higher risk allowing us to reduce unnecessary hospital admissions and emergency room use. Prompt follow up visits to address physical and mental health concerns provide the biggest impact in reducing unnecessary readmissions. Team members make a concerted effort to identify and outreach individuals who have missed scheduled appointments or simply have not received services in the last 12 months. During the outreach effort with individuals we take the opportunity to identify any social determinants of health barriers, brainstorm ways to engage families and support systems in their care, and share with individuals how consistent contact with their outpatient providers can eliminate the need for continued hospital use. Our Hospital Navigator Teams have made significant progress in connecting with inpatient providers and consistently following up with individuals; this in turn reinforces the benefit of outpatient care to our members and the community.

In 2018, SB&H was the recipient of the Healthcare Leadership Award from AZ BIG Media for outstanding achievement in Behavioral Health Management or Treatment for our work statewide to help alleviate the opioid crisis. We were also named one of Phoenix Business Journal's 2018 Healthiest Employers for Midsize Companies thanks to our comprehensive corporate wellness program.

Working with our community's most at risk populations, we focus on putting the individual members needs above all else. We believe in creating safe and supportive environments for our members to participate in creating a healthy future for themselves and their families. We achieve this goal by ensuring caring accountability through successes and setbacks.

Our work has not been without challenges especially when providing whole health care to our members. 42 CFR Part 2, while critical in protecting personal health information for individuals receiving services for substance use dependence (SUD), limits the exchange of physical and behavioral health information. We are an active member of Arizona Opioid Treatment Coalition (AOTC) which is the official link to the national affiliate, the American Association for the Treatment of Opioid Dependence (AATOD). AATOD promotes education and advocacy for opioid treatment at both the federal and state levels. We value the community partnerships that we have formed with other healthcare organizations as we continue our goal to build a healthier community for our patients and families.

The following patient success story was written, and is shared by permission, from a woman receiving services at one of our Medication Assisted Treatment (MAT) programs. This is just one of many success stories.

> "*I was a very private person and was ashamed of my heroin use. I did not communicate with others about my use. I never really knew anything about getting methadone treatment. I eventually realized that I needed to get help otherwise I would die by an overdose or I was going to kill myself because I didn't want to continue to live my life using. I put aside my pride and went to my family for help. I was at my breaking point. I decided I was going to be faithful to my recovery and not take anything outside of the program. I am proud to report that I have not used Crack in 6 years, Methamphetamines in 2 years, and heroin in 2 years.*
>
> *I am glad I was faithful to my recovery. The counseling I get at SBH has been a godsend to my recovery.*
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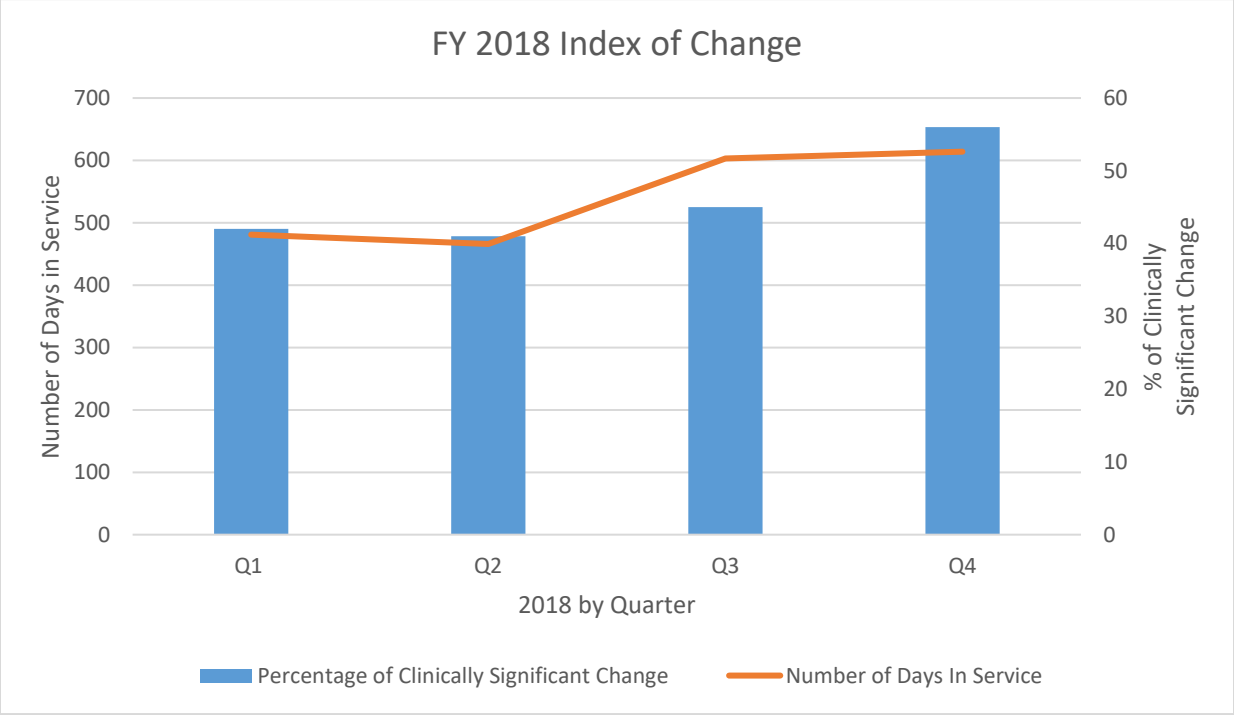
> *When I detoxed from methadone it was really helpful to have my counselor there to support me and I think that she was amazing. I had a mentality that I thought I could connive my way through recovery and my counselor got in there slowly and got over the wall I had built. She taught me that I had to take responsibility for my actions to be successful in my recovery. She had made the road smoother towards recovery. She educated me about addiction, emotions, have a sense of my own well-being and my worth. My self-worth and how to forgive and love myself have been some of the most important lessons I have learned in counseling. My counselor has been preparing me for my new life and now that I have completely detoxed off methadone I am learning to gradually let go of the program and move forward in my life.*
>
> *Thank you Southwest Behavioral and Health Services 7th Avenue Clinic staff for giving my life back*."

We utilize the Outcome Rating and Session Rating Scales (ORS/SRS) to get client directed feedback/scores in 4 domains at the beginning and end of each counseling visit. The ORS scale asks the

individual to look at how well they believe they are doing since their last visit relative to individual, interpersonal, social, and overall functioning. It is a 0-10 point Likert scale, with 0 being the worst and 10 the best with an overall possible score of 40. The SRS scale asks the individual to rate the session they just had with their clinician relative to the relationship between individual and clinician, did they work on goals/topics the individual wanted to discuss, did the approach or method work well, and overall how did the session go? It is also a 0-10 point Likert scale, with 0 being the worst and 10 the best with an overall possible score of 40.



Through fiscal year 2018 we saw a steady increase in the percentage of change index relative to the ORS for individuals discharged from the program. The change of index percentage is calculated by measuring the amount of change in the admit and discharge ORS scores for the discharged clients by quarter. We identify the change to be clinically significant if there is a change of 6 points or more. There was an increase in the length of stay over the same period of time for the individuals discharged. This is also measured by quarter. We believe individuals receiving MAT services tend to report they feel better and perform better in their lives when services are continued for more than 2 years.

We find a great deal of value in consistently checking in with individuals we serve, engaging them in services and focusing on what they find important. While we share one specific success story that reinforces this data and approach, we have scores of individuals who share the same outcome. We consistently review the data, analyze reports, and engage individuals and families in their own care. This approach allows us to continue meeting or exceeding the measurement goals established with our contracted health plans.

Southwest Behavioral & Health Services is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.

As of February 2019, SB&H *has completed all 5 Phases of Transformation.*

Practice Innovation Institute

Engage. Transform. Reward.