

**TCPI Exemplary Practice Performance Summary, May 2019**

**Bayless Integrated Healthcare**

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*Serving the community with a holistic full spectrum care delivery approach.*

**Bayless Integrated Healthcare** (Bayless) is an integrated care provider that serves a diverse, broad spectrum underserved population. Our payer mix is approximately 70% Medicaid, 25% private insurance, and 5% Medicare and self-discount cash pay/sliding fee. Currently our Medicare population is primarily dual eligible (meaning eligible for both Medicare and Medicaid and may not be 65+), however, we are committed to serving the geriatric population in our community, and this population is growing within Bayless. We have providers who focus on pediatrics through adult medicine, allowing us to deliver “cradle to grave” services. Bayless offers full behavioral health services, psychiatry services as well as primary care services. Additionally, Bayless has focused heavily on the opioid crisis. Bayless services a large substance use disorder population in the form of medication assisted treatment (MAT) in conjunction with an evidence based intensive therapy program called the MATRIX model.

In our relentless pursuit of a better patient experience, Bayless focuses on high quality care, closing care gaps, and decreasing costs through improved outcomes including a significant reduction of medically unnecessary hospital and emergency department use.

Bayless strives to eliminate barriers and provide comprehensive healthcare in a “right patient, right service” mentality. Following are examples of ways in which we do this.

**Reducing hospitalizations/re-admissions and reducing medically unnecessary ED utilization** is a key aim across the Bayless service lines. Bayless has made great strides in reducing inpatient and emergency department use and reducing the associated costs. We are reporting marked improvements from year 1 to year 2 of the TCPI initiative and even further improvement is expected in Q15, and ongoing (see Table 1.) This AIM has and always will be a primary focus at Bayless and is a big reason we deliver healthcare in the way we do.

Providing both Behavioral Health and Physical Health services in a “whole person” approach, literally under one roof, is the Bayless way. Data has shown, repeatedly, that emotional and physical health is intertwined. We truly strive to have bidirectional integration. Often, primary care is first contact for a patient with underlying emotional health needs. Ensuring our patients have the behavioral health services they need coupled with their physical health needs translates not only to decreased ED visits for diagnosis such as anxiety, but also to improvement in chronic disease outcomes as well because patients have increased motivation to achieve their goals. Assisting our patients in achieving improved mental and physical health for an overall healthier population is our passion. Delivering this model of integrated health to a mostly underserved population makes it necessary to be innovative in care delivery. Focusing heavily on access to care, eliminating barriers, patient education, social determinants of health and other factors has been necessary for our quality patient focused model. Dedication to these efforts has contributed to our reduction in hospitalization and ED utilization (see Table 1) and resulting reduced events and cost savings (see Table 2).

**Table 1: Reductions in ED Visits and Inpatient Admissions**

Measure	Per 1,000				% Change from Baseline		
	Baseline	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
ED Visits	1,895	1,648	1,203	1,010	-13.0%	-36.5%	-46.7%
IP Admits	632	436	281	431	-31.0%	-55.5%	-31.8%

**Table 2: Reduced Events and Cost Savings**

Measure	Reduced Events			Savings from Reduced Events		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
ED Visits	10	155	466	\$4,939	\$73,636	\$219,561
IP Admits	8	79	106	\$51,849	\$478,163	\$639,471

**Improving key outcomes** is another primary aim at Bayless Integrated Healthcare. The physical health metrics we focus on our numerous, primarily involving chronic disease management and preventive medicine. Our quality committee collaborates with our department of quality and compliance to identify and focus on key metrics implementing companywide protocols to achieve favorable patient outcomes/results. We have been very happy to see these quality metrics improve under this model and look forward to continuing this trend. We have composed a high-risk patient registry of Bayless patients with chronic diseases such as: Diabetes, HTN COPD, CHF, and asthma. These patients are monitored closely to ensure they are following up for appointments and keeping up on their required health needs. Additionally, our Patient Care Coordinator under our department of Quality and Compliance works closely with our providers to assist with management of our “extremely” high-risk patient panel. This panel consists of patients with two or more chronic diseases, with one being uncontrolled. Thanks to this model we have seen steady improvement in quality metrics around behavioral health screening and in health outcomes.

Bayless embraces innovation in its quest for “Right patient, Right service” for all patients.

**Integrated Care Coordination:** Our innovative, integrated model has been a crucial key to success. Organizing care activities and sharing information among psychiatric, medical, therapeutic and social treatment teams has allowed for improved patient outcomes. Here are a couple of examples from within our pediatric population:

- In the course of one year, two young children (3 and 4 years old) diagnosed with autism at outside facilities when they spontaneously regressed from a developmental standpoint, came to Bayless primary care. Both were diagnosed with lead toxicity, and the Bayless team was able to assist with lead abatement and getting the children on the road to recovery.
- A second story involves an adolescent with obesity and metabolic syndrome. After integration and receiving behavioral health services, her pre-diabetes, blood pressure, BMI and mood improved drastically, hopefully preventing the diabetes and hypertension that were inevitably in her future. Every patient seen on the physical health team is screened for depression and anxiety and if identified, integration is instantaneous to see a behavioral health specialist. A warm hand off the same day of physical health service will occur if needed, or the patient will be connected in the exam room to behavioral health instantaneously using the integration line. This eliminates the weeks patients typically wait in much of the healthcare world to get mental

health assistance. Reverse integration is happening from behavioral health to primary care at Bayless as well. All patients being seen by behavioral health and psychiatry providers who do not have a primary care provider or those in need of primary care services will be integrated and leave with a scheduled appointment or seen immediately if medically necessary.

### **Care Teams and Care Managers:**

Once a patient is identified as high-risk, our patient Care Coordinator, an RN, contacts them by phone and face to face during office encounters to reinforce the personalized care plan, ensure patient understanding, and assist in eliminating barriers. Currently, over 50% of these high-risk patients have been integrated for underlying emotional health issues. This integrated care model has decreased medically unnecessary hospitalizations in this population. This is a new model of care at Bayless, and we look forward to gathering data on the exact health outcome numbers soon.

### **Technology:**

The quality team also utilizes the HIE and health plan data to identify patients that have been in the hospital. The patient is contacted within 48 hours of discharge and scheduled for a follow up visit within 7 days of discharge.

Bayless utilizes the electronic medical record to outreach patients as well. Text pushes for chronic disease reminders are sent, as well as for preventive care measures. Most recently, a text push for childhood immunization and breast cancer screening was sent out.

There is a pharmacy kiosk on site at most Bayless locations that carries over 600 of our most commonly prescribed medications. This allows patients to pick up their medication at check out and avoid another trip to the pharmacy. This is especially appreciated in the pediatric population as parents with sick children can avoid another stop and get their little one home, and in our patients reliant on public transportation, as coordinating another ride to the pharmacy through their plan can often be difficult. The kiosk has also allowed us to ensure our high-risk patients can leave with their medications in hand, leading to an improvement in chronic disease medication adherence.

Bayless believes their “whole person” approach to well-being saves money while improving lives. That is why we added Virtual Care services. Partnering with a simple to use, HIPAA compliant telemedicine software, we offer virtual visits so that patients can meet directly with their provider from anywhere in Arizona. When an in-person visit isn’t necessary, or desired by the patient, Bayless Integrated Healthcare’s Virtual Care program connects patient with their provider using their cell phone, tablet, laptop or desktop computer. Over the past year of virtual services, Bayless Integrated Healthcare has provided over 5000 virtual behavioral health and psychiatry visits for our patients. These services have been well received with an overall 4.9/5 star-rating on internal surveys and the majority of patients returning for repeat visits. We are very excited to expand these services to primary care this summer to further alleviate barriers.

Above are just a few highlights of how Bayless Integrated Healthcare has utilized technology in the spirit of innovation for patient care.

### **Aim 3: Reduce Unnecessary Hospital Use**

In conclusion, the innovative integrated process at Bayless, described above, has led to significant decrease in medically unnecessary ED visits and hospitalizations. Emergency department avoided visits increased from 10 in year one to 155 in year two and 466 in year three. The integrated Bayless model has led to this drastic decrease in ED utilization and hospitalizations and has resulted in a total cost savings of \$1,467,619 over a three-year period.

As mentioned above, over 50% of our high-risk population has been diagnosed with co-occurring behavioral health diagnosis, and these emotional needs are being met alongside our patients' physical health needs. Additionally, immediate access for our patients through same day visits or virtual care have likely contributed to the decrease in ED utilization and hospitalizations in the physical and behavioral health populations.

*Bayless Integrated Healthcare is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.*

*As of October 2018, Bayless Integrated Healthcare completed the 5 Phases of Transformation.*



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