

TCPI Exemplary Practice Performance Summary, May 2019

Community Partners Integrated Healthcare

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Providing exceptional integrated care service to every member by keeping the member at the center of all we do.

Community Partners Integrated Healthcare (CPIH) currently serves members throughout Arizona in 11 counties, with physical locations in 7 counties. Over 10,000 members are served across a broad continuum of care. CPIH is comprised of five fully integrated clinics, three behavioral health homes, a subacute/inpatient unit, a Brief Intervention Program (BIP), and an Assertive Community Treatment Team (ACT). The integrated clinics offer primary care and behavioral health services under one roof. Primary care services include physical health, nutrition, pharmacy and lab services, chronic disease management, and health screenings. In addition to these primary care services, all locations provide behavioral health services, including intake and assessment, psychiatric services, case management, peer support, group and individual therapy, wellness education, and skills building. There are specialized therapy groups unique to each location, with licensed therapists and counselors. There is a focus on whole health and wellness at each of the Community Partners Integrated Healthcare locations.

Member Experience:

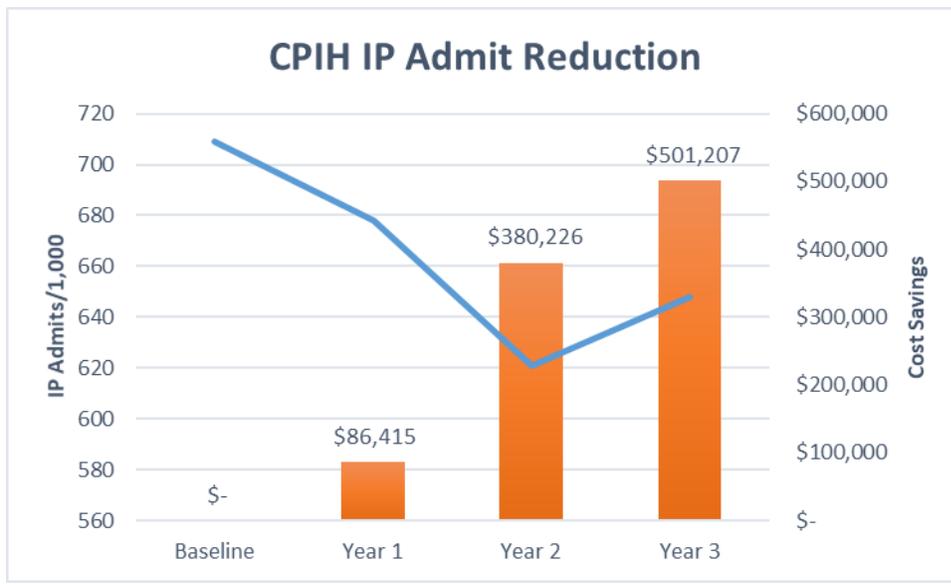
CPIH identified a need to focus on TCPI Aims/Goals 3 & 4 (improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other members and reduce unnecessary hospitalizations for 5 million patients) to reduce the unnecessary hospital and emergency room use and reduce the associated costs. With the help of the Care Manager through Mercy Care and Practice Transformation Consultant from the Practice Innovation Institute (Pii), CPIH was able to review the list of high utilizers of inpatient and emergency department use. This area was necessary due to the high population of homeless and transient members. After completing the 5 Phases of Transformation with Pii, CPIH leadership reviewed the data of the high utilizers of inpatient and emergency department from the period, including before practice transformation through completion of the 5 phases. While it was clear through the data that significant progress and transformation had occurred, one member stood out as an example of the depth and significance this process had on the quality of care and treatment outcomes for CPIH's most at-risk members.

In April 2018, after identifying the need to update workflows of the member care and clinical teams, CPIH implemented a team huddle process. This process increased collaboration between the medical staff and clinical staff to review crisis events, members with recent incarceration, medication needs, review of no shows, injections, abnormal medical testing results, and behavioral health service needs. The team, including doctors, nurses, case managers, peer supports, therapists, and hospital discharge planners all intend to improve the continuity of care of our members. The workflow also includes working closely with the member's health plan to move members into more permanent housing whenever possible. Through the increased focus on high utilizers of inpatient and emergency department use, CPIH was able to identify

Nancy*, a 59-year-old member, engaged in services at CPIH since 2015. Nancy dealt with drug use, homelessness, and was not actively engaged in behavioral health and medical services to manage her substance use disorder and associated medical diagnosis that was leading her to acute liver failure. Nancy did not have stable housing and had multiple emergency room visits and several inpatient stays. Ultimately, Nancy received hospice services in 2018, and her medical prognosis was grim. Through the use of the huddle process and consistent wrap-around supports, CPIH identified Nancy’s needs and created a constant flow of information to ensure that her integrated care needs were being met. “By sharing information through our huddle process, it allows for better awareness and collaboration to improve the quality of care for our members,” says Shakuntala Jain, Medical Director at Community Partners Integrated Healthcare. CPIH wrapped Nancy in services and was able to reengage Nancy in treatment. Nancy began seeing the Psychiatric provider every 30 days, made it to her RN appointments every 30-45 days, engaged in the regular transportation for coordinated services, and she received peer support services multiple times every month.

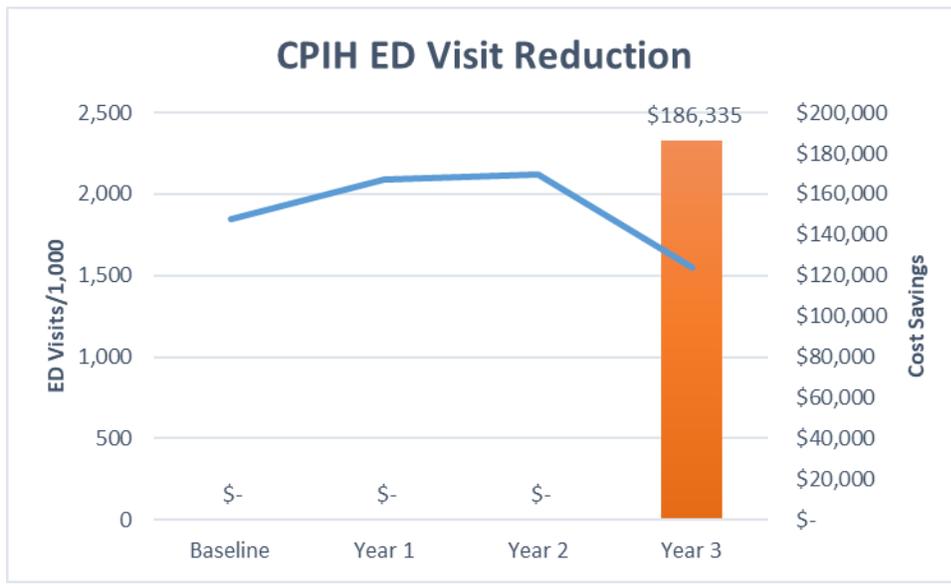
Over the last six months, by focusing on the Social Determinants of Health and the need for more permanent housing, CPIH has made great efforts in stabilizing housing for this population. In Nancy’s case, her symptoms improved to the point that she no longer needed hospice services and was able to receive all her medical and behavioral health services through her regularly scheduled non-crisis services. This process has been in place for one year. During that time, CPIH has a reportable reduction in inpatient and ED and resulting reductions in cost as reported by Pii (See Figures 1 and 2).

Figure 1: Reductions in Inpatient Admissions



Data Source: Pii

Figure 2: Reductions in ED Visits



Data Source: Pii

This process is replicable in other locations that serve the same population type as well as any organization that has identified their high-risk membership, identified any underlying social determinants of health issues, works closely with the member’s health plan(s) and puts into place, ongoing outreach efforts and work to alleviate the identified primary problem (i.e., homelessness).

By providing award-winning services and supports such as Member and Family Advisory Council, Chronic Disease Management registries, Diabetes Self-Management Program, Opiate Reduction, and Chronic Pain Management Programs along with combining these with efforts to reduce homelessness, exemplify putting the member first in every aspect of care.

Nancy has now been sober for more than eight months. She takes pride in her appearance, is showing off her cooking skills by regularly cooking for her roommates and has set a goal to become a peer support specialist to help others gain self-esteem, self-sufficiency, and sobriety. During a recent interview, Nancy stated, “Having a clinic that never gave up on me made a huge difference for me. I have a lot more desire to do things and to follow my dreams and my instincts. Whereas before I used to have dreams and never pursued them, but now I have the dog that I wanted to have for years, and I enjoy baking classes. I’m doing things in my life to keep out the depression. The medication is a huge factor, but I’m up and doing things in my life that makes me feel better. My clinic and my team have had a big impact on me and my recovery.” Community Partners Integrated Healthcare celebrates Nancy's success and is proud to be part of the team that supports her stability.

As an organization, Community Partners Integrated Healthcare is continuing to evolve and develop processes to ensure that members are receiving the highest level of integrated services. CPIH strives to be a leader of integrated services in the state of Arizona.

**Client name has been changed to protect privacy.*

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

As of March 2019, Community Partners Integrated Healthcare has completed the 5 Phases of Transformation.



Practice Innovation Institute

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