TCPI Exemplary Practice Performance Story, July 2019
Partners in Recovery
Christy Dye – CEO at Partners in Recovery
Your voice, your choice!

Partners in Recovery (PIR), is a Phoenix, Arizona-based outpatient integrated behavioral health provider that specializes in treating adult patients with a Severe Mental Illness (SMI) diagnosis. We provide multidisciplinary services to over 8,000 members in 7 facilities throughout Maricopa County, Arizona. PIR receives funding for services through health plan contracts with Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, Medicare, and other commercial and third-party plans. Standard services include psychiatry and medication management, integrated primary care, case management, counseling, peer and family support, and health and wellness. Additionally, we provide evidenced-based practice programs such as Assertive Community Treatment (ACT), Wellness Recovery Action Plan (WRAP), Integrated Dual Disorder Substance Abuse Treatment (IDDT), and employment programs. We employ 32 psychiatric providers, 6 primary care providers, and 390 direct care support staff (case managers, clinical supervisors, peer/family staff, etc). Medicaid members make up 67% of our population, and one in three (31%) are dually eligible for Medicaid and Medicare. A large number of our population has multiple social determinants of health (SDOH) risk factors, including homelessness, food instability and isolation.

The tables below reflect the chronic disease burden of our SMI population. The majority have multiple chronic medical conditions coupled with a severe behavioral health diagnosis (Table 1). Our population complexity was validated by the 10 bonus points we received during the 2019 MIPS submission for meeting the Complex Patient criteria (2017 data averaging Hierarchical Condition Category (HCC) risk scores and dual eligibility). In reviewing the health plan's data for the highest utilizers of emergency departments, we found that over 40% of our SMI members with frequent ED visits had not seen a PCP in more than 2 years. The combination of severe mental illness, SDOH factors and chronic co-morbid health diagnoses poses added challenges for clinicians to support treatment adherence and self-management. For this reason, PIR multidisciplinary teams focus on *health literacy*, including education on chronic diseases and developing skills for daily self-management, as well as wellness services that support patient engagement and active involvement in their care.

Table 1: Top Medical and Behavioral Health Conditions in PIR Service Population

Eligible Members	Hypertension	ESRD	Diabetes	COPD	Chronic Kidney Disease	Coronary Artery Disease	Congestive Heart Failure
8118	3607	48	1407	827	457	552	247
8118	44.4%	0.6%	17.3%	10.2%	5.6%	6.8%	3.0%

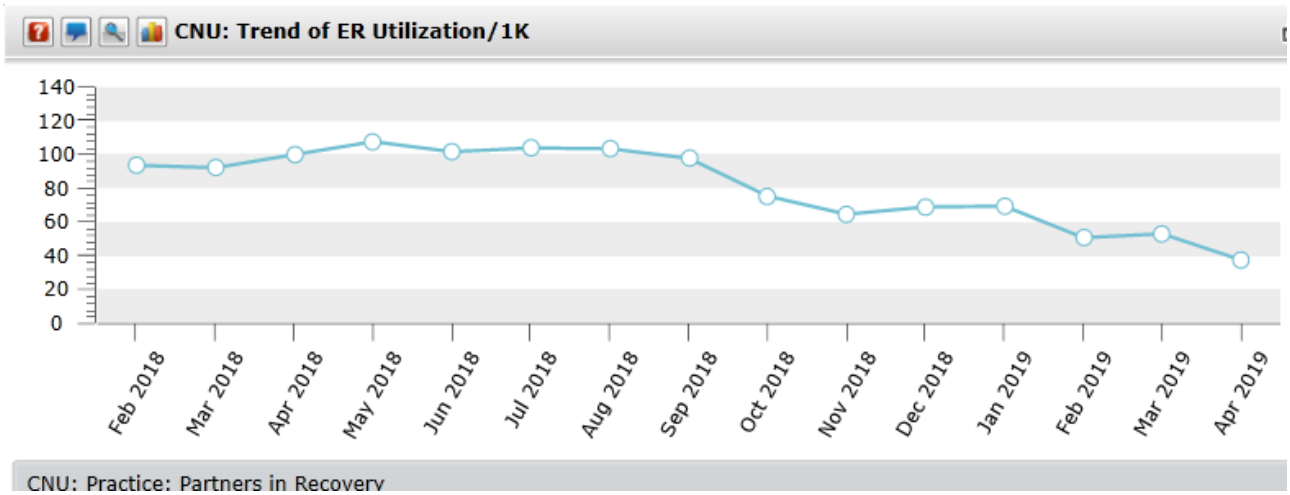
Eligible Members	Substance Abuse	Schizophrenia	Bipolar Disorder	Anxiety and Depression	Alcohol Abuse
8118	3678	4564	5300	6178	1770
8118	45.3%	56.2%	65.3%	76.1%	21.8%

Our efforts to improve the quality of care of our patients aligned well with TCPI bold aims to reduce unnecessary hospital use (Aim 3) and reduce costs (Aim 4). Understanding the complexity of our population, we developed a practice-wide process to reduce unnecessary hospitalizations/ED visits by focusing on the highest risk patients. Recognizing that the Medicaid SMI population is already a high-risk group, we used a modified version of the **C**linical evaluation, **U**tilization, **P**otential physical limitations and **S**ocial determinants (CUPS) tool to help us identify and build a more targeted high-risk registry. The process encompassed collecting and analyzing risk metrics from claims, alerts from the state's health information exchange (HIE), and clinical extracts from our electronic health record. We used this data to establish a high-risk registry and to develop person-centered interventions that address the root cause of each person's unnecessary utilization.

PIR's High Risk Registry launched in January 2018. Between Feb 2018 and April 2019, we demonstrated a significant, positive impact on all-cause ED utilization per 1,000, reducing ED visits by almost 60% (Table 2).

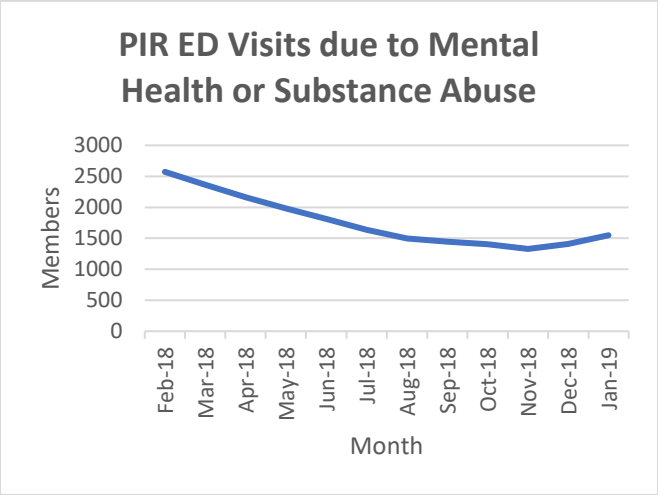
Table 2. Trend of ER Utilization/1k

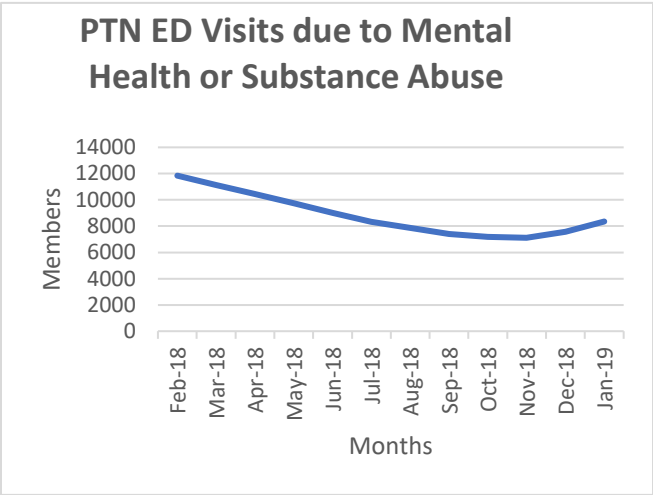
Source: PTN CareQuotient



We also compared ourselves to the HEDIS measure for ED Visits Due to Mental Health. The Arizona PTN utilizes a population health tool, CareQuotient, which collects and analyzes claims data from one local payor to generate the HEDIS measure. In this comparison, our organization showed a **40% reduction** in ED visits versus the PTN as a whole, which experienced only a 29% reduction in the same time period (Table 3).

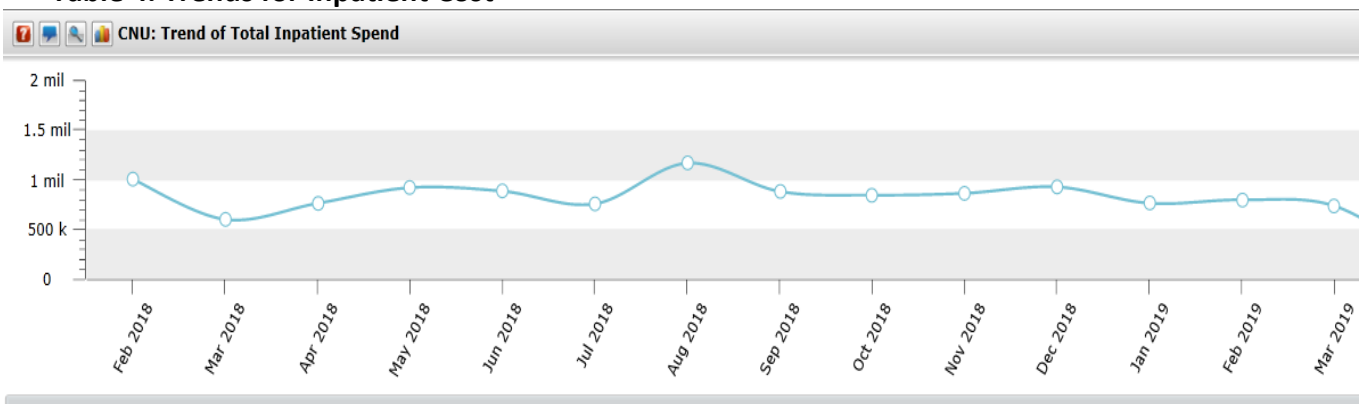
Table 3. HEDIS Measures for ED Utilization





We experienced similar reductions in total inpatient spend over the same 12-month period. Between February 2018 and March 2019 PIR's total cost for inpatient services **fell by almost 27%** -- from $1,005,580 to $737,371 (Table 4).

Table 4. Trends for Inpatient Cost



Source: CareQuotient

With respect to patients on the high-risk registry, PIR can calculate savings from all service utilization for the group including pharmacy (Total Cost), as well as the Per Member Per Month savings (PMPM). For the one-year period October 2017 to September 2018, Total Cost for high risk patients declined more than $375,000, while PMPM costs decreased from $6,200 PMPM to $1500 PMPM (Table 5).

Table 5. Total Cost Savings

By providing multiple services under one roof, facilitated by a multi-disciplinary collaborative care team, we implemented technical, workforce and training strategies that support an integrated workflow and clinical improvements. Recognizing that the right technology plays a significant role in supporting an integrated care practice, we adopted a single electronic health record for both psychiatry and primary care very early on. There is a single, shared care plan that the entire team, including both primary and behavioral health providers, can access, review and document. This supports real-time sharing of critical medical and behavioral patient information and appropriate therapeutic interventions based on each patient's risk indicators. In the early stages of our PTN participation, PIR also established bi-directional information sharing with Health Current, the state's health information exchange. HIE participation provided an immediate pay-off in delivering real-time alerts for PIR patients admitted to emergency departments and hospitals that we could track for our high-risk members.

Workforce development included, both, enhanced training in integrated care and disease education, and designing workflows to support cross-disciplinary practice. PIR developed specialized training in health literacy using the *Teach Back* method, *patient activation*, *motivational interviewing* and *health coaching*. We also examined our workflows to determine if these were efficient and supported integrated care outcomes. Our PTN consultant provided an expert practice review focused exclusively on scheduling, staff roles and functions and improvement opportunities within the integrated primary care delivery. Ultimately PIR published more than a dozen workflows with corresponding training in the areas of pre-visit planning, huddles and morning meetings, high risk registry protocols, standing lab orders and other essential operations within the practice sites.

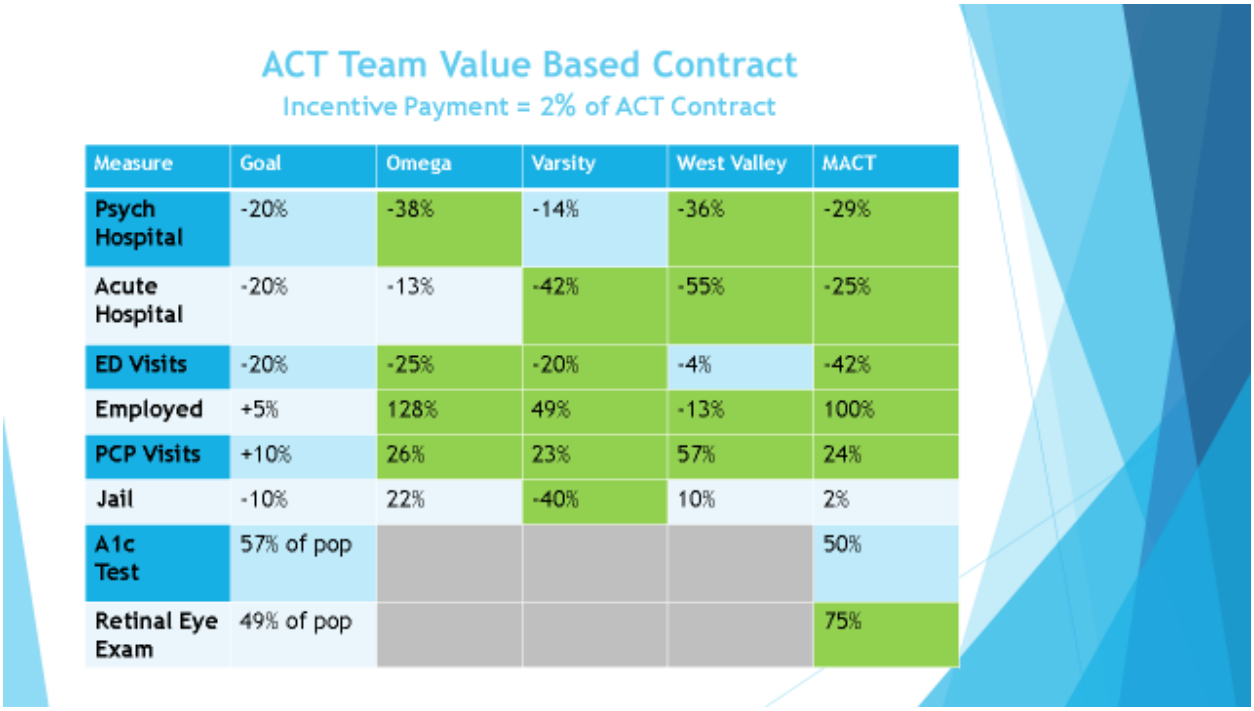
Finally, our approach emphasizes using data to identify clinical interventions and improvement opportunities. These can encompass initiatives to close gaps in care, address over-utilization or improvement in health care outcomes and costs. As we track data, we find some individuals simply need

better coordination between primary care and behavioral health. For others, basic unmet needs were a source of over- or inappropriate ED utilization. For instance, in Arizona, some homeless individuals use the ED as a place to cool off 24 hours a day. For others, without adequate transportation, the ED is the closest medical facility and serves as their impromptu "health home."

Consequently, our data-driven processes have enabled us to be successful in key outcome domains: (1) reducing avoidable emergency department visits; (2) clinically intervene with high risk members to reduce overall system costs on both a Total Cost and Per Member Per Month basis; (3) developing a service delivery model that is responsive to and respectful of the unique needs of patients with multiple, chronic co-morbidities exacerbated by severe mental illnesses.

While PIR has made some significant progress through our participation in the Arizona PTN, we recognize that practice transformation is a journey, not a destination. One key lesson we've learned is the need to seek improvement opportunities on an on-going basis, use data to measure your improvements, and ensure your payer is aware of your successes. PIR was able to earn a value-based contract bonus due to improvements in ED and inpatient utilization driven by our high-risk registry process (Table 6).

Table 6. ACT Team Value Based Contract



Measure	Goal	Omega	Varsity	West Valley	MACT
Psych Hospital	-20%	-38%	-14%	-36%	-29%
Acute Hospital	-20%	-13%	-42%	-55%	-25%
ED Visits	-20%	-25%	-20%	-4%	-42%
Employed	+5%	128%	49%	-13%	100%
PCP Visits	+10%	26%	23%	57%	24%
Jail	-10%	22%	-40%	10%	2%
A1c Test	57% of pop				50%
Retinal Eye Exam	49% of pop				75%

Partners in Recovery *is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.*

As of April 2019, Partners in Recovery has completed the 5 Phases of Transformation.

Practice Innovation Institute
Engage. Transform. Reward.