Practice Innovation Institute


Exemplary Work by
Arizona’s Practice Transformation Network
Thank you for being a part of the Practice Innovation Institute (Pii). Utilizing funds granted to us by the Centers for Medicare & Medicaid Services (CMS) under the Transforming Clinical Practice Initiative (TCPi), we were able to establish Pii to assist Arizona clinicians in developing innovations in clinical practice and care delivery in order to prepare for successful participation in value-based, alternative payment programs.

During the four-year grant program, we were able to provide countless hours of no-cost technical assistance to our participants and to strive for the bold AIMs set forth by CMS nationally for TCPi including:

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled

Thanks to all involved, we were able to achieve, and in most cases exceed, our commitments.

We hope that those participating in Pii learned useful information about transforming your practice, gained skills in population health management, improved outcomes for your patients, and as important, have had the chance to experience some joy as part of your vital work. We hope that these experiences will strengthen the clinician community and increase success in participation of value-based contracting.

Thank you for choosing to be part of the Practice Innovation Institute!

Sincerely,

Stacey Rochman
Pii Program Director

Jenn Barrett
Director, Physician Organizations & Relations
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Pii Overview

The Practice Innovation Institute (Pii) is Arizona’s Practice Transformation Network (PTN) under the Center for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI). In 2015, Health Current, Arizona’s health information exchange, was awarded a four-year grant under the TCPI program, and in collaboration with Mercy Care, Pii was formed.

Pii is a peer-based learning network designed to coach, mentor, and assist clinicians and their practice staff in developing core competencies specific to practice transformation. This approach allowed practices to become actively engaged in their transformation and ensured collaboration across a broad community of practices, thereby creating, promoting, and sustaining learning and improvement across the health care system.

Pii is comprised of 435 practices which represent several areas across the care spectrum including Federally Qualified Health Centers (FQHCs), behavioral health providers, integrated care clinics, and other primary and specialty services.

Crucial to the transformation that occurred was the support to practices, by the practice transformation consultants, educational webinars and consultation on quality improvement projects as well as providing technical support such as access to the HIE. As a result of the efforts, we can claim the following about Pii practices:

- Pii practices demonstrate quality improvement processes that far exceed typical practice environments and have implemented evidence-based sustainable solutions that benefit the patient and payer
- Pii Practices have received education on management protocols and have integrated targeted approaches for outreach to address high risk patients, outstanding screenings, and other care needs
- Pii Practices have implemented Patient and Family Engagement metrics
- Pii Practices have integrated Health Information Technology into their workflow including connectivity to Health Current

Before the end of the grant period, Pii was able to claim achieving all program commitments.
The use of Health Current, Arizona’s health information exchange (HIE), provides our practices with a more complete and timely view of a patient’s medical history which allows for the right care to be provided at the right time. Health Current integrates physical and behavioral health information and helps providers integrate health information with the delivery of care to improve individual and community wellbeing. Health Current’s services include portal access to the HIE, real-time Alerts, which are the delivery of information on hospital admissions, discharges, or transfers (ADTs) on groups of patients that have been identified as needing to be followed closely, Direct Email which allows for secure communication, data exchange, and clinical summaries. The State’s Controlled Substances PMP database can also be accessed through Health Current. By providing actionable data, Health Current enables better clinical decisions and care coordination.

Evidence of our PTN’s success is shown in our progress towards our commitments. Reductions in unnecessary testing and procedures, emergency department, inpatient hospitalizations, and overall healthcare costs, along with improvements to overall health outcomes have been credited to utilization of information made accessible by Health Current.

Pii participant Horizon Health and Wellness attributes the use of Health Current to reducing hospital utilization. Serving a patient base of 12,000 with over 600 staff members, Horizon Health and Wellness offers mental health, behavioral health, and primary care services at multiple locations in Arizona. To address high hospital utilization, Horizon Health and Wellness identified 30 of their top utilizers (those frequenting the hospital an average of three times or more a month). Using Alerts from Health Current, they developed a successful three-part strategy to decrease visits. First, they designated one person to receive and process all Alerts received from Health Current, forwarding patients’ information to specific case managers who could then follow up with the patient. Second, they developed an education pamphlet to better inform patients about the appropriate care to seek from the hospital ED versus other alternatives for care. The pamphlet also provides information on the services that Horizon Health and Wellness provides for each of their various locations. Third, they focused on the needs of their seriously mentally ill (SMI) population, providing more weekend hours and encouraging them to come in without an appointment.

The results have been very positive. Not only did they improve service and outcomes for their high-needs patients, they were able to reduce hospital emergency and inpatient visits. By receiving Alerts from Health Current on hospital admissions and discharges, their strategy that focused on these top utilizers saw the average number of visits to the hospital fall from 3.1 to 1.5 visits per month.

“… shocked to learn how many of our patients were spending so much time in the hospitals.”

Dr. Fred Karst
Horizon Health and Wellness COO
Additionally, Horizon Health and Wellness has seen a **reduction in unnecessary tests and procedures**. An example of this was an elderly woman who came into the facility and needed blood work. As the staff faced a difficult time finding a vein for blood draw, the practice remembered the information needed could be obtained through Health Current. By using the portal, the practice was able to access hospital records from the previous day that included results on the desired blood work.

**North Country HealthCare**, a federally funded health center in northern Arizona providing a range of health services including primary care, obstetrics and gynecology, pediatrics, and behavioral health, acknowledges that use of Health Current services allows them to deliver services “in the right place at the right time” which has assisted in helping patients avoid readmission and to improve health outcomes.

North Country Healthcare Leverages Alerts received from Health Current and directs them to care managers assigned to the patients on their panels. Alerts are received daily at 8am regarding any discharges that have occurred within the previous 24 hours, and care managers ensure that clinic providers have the latest information to see which patients are complex or have a higher risk of readmission so they can be seen first. The Alerts are typically used as a trigger to start a series of follow ups that make patient-provider time more valuable, and this enhanced transition of care ensures that once a patient leaves the hospital, they are ready to resume care at their primary care facility. This enhanced transition of care period is critical especially for high risk patients with multiple problems that could lead to hospital readmissions and/or further medical problems.

In a particular example, a care manager that was advised of a discharge by an Alert was quickly able to realize that the patient had cardiac issues. By early involvement of the care manager, and proper referral to a cardiologist, a hospital readmission was avoided, and health outcomes were improved.

**Southwest Network**, a nonprofit charitable organization that serves emotionally disturbed children and SMI adults in Maricopa County, Arizona, has seen many positive benefits through their connection with Health Current. **Avoiding duplicate testing**, specifically lab work, is a good thing especially with the population seen by Southwest Network. By being able to access Health Current’s portal to check for lab work results, traumatic patient blood draws can often be avoided. Additionally, Southwest Network is able to identify medications already prescribed to their patients by viewing the information in the portal.

Another benefit that Southwest Network has realized from their use of Health Current includes locating members who are not currently engaged or re-engaging them in their behavioral health services. Additionally, they are able to identify new or existing medical conditions of their members, such as pregnancy, and tailoring their services to support the health of the whole individual leading to improved health outcomes.

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**Lori Pearlmutter**
North Country Quality Manager

“The HIE is such a beneficial system that has helped our team receive the most efficient information we have ever seen. From Alerts, to the follow-ups, all of the data has become more valuable and allows us to provide better care”

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**Danielle Griffith**
Southwest Network Corporate Compliance Director

“As soon as we know we have a member who has been hospitalized, we can contact the hospital and any involved family members to initiate the discharge planning, which helps prevent re-hospitalization”
Pii Honor Roll

The following Pii organizations have completed all 5 Phases of Transformation as part of the CMS Transforming Clinical Practice Initiative:

- A New Leaf
- Agave Pediatrics
- Arizona Otolaryngology Consultants
- Arizona’s Children Association
- Bayless Integrated Healthcare
- Biltmore Ear Nose & Throat
- Catalina Pointe Arthritis & Rheumatology Specialists
- Chicanos Por La Causa
- Children’s Clinics
- Circle the City
- Community Bridges
- Community Medical Services
- Community Partners Inc
- Comprehensive Health Center
- ConnectionsAZ
- Crazy About Kids Pulmonary Services
- Crisis Preparation and Recovery
- Desert Senita Community Health Center
- Desert Shores
- Desert Sun Pediatrics
- DMG – Children’s Rehabilitative Services
- GB Family Care
- Horizon Health and Wellness
- Jewish Family & Children’s Service
- La Frontera EMPACT
- Lifewell
- Marc Community Resources
- Maricopa County Correctional Health Service
- MomDoc
- Mountain Park Health Center
- MVP Kids Care
- Native Health
- Neuromuscular Clinic and Research Center
- North Country HealthCare
- Open Hearts Family Wellness
- OrthoArizona
- Partners in Recovery
- Pediatrics of Queen Creek
- Pendleton Pediatrics
- Phoenix Children’s Medical Group
- Phoenix Medical Group
- Piller Child Development
- Pulmonary Consultants
- Pulmonary Institute of Arizona
- Relieve Allergy Asthma & Hives
- Resilient Health
- RI International
- San Tan Allergy & Asthma
- Southwest Behavioral Health & Services
- Southwest Network
- St. Elizabeth’s Health Center
- Sun Life Family Health Center
- Sunset Community Health Center
- Terros Health
- Touchstone Health Services
- True Care MD
- Valle del Sol
- Wesley Community & Health Centers
Pii Plaque Presentations

In recognition of Pii organizations completing the 5 Phases of Transformation, plaques were presented, and the accomplishments celebrated. To follow are pictures from some of those presentations.
Emerging Patient and Family Engagement (PFE) Story

The leadership of CMS’ Transforming Clinical Practice Initiative (TCPI) recognized RI International for their excellence in Person and Family Engagement. To follow is their Emerging Patient and Family Engagement Story....

RI International

In what way were persons, family, and community members involved in the implementation of this PFE intervention/program?

- Surveyed
- Informal interviews/ad hoc feedback
- Patient/Family member suggestions

When were patients involved in the implementation of this PFE intervention/program?

- During the planning stages of the intervention
- Patients were involved from design through evaluation
- Peers (people with lived experience defined as having received prior mental health or behavioral health treatment) were members of the design team.

PFE Metrics and Concepts that were integrated into Plan-Do-Study-Act (PDSA) effort:

- Metric 1. Person & Family Voices in Governance & Operational Decision-Making
- Metric 2. Shared Decision-Making

Patient and Family Engagement Concepts:

- Listen to Person and Family Voice
- Respect Values and Preferences
- Collaborate with Persons and Families

PLAN

RI International is an organization that offers services in crisis, health, recovery and consulting. The crisis program in Peoria, AZ is a Recovery Response Center (RRC) and is a Crisis Stabilization Program. The program served 5,300 individuals in 2017 with 81% of those served in the facility arriving in the back of a police car. The practice identified having a problem with the intake of patients who were in crisis brought in by the police and developed a project to address.

Fundamental to this project was the input from peers. Peers bring lived experience to the workplace and the members they interact with. RI International has employed persons with lived experience at all levels of the organization for many years. Additionally, RI International has 116 team members on the RRC units and 35% are in peer roles. As a company, approximately half of the employees have lived experience.

This performance improvement project was initially started in 2014 and has been conducted in phases.

Phase 1: The first phase, that began in 2014, was largely focused on becoming better partners with law enforcement through a process that started with accepting all law enforcement drop-offs without a screening process. The practice delivered crisis stabilization care and patients who were brought in by law enforcement officers had higher rates of emergency department (ED) visits and incarceration.
This initial step contributed to increasing the number of individuals served and provided diversion from EDs and (2) incarceration.

The practice then worked with staff, clinicians and peers to understand the processes and determined a need to display information. The dashboard design that followed in 2016 then supported improvements in throughput; creating a more efficient resource that lowers cost of care in the behavioral health system by continuously evaluating performance in terms of length of stay, readmission rates, diversion success and metrics viewed as essential to increasing referral volume (which again contributed to diversion from EDs, jails and acute inpatient admissions).

**Phase 2:** In 2018, based on peer and patient feedback, there was increasing awareness that the facility design was not optimal for patient flow and throughput. There was a greater emphasis on the physical environment in a manner that improved the experience of those served in the program in a manner that increases satisfaction, enhances diversion numbers, lowers use of seclusion/restraint, shortens time to stabilization and strengthens relationships in a manner that enhances the connection to ongoing care with outpatient providers (achieved through peer connections). The 2018 project phase was initiated by patient feedback to improve their ability to address the experience of those they serve in their crisis observation/stabilization unit. The practice had high volume demands, high rates of seclusion and restraint incidents, high average lengths of stay and readmission rates and sought to increase the number of individuals served, guest satisfaction and conversion rates of involuntary commitments to voluntary treatment. See table 1 for baseline and post data.

To summarize, the intervention was a two phase plan: 1) design and implementation of the practice that included CrisisTeach360 dashboard that provides data to the practice and 2) facility redesign based on feedback from peers, patients and the clinical teams, as well as re-design the facility by getting input from peers (workforce of Peer Support Specialists who transform their past experiences into healing for others).

Phase 1 was informed member and stakeholder feedback that drove a collaboration with Behavioral Health Link to design the dashboards. Phase 2 was largely designed by feedback received from those directly receiving services at the site, their family members and RI team members, including peers with lived experience.

**DO**
RI International partnered in the design of the CrisisTech360 Dashboard that offers real-time and monthly data views to support the evaluation of progress in addressing these metrics. Additionally, facility redesign efforts were informed by peers on the service delivery team (approximately ¼ of those working in the program) and those who were actually receiving services at the facility.

**How was the change managed internally? (staffing, training, etc.)**
RI’s planning team is comprised of leadership, the direct care team, individuals receiving services and peers working for RI that fall into all these categories. RI’s planning team reviewed baseline data of care delivered to individuals who are in a mental health crisis and typically brought in via law enforcement drop off. The baseline included longer lengths of stay, fewer law enforcement diversions that resulted in incarcerations and emergency room boarding, and higher rates of seclusion and restraint.

The team identified opportunities to improve throughput and the patient experience by engaging in the two phased approach to quality improvement.

The program has two phases:
Phase 1: Dashboard development and training to improve throughput and crisis stabilization

The initial dashboard design was geared towards effort to increase efficiency in a manner that lowers cost of care. Metrics such as law enforcement drop-off time and % referred by law enforcement were put in place to measure how successful efforts were to partner in a manner that increases diversion from EDs and jail in a manner that also translates into serving more individuals with the existing resource, therefore lowering cost of care. Length of stay, readmission rates and diversion from higher levels of care were also important to efforts to truly lower the cost of care while also pointing towards better health outcomes. The inclusion of seclusion and restraint numbers and total number served have furthered that effort. Although the initial design did not include a formal process of gather input from individuals served in the crisis facility, it was informed by peers on the team with 50% of RI’s team reporting their own lived experience. Dashboard redesign efforts are currently underway to incorporate satisfaction data and a balanced facility performance metric based on feedback received during the 2018 quality improvement efforts that have been informed by those served by the program.

Using member and stakeholder feedback, RI designed a dashboard to measure and drive performance and improvement around law enforcement engagement, lengths of stay, utilization, the use of seclusion and restraint and readmission rates.

The dashboard provides a view of real time occupancy, length of stay, percentage referred by law enforcement, and high acuity members. The dashboard also offers monthly views of readmission rates, census count, and diversion from acute inpatient, seclusion and restraint and hand off time. The CT360 dashboard view that follows represents the 30 day look back at (1) occupancy rate, (2) performance related to target length of stay for the program, (3) number served, (4) % of individuals served that were discretionary law enforcement referrals, (5) % of individuals who escalated to a higher level of care, (6) readmission rate, (7) seclusion and restraint volume and (8) average time for law enforcement drop-off in minutes.

![Dashboard Image]

Staff and peers underwent training on the use of the dashboards to help facilitate the disposition of patients who were in crisis. Staff and peers collected patient feedback and measured performance in defined metrics while also evaluating alternative metrics for inclusion in future dashboard designs.

Phase 2: Facility Design - to enhance the patient experience
RI International engaged in a comprehensive campaign to change the way services were delivered on the unit; emphasizing an engaging approach to meet the unique needs of individuals in a mental health crisis who typically arrive via law enforcement drop-off. Every employee, including peers (those with lived experience), attended a live training and monthly meetings around progress continue. Employee safety surveys have been taken and staffing ratios were increased to address the need for higher flow with the limited number of chairs/beds.

Facility redesign activities that have already been completed include changing colors on the unit, moving observation chairs into conversational layouts, added tables and chairs throughout the facility, offered ongoing group services, incorporated murals throughout the facility and redesigned space to offer additional private space for members.

Efforts are underway to expand the space based on additional feedback from those served in the program as well as the staff and peers. Expansion will include a smaller separate six chair space for individuals with high acuity needs; reducing disruption to others and supporting more focused care for those with needs for this alternative environment. RI International has not asked for any capital support in making these programmatic changes designed to improve care while lowering overall health care costs.

The design of the existing space is largely completed with the last phase of construction is scheduled to begin in October 2018, leading to the addition of a high acuity area with 5 crisis stabilization chairs and an additional seclusion and restraint room. The program is adding a direct door from the law enforcement drop-off area to the existing seclusion and restraint room to minimize unit disruption during drop-offs that require these types of interventions. Construction is scheduled for completion in December 2018.

**What barriers did the staff identify and how did they address them?**

The physical environment met licensure expectations for space demands but was not necessarily conducive to delivering care that aligns with the exceptional practice standard of retreat or living room “home-like” environments. RI did have to lower the total number of chairs to create the desired environment and to also align with Joint Commission expectations that there be no more than 8 people in an environment in which the person might sleep as part of their 23-hour service delivery period. Length of stay was impacted by duration of time needed to engage and the modified environment immediately influenced outcomes in that area, but the current lack of a separate high acuity area does mean that an escalated guest may adversely impact the experience of others on the unit. Expansion of the facility is pending approval by the city and then licensure.

**STUDY**

Early returns from the implementation of the dashboard resulted in decreases in length of stay which escalated program capacity to serve more individuals in the program. These higher numbers were able to be served despite escalation in the acuity of those served by the facility that has been quantified by the percentage and overall number of individuals arriving via law enforcement drop-off.

The table below represents the programs increased ability to serve more individuals and a significant escalation of in the numbers of individuals being diverted from law enforcement alternatives of emergency department drop off or incarceration. Law enforcement has been able to drop off an additional 2,050 individuals, which is a 91% increase over a 3-year period. RI has increased the number of members served by 35% over this same period.
In addition to supporting RI’s ability to measure and evaluate performance through the dashboard, as a funder, Mercy Care has access to this data as well. Phase 2 activities resulted in the following:

1. Reducing the number of observation chairs in the open area of the facility from 15 to 8 (17 additional chairs are located in rooms that contain no more than 2 chairs each);
2. Rearranged chairs from rows facing a single direction to conversational style arrangements;
3. Added more tables and chairs to support interaction / engagement;
4. Painted the walls based on colors recommended by peers;
5. Added murals with themes identified by those receiving services on the unit at the time that were painted by peers; and
6. Offer interactive group support opportunities throughout the day.

What key goals or measures did the practice meet?

- Increased the number of law enforcement drop-offs at the facility by 91% from 2014 to 2017;
- Increased the number of individuals in mental health crisis served in the facility by 35% from 2014 to 2017;
- Following changes to the facility that began on February 1st, 2018 and continue today, there has been a 29% decrease in the average number of monthly seclusion and restraint incidents with only one month out of the previous seven having 35 or fewer incidents while five of the six months since the change have been below this threshold; and
- Dramatically improved Joint Commission safety and quality review performance with only one finding during the last one site review that was resolved before the reviewer left the facility.
**ACT**

RI international is also focused on achieving additional outcomes that are more difficult to quantify but important to monitor with the best available resources. These include diversion success. 50% of those who arrived by law enforcement arrive as discretionary drop-offs, representing individuals who would otherwise be referred to emergency departments or incarcerated for misdemeanor offenses. Over the past four years, RI International has accepted approximately 12,000 law enforcement referrals without a refusal. This translates into true cost savings to the healthcare system, particularly when one considers the two-day average length of stay in the adjacent subacute facility that has a lower per diem rate than the AZ Medicaid published rate for a psychiatric hospital bed. Therefore, cost savings can be calculated within the following factors:

- No cost on healthcare system for transport by law enforcement ($316 Medicaid transport rate);
- Low demand on law enforcement with average drop-off time under three minutes (justice system savings);
- 96% of individuals served did not require referral to ED for medical clearance (average cost estimated at $1,233);
- Lower per diem rate in subacute than psychiatric hospital; and
- Lower average length of stay (two days) than typical psychiatric hospital which is estimated to be at nine days despite high acuity served by RI International (81% were law enforcement transported).

**How did Pii support the successful outcome?**

The Pii team continues to be a source of support for the RI International team. Regular discussions are held to review approaches to better using data and alternative ways of evaluating success around larger system outcomes when data may not be readily available. Pii has also helped by informing future service delivery design in our Peoria campus of care that will soon add a non-IMD 16 bed unit and an integrated outpatient program. The driving force behind this addition has been data showing that RI International serves approximately 150 Medicaid enrolled members each month who are not currently engaged by an outpatient treatment provider and often have co-morbid physical health conditions that are not being addressed.

**How/Can the workflows, project plans, etc. be scaled up, utilized by other practices or otherwise drive further change – in the same practice and among others?**

RI international continues its development of tools to support crisis system design and evaluation to better serve members and makes information broadly available through posting in NASMHPD’s [www.crisisnow.com](http://www.crisisnow.com) website. RI International has published documents, presented with Arizona’s Medicaid Director on two occasions nationally, posted business case videos and shared system analytic tools that support efficient design of crisis services based on community specific data (example below of RI International-developed tools from the Crisis Resource Needs calculator as well as self-assessment resources).

RI International has a continuous improvement process related to infuse patient and family voice into all operations of the organization. For instance, RI Internal employees peer with lived experience in all settings and at all levels of the organization including leadership. Additionally, surveys are conducted to infuse personal preference and choice into all areas of operation. Survey’s responses are tracked, and trends are identified.
PFE Intervention Positively Affected a TCPI Aim - Which of the TCPI Aims were positively affected

- Practice Transformation
- Effective Solutions Moving to Scale
- Reduced Avoidable Hospitalization or Emergency Room Usage
- Reduced Costs
- Documented Value

PTN Assistance:
RI International has been commitment to Patient and Family Engagement initiatives for many years. They pioneered the value of employing members with lived experience. The TCPI PFE milestones around PFE reiterated the great work already going on with peers and families however, RI International is always ready to raise the bar again. TCPI’s influence was to continue the already on-going conversation at RI International

Through what means did the PTN prompt your practice to strengthen the PFE effort?

- One-on-one coaching
- Peer-to-peer engagement
Pii Exemplary Practices

The following Pii organizations have practices that have been certified to have met Pii’s definition of an Exemplary Practice.

A New Leaf
Agave Pediatrics
Arizona’s Children Association
Bayless Healthcare Group
Bethesda Pediatrics of Queen Creek
Chandler Pediatrics
Chicanos Por La Causa
Children’s Clinics for Rehabilitative Services
Community Bridges, Inc.
Community Medical Services
Community Partners Inc
ConnectionsAZ
Crisis Preparation and Recovery, Inc.
Desert Senita Community Health Center
Desert Shores Pediatrics
Desert Sun Pediatrics
Desert Valley Pediatrics
District Medical Group
GB Family Care
Gilbert Pediatrics
Healing Hearts Pediatrics
Horizon Health and Wellness
Jewish Family and Children’s Services
La Frontera EMPACT
Lifewell Behavioral Wellness
Marc Community Resources
Maricopa County Department of Corrections
Mesa Pediatrics Professional Association
MomDoc
Moon Valley Pediatrics
Mountain Park Health Center
MVP Kids Care
Native Health
North Country HealthCare
North Valley Peds
OrthoArizona
Paradise Pediatrics
Partners in Recovery
Pendleton Pediatrics
Phoenix Children’s Medical Group - PCMG
Phoenix Medical Group
Piller Child Development
Pulmonary Consultants
Resilient Health
RI International
Southwest Behavioral & Health Services
Southwest Network
St. Elizabeth’s Health Center
Sun Life Family Health Center
Sunset Community Health Center
Terros Health
Valle del Sol
Wesley Community and Health Centers

A Pii Exemplary Practice is one that meets the following criteria:
• Practice has met Phase 3 and/or above
• Practice has implemented one of the six PFE metrics
• Practices are performing on one or more of the following TCPI service delivery aims:
  – Health outcomes at benchmark standards
  – Reduction in unnecessary hospitalizations
  – Cost savings to payers
  – Reduction in unnecessary tests and procedures

Performance Summaries from our Exemplary Practices are shared on the following pages
Shining Star Practice

The Practice Innovation Institute (Pii) identified Jewish Family & Children’s Services (JFCS) as being a **Shining Star Practice** based on their exemplary performance while participating in CMS’ Transforming Clinical Practice Initiative (TCPI). To follow is their exemplary Shining Star Story....

**Jewish Family & Children’s Service, LLC**

**Jewish Family & Children’s Service, LLC (JFCS)** is a non-profit organization dedicated to strengthening the community through quality behavioral health social services, and primary medical care to children, families and adults. Through our four healthcare centers, we provide physical and mental health services to over 14k Arizonians, many of which have co-occurring physical and behavioral health needs. Much of our population (63%) is covered by Arizona’s Medicaid program (Arizona Health Care Cost Containment System or “AHCCCS”).

We joined the Practice Innovation Institute (Pii), Arizona’s Practice Transformation Network, in May 2016, completed the 5 Phases of Transformation in September 2018, and have met the Transforming Clinical Practice Initiative (TCPI) definition of “graduated” by joining a Medicaid alternative payment model (APM). Our transformation efforts have led us to achieving success reducing unnecessary hospital and emergency department (ED) use (Aim 3) and reduction of unnecessary healthcare costs (Aim 4).

Leading our efforts is the utilization of a Care Coordination Team. This team provides prompt follow up care after a hospital admission or ED encounter. As part of our processes, we actively use reports from Mercy Care (an AHCCCS health plan), admission, discharge and transfers alerts from Health Current, Arizona’s health information exchange (HIE), and notifications from hospitals to identify patients currently in a hospital or recently discharged. Using the information gathered, we reach out to patients to schedule follow up care with the patient’s assigned care team. Our process has resulted in a decrease in psychiatric hospital admissions within the seriously mentally ill (SMI) population by 45% compared to baseline (see Table 1) and an estimated savings of over $41,000 (based on an average admit cost of $5,761) (see Table 2).

**Table 1. Reduction in Psychiatric Hospital Admissions for SMI Patients**

<table>
<thead>
<tr>
<th>Measured Outcome</th>
<th>Quality Measure</th>
<th>Baseline (Jul 2015-Jun 2016)</th>
<th>Performance (Jan-Dec 2017)</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospitalization Decrease</td>
<td>Decrease in the number of psychiatric hospital admissions per 1,000 members</td>
<td>24.7</td>
<td>13.7</td>
<td>-44.5%</td>
</tr>
</tbody>
</table>

*Information obtained from value-based contract with Mercy Care*
Table 2. Cost Savings Due to Decreasing Psychiatric Hospital Admissions

<table>
<thead>
<tr>
<th>Measured Outcome</th>
<th>Quality Measure</th>
<th>Avoided Admissions</th>
<th>Average Cost/Admission</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospitalization Decrease</td>
<td>Decrease in the number of psychiatric hospital admissions per 1,000 members</td>
<td>7.2</td>
<td>$5,761</td>
<td>$41,536</td>
</tr>
</tbody>
</table>

Information obtained from value-based contract with Mercy Care

Additionally, we have seen an increase in non-SMI members being seen by the clinic for a Behavioral Health Medical Provider (BHMP) appointment within seven days of hospital discharge during the reporting period of October 2016 through September 2017. The percent of members seen within seven days increased by 64% compared to baseline (see Table 3).

Table 3. Follow-up with BHMP within Seven Days of Discharge

<table>
<thead>
<tr>
<th>Measured Outcome</th>
<th>Quality Measure</th>
<th>Baseline (Oct 2015-Sep 2016)</th>
<th>Performance (Oct 2016-Sep 2017)</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Follow-up Care</td>
<td>Percent of members seen by a Behavioral Health Medical Provider within 7 days of discharge</td>
<td>46.1%</td>
<td>75.6%</td>
<td>64.2%</td>
</tr>
</tbody>
</table>

Finally, our efforts have also resulted in reductions in ED visits for our traditional Medicaid (AHCCCS Acute) membership over a 42-month period from October 2015 to March 2019 (see Table 4). Using October 2015 to September 2016 as the baseline year, we saw a 21% reduction in year 1 (October 2016-September 2017), a 10% reduction in year 2 (October 2017-September 2018), and a 37% reduction in year 3 (October 2018-March 2019). Although the October 2017-September 2018 rate was higher than the October 2016-September 2017 rate, it was still lower than baseline and there is an overall downward trend. With the processes put into place, we anticipate seeing continuation of this downward trend.

Table 4. ED Visits/1,000 for AHCCCS Acute Population

Updates to workflows and job responsibilities were made to meet the challenges of both reducing unnecessary hospital use as well as post-hospital visits. Some of the updated tasks included:
• Receipt and review of hospital discharge notifications from the Health Current (HIE)
• Post hospital care outreach calls and scheduling of follow up visits
• Notification of the patient’s care team

Our workflows are consistent at each one of our locations and can be replicated by other integrated care organizations.

During post hospital visits, patients are provided with their care team contact information and are educated on what a true emergency is - when to reach out to their care team and when to go directly to the hospital. Through the education and outreach, we continue to see cost savings and hospital use reduction.

Additionally, **driving high performance is our focus on quality integrated care and engaging the patient and family in all decisions.** Continually reviewing and updating workflows and job responsibilities to meet the needs of those we serve is paramount in the process. We strongly believe that quality is best achieved through an open collaborative process that values input from members, families, employees, practitioners, accrediting and regulatory agencies, community members and funding sources.

Opportunities to improve the health outcomes of members, families and communities are identified through a systematic process of both prospective and retrospective monitoring, evaluating, measuring, and re-measuring. By using reports, tools and notifications to monitor such measures as hospital and ED use, our on-going process allows services to evolve to best meet the needs of members and families.

We engage patient and family voice in all decisions and receive their feedback at each visit through surveys. An example of our responding to a survey, one of our Spanish speaking family members let us know that it took too long in our voicemail to receive a prompt to select to hear the message in Spanish. We took immediate action. By simply moving the option to hear the message in Spanish near the beginning of the message, we met the needs of our Spanish-speaking members and families. JFCS has received many confirmations and thanks for this change.

To further our transformation, we were challenged by our Pii Practice Transformation Consultant (PTC) to create a patient advisory council. We now host a Community Advisory Council (CAC) that includes both adult and youth patients as well as family members with members representing all areas of services provided JFCS. The CAC acts as a subcommittee to the Quality Management Department. Both use input from patient surveys to routinely monitor key performance indicators and gather and share feedback with leadership, staff and members. We envision the CAC having a direct effect on continued quality care for the patients we serve. Following the success of the first few council meetings, we were asked to share with other Pii organizations about putting together a patient advisory council. The “Mini Pii Session” was well attended and our replicable process was well received.

JFCS also attended the TCPI Quality Conference in 2018 during which we shared our transformation story. The round table discussion of the highlights of our exemplary story and transformation successes were well received. We are grateful for the encouragement of Pii and our PTC.

Focusing on quality care and patient and family engagement to lead our transformation, we serve as an outstanding example for other healthcare providers as an organization that does the right thing for the right reason - improving patient service and healthy outcomes in the community we serve. We are proud of the successes already achieved and commit to further our transformation efforts as we strive to meet the needs of the community we serve and to provide value-based care.
A New Leaf Exemplary Practice Performance Summary

A New Leaf achieved success on TCPI Aims 3 and 5 through innovative collaboration with a community partner and adopting an evidence-based protocol for lab monitoring of members prescribed atypical antipsychotic medications. In both interventions, A New Leaf demonstrated innovative prowess in our approach to achieving the aims as defined by TCPI. We leveraged relationships with our community partners and the Health Information Exchange to create successful sustainable solutions.

A New Leaf is a pediatric behavioral health organization that is part of a larger community agency. Our agency was founded in 1971, and promotes the concepts of “growth, hope, change and new beginnings,” (A New Leaf, 2018). Our agency serves a population that includes families in transition from homelessness, domestic violence, and low-income families. We also serve children and families in the foster care system, and children and families in need of counseling, financial literacy and employment support. Last year, A New Leaf served more than 22,000 men, women and children in the community. We provide an array of behavioral health services to children 0-18 on Medicaid including children in the foster care system.

Our agency’s pediatric behavioral health practice serves children and adolescents at two locations with 9 clinicians through outpatient counseling and an after-school program.

A New Leaf’s outpatient counseling is offered at the Dorothy B. Mitchell Counseling Center and the West Valley Behavioral Health Center. The program focuses on strengthening family relationships, helping children to be successful at home and school, developing skills for self-care, management, regulation and sufficiency, addressing and resolving trauma related issues, and promoting health initiatives for the child and family (A New Leaf, 2018). The services include crisis management, cognitive behavior therapy, family counseling, group and individual counseling, and PACTT- Parent and Child Teaming Together Program supports (A New Leaf, 2018).

A New Leaf’s After-School Program support children and adolescents through learning and social activities, behavioral therapies and other life-skill building activities.

Bold Aims in Practice

A New Leaf has addressed unnecessary testing as defined in Aim 5, by sustaining efficient care delivery by implementing protocols to eliminate duplicate testing. We are also committed improving healthcare as defined in Aim 3 by increasing access to care for at-risk members of the population that include pediatric and adolescent participants in the After-School Program. We achieve this through innovative and mutually beneficial collaborations with partners in our medical neighborhood. Specifically, our collaboration with A.T. Still University, as an inter-professional partner to provide preventative health screenings to this underserved population, demonstrates innovation and evidence-based care that is significant and meaningful for this agency.

A New Leaf was challenged by Milestone 2, demonstrating improvement in reducing unnecessary tests. Our practice transformation consultant suggested we panel patients by diagnosis, and further, the medications most commonly prescribed for the identified diagnoses. Our analysis identified the commonly prescribed medications included the atypical antipsychotic class. We worked with our consultant and the Health Information Exchange to create a panel of these patients and applied the evidence-based recommendations for lab monitoring when evaluating lab orders for these members. Our providers were
able to avoid duplicate testing by monitoring the alerts and results received from the HIE and by adhering to the standard protocol for lab testing.

Patients by diagnosis, A New Leaf, 2018

### Comparison of metabolic effects of atypical antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Weight gain</th>
<th>Dyslipidemia</th>
<th>Hyperglycemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>+++</td>
<td>+/0</td>
<td>++</td>
</tr>
<tr>
<td>Risperidone</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Iloperidone*</td>
<td>++</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Paliperidone</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Asonapine*</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Lurasidone*</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
</tbody>
</table>

*+++ = significant; ++ = intermediate; + = low; +/- = low or neutral.

*Limited data or long-term data are not available.

### Recommended monitoring for a patient taking an atypical antipsychotic

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>1 Mo</th>
<th>2 Mo</th>
<th>3 Mo</th>
<th>6 Mo</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body mass index*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HbA1c*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting plasma glucose</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting lipid panel</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Encourage patients to monitor their weight in addition to being weighed at the clinic.

Aim 3: Improving Health Outcomes

**A New Leaf** is partnering with AT Still University’s (ATSU) Center for Resilience in Aging to integrate physical health services into their program by utilizing residents in audiology and occupational therapy to provide screening services to children participating in A New Leaf’s After School Program. The bold aim is to systematically screen patients to rule out that physiological barriers (e.g. hearing loss) are root causes of behavioral health issues. The goal is to improve clinical care and quality and reduce costs. This program launched in October 2017 and was repeated in October 2018. A New Leaf and A.T. Still University had mutual interests in this intervention that included (1) integration of physical medicine with behavioral health, (2) patient and family engagement through education, screening and referral to other community resources, (3) audiological and physical health assessments will create a more comprehensive assessment of the behavioral client, (4) creating an opportunity to expose students (future clinicians) to a model of
inter-professional collaboration, and (5) the collaboration will be the focus of scholarship with ATSU faculty that will be disseminated through publication.

**Preventative Care Screening Intervention**

An interdisciplinary team of stakeholders that included PTN staff as well as leaders and clinicians from both ATSU and A New Leaf participated on the improvement team that developed this new service model. Seven groups of children (28 total) were screened by the doctoral audiology students during the first session. In the participant population there was 1 non-verbal student and 1 Spanish speaking only student. The doctoral students made accommodations to support the needs of these students. For participants that had challenging behavioral concerns, a member of A New Leaf’s care team accompanied the child throughout the screening session. If a child screened positive for possible hearing loss on the active screening test, a second passive screening was conducted on the participant to confirm or rule out findings. In the group of 28 screened, 1 student screened positive for referral to a complete audiological screening for hearing loss. The session lasted two hours, and the audiology team cleared the workspace to allow the physical health screening teams to set up for the second screening. First year doctoral students in the school of osteopathic medicine conducted the second screening under the supervision of two academic physicians attending. Participants entered allowing for 4-6 children to be screened simultaneously at different stations. Children were measured, weighed and BMI calculated before advancing to the otoscopic exam. Temperature, nose and throat exams were conducted at the next station, and heart and lung exams were conducted at the final station. The students recorded their observations on the form, and the attending physician reviewed the results and exited the participant from the screening. At the conclusion, 28 participants were screened. All the participants passed the physical health screening, and none were referred for additional evaluation. The results sheets were returned to A New Leaf, and the assigned case manager was going to contact parents about the findings and materials that would be sent home. Additionally, for the one participant who screened positive for hearing loss in the audiology screening, coordination of care with the PCP and a referral to an audiology specialist would be managed by the case manager.

The 2018 intervention was a measured improvement over the 2017 intervention. In the table below, the rate of referrals resulting from the 2017 intervention reflect audiological screening outcomes.
In 2018, students received more comprehensive preventative screening, including audiological, ear nose and throat, chest and lung exams and BMI assessments.

Sustainable Application of Interprofessional Collaboration

In 2018, providers at all levels are faced with the increasing demand of growing patient panels, clinician burden and burnout. As we prepare the next generation of clinical providers, it is important to drive them away from the silos that define the current healthcare model. Improvement will only come from a model of healthcare the supports interdisciplinary collaboration among providers. The key to this best practice collaborative model will come from preparing tomorrow’s providers through interdisciplinary education. The interprofessional collaboration between A New Leaf and A.T Still University demonstrates how access to care can be improved through partnerships with medical professional educational institutions.

Additionally, the outcomes of the audiological screenings are significant and relevant. In a 2017 report on the costs of unaddressed hearing loss on the global health care system, the World Health Organization concluded hearing loss must be addressed as a public health issue and public health strategies should
address prevention, screening and early intervention of hearing loss (World Health Organization, 2017). Additionally, the WHO conservatively estimates “the cost to the education sector of providing support to children (5–14 years) with unaddressed hearing loss is $3.9 billion. This assumes that only children with at least moderately severe hearing loss (hearing level greater than 50 dB in the better-hearing ear) require educational support” (World Health Organization, 2017).

Given the significance of these findings, it is imperative the clinical community embrace a more cross-disciplinary, integrated approach to management of its patients. In the context of A New Leaf, this means coordinating with other clinical specialists and primary care physicians to provide the comprehensive diagnostic framework through which they could best address the patient’s needs. The collaboration between a behavior health agency and a health professions graduate school provides the dual benefit of screening for the children and clinical training opportunities for the future providers.

References:

Agave Pediatrics Exemplary Practice Performance Summary

**Agave Pediatrics (Agave)** is a multi-provider pediatric practice in Phoenix, Arizona, with five locations serving over 10,000 Medicaid patients. With a mission to provide the best possible pediatric care in the Valley, we believe in the importance of individualized and personalized care and focus on fostering growth and child development. There is nothing more precious to us than the trust of our patients and their parents' faith in us. We believe strongly in the importance of human-to-human contact and experience, preventative medicine and availability to our families.

Our patients are treated as an extension of our family, and we keep patient and family engagement at the center of everything we do. Access to care is also a very important part of the package that we offer. By providing multiple locations, same day sick appointments and the ability to reach an Agave provider around the clock, we have made access to care more manageable for our patients, thereby reaching our goal to reduce the use of the emergency department (ED).

In addition, our partnership with Innovative Care Partners, an accountable care organization (ACO), allows us to access Honor Health's portal to view ED records. Using that information along with other resources and reports available through our electronic health record (EHR), quality reports from contracted health plans, and hospital admission/discharge reports directly from the facilities, we monitor the care our patients receive. We also participate in a secure group texting system with ED physicians and hospitalists at Honor Health. We connect with them to obtain patient information and discuss a plan of care. All of these efforts have led to reduction in ED visits.

Based on Mercy Care claims data for Agave members, we have avoided 549 ED visits for our patients. With an average cost of $450 per visit, the total savings is more than $247,000.

**Mercy Care reduction in ED use:**

<table>
<thead>
<tr>
<th>Year 1 Avoided</th>
<th>Year 2 Avoided</th>
<th>Year 3 Avoided</th>
<th>Q14 Avoided</th>
<th>Total Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>49 visits</td>
<td>62 visits</td>
<td>346 visits</td>
<td>92 visits</td>
<td>549 visits</td>
</tr>
</tbody>
</table>

Involving families in treatment has always been a focus at Agave Pediatrics. It is evident in our policy and procedures for vaccinations. We believe that every child should be vaccinated. However, we continue to see patients whose families feel differently and prefer to not vaccinate or choose to follow a different vaccination schedule. Our workflow requires that we educate families about the need for vaccination at every well child visit, and if they choose not to vaccinate, we have them sign a formal request to forgo vaccination at each visit. We continue to promote vaccines to non-vaccinating families by using a gentle, decisive, and educational approach. Giving parents an opportunity for individual expression of their concerns makes them more open to discussing vaccinations in a safe space. After the discussion, if they still choose not to vaccinate, per the American Academy of Pediatrics (AAP) protocol, we require them to sign the AAP declination form at each visit. With this non-judgmental tactic, we have been able to convince
many families about the importance of vaccines who later turn around and decide to vaccinate their children. We have been able to positively influence many families who otherwise would not have considered vaccinating their children.

The approach is working and proven as we see continued increase in the number of patients that are being vaccinated. In 2017, we vaccinated almost 31,000 children and in 2018 over 34,000.

Working directly with contracted health plans, we take our partnership very seriously in reducing unnecessary hospital use for both inpatient and emergency care and in meeting HEDIS measures. We educate patients at each point of contact by setting expectations during each visit and addressing possible symptoms that may arise. Our providers are available to answer questions to guide parents regarding symptoms and use of ED services through our Triage Service. This safety net, along with the ability to be seen, in office the next day, decreases anxiety in parents and enhances confidence in the Primary Care Physician's office. We make follow-up calls to check on all patients who have called the Triage Service the previous day and offer an appointment if needed.

Another focused area of improvement is the Adolescent Well Care HEDIS measure. With a baseline measure of reaching 36.8% of our members in this age range, we have reached 48.3% as of Q14 of the TCPI grant period. Agave physicians are active participants in the TOPS (Team of Physicians for Students - http://www.aztops.org/) program and participate in the annual screening for adolescents by assisting in providing comprehensive physical screenings, free of charge, to all students participating in interscholastic athletics or allied activities. This focus translates into each of our offices and evidenced in the outcome measure reported by Mercy Care.

Mercy Care improvement in Adolescent Well Care:

<table>
<thead>
<tr>
<th>Measures</th>
<th>AWC</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Denom</td>
<td>Baseline</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
</tr>
<tr>
<td>5.2%</td>
<td>36.8%</td>
</tr>
</tbody>
</table>

Agave Pediatrics was founded on the concept that all children, regardless of circumstance, deserve access to prompt, individualized health care. We believe that we must promote health, prevent illness, and above all protect our most vulnerable - our children. We want to "Grow Healthy Children"! Our commitment to community health and well-being has led to unparalleled expansion, and we are proud to provide care at
five valley locations! At Agave, we understand that there is more to healthcare than treating physical ailments. We create a warm and personal atmosphere with an emphasis on meeting individual and family needs by providing excellent support. Our community outreach and excellence in patient care have led to countless service awards, and we are always looking for opportunities to improve health outcomes in a timely manner. We are here to serve the communities that have long supported us!

In addition to our outstanding pediatric primary care services, we are proud to offer several specialty services including:

- Tongue and lip tie evaluation and management
- Pediatric allergy and immunology
- Infant feeding therapy
- Lactation support
- Pediatric Nephrology
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**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Per 1,000</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Year 1</td>
</tr>
<tr>
<td>ED Visits</td>
<td>1,895</td>
<td>1,648</td>
</tr>
<tr>
<td>IP Admits</td>
<td>632</td>
<td>436</td>
</tr>
</tbody>
</table>
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.
Community Bridges, Inc. (CBI) was incorporated as a private non-profit, 501(c)(3) organization in 1982 and has a 31-year history of providing comprehensive, medically integrated behavioral health programs which include prevention, education and treatment services using cutting edge, nationally recognized treatment models throughout Arizona.

We are one of the largest statewide providers offering fully integrated medical and behavioral health care in 14 communities in Maricopa, Pinal, Gila, Yuma, Navajo, Apache and Cochise Counties. We provide a continuum of care that begins with prevention and continues for individuals and families through crisis and residential services to outpatient treatment and recovery.

During the past four years, CBI has transformed recovery of those we serve holistically and more effectively, by delivering direct physician and nurse practitioner services, both on site and through telemedicine, to each of our service locations throughout Arizona.

CBI operates 29 programs throughout Arizona that are all licensed by the Arizona Department of Health Services Division of Behavioral Health. Our prevention and clinical programs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Early in 2012, CBI received another 3-year accreditation cycle, adding 14 NEW clinical programs to our list of services.

Our Comprehensive Continuum of Care services include:

- Community Outreach & Prevention
- Crisis
- Residential
- Inpatient
- Integrated – Patient Centered Medical Homes

**CBI Demographic and Special Populations:** CBI serves approximately 7,783 patients annually in the outpatient setting (see graph below). Our major outpatient programs include integrated Patient Centered Medical Homes (PCMH), Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Comprehensive Community Health Program (CCHP). The latter three programs cater to special populations who have serious mental illnesses (SMI), criminogenic behavior, high recidivism, or have general mental health and substance use disorders (GMHSU) along with an inability to thrive in a traditional treatment setting.

![Outpatient Program Breakdown, %](Graph 1. Outpatient Programs)
Cost and Utilization

The majority of our patients are insured through the state Medicaid program (AHCCCS) while about 30% are contracted through the Regional Behavioral Health Authority (RBHAs). Approximately 15.4% of our PCMH patients are co-morbid across all three dimensions of physical, mental, and substance use disorders. Around 60% of these co-morbid patients also have at least one social determinant of health associated with their diagnoses. We care for a very high acuity population, and managing cost and utilization are critical components of CBI’s model of care.

Accordingly, our strategic planning aligned with TCPI Bold Aims of Reducing Unnecessary Hospitalizations, both emergency department (ED) visits and hospital readmissions, (Aim 3) and Reduction of Costs (Aim 4). The two graphs below represent a segment of CBI’s total population. The claims-based data is associated with over 1,900 members attributed to CBI. Between Baseline and Year 3, ED visit trend decreased by a margin of 32.5%. Similarly, between Year 1 and Year 3, Cost Savings increased by a margin of 174%.

Graph 3. Emergency Department Visits

Our transformation initiatives also had a positive effect on our inpatient admissions. We decreased inpatient visits by a margin of 14.6% between Baseline and Year 3. Overall, we had $5.1 million in Cost Savings over those 3 years.
Community Bridges recognizes the importance of comprehensive, collaborative health and has adopted evidence-based models to care for the high acuity – high needs patients. CBI has three FACT and ACT teams, as well as a CCHP team that primarily serves the GMHSU population. Unnecessary use of crisis systems and hospitals, and high recidivism leads to duplication in efforts and costs the system millions of dollars annually. Additionally, it is important to note that the traditional treatment settings do not serve this population well as evidenced by lack of improvement in their health outcomes over time.

- FACT and ACT teams have value-based contracts with the Mercy Care/RBHA that incentivize patient outcomes such as reduction in unnecessary psychiatric and medical hospitalizations, crisis utilization, homelessness, and increase in employment for the seriously mentally ill (SMI) population.
- CCHP team is contracted with all seven Arizona Complete Care health plans and focus to improve unnecessary hospitalizations, crisis utilization, housing stability, and decrease in substance use for the GMHSU population.
- PCMHs are piloting an incentive-based contract with United Health Care utilizing intensive care coordination for high risk patients.
- Additionally, we identify high risk patients, quarterly, based on internal crisis and inpatient utilization, chronic physical health conditions, and social determinants of health. The internal CBI high risk panel comprises of 1.6% of all PCMH patients and use a combination of intensive case management and care coordination approach.

The graph below illustrates psychiatric hospitalization and utilization for the 13% CCHP segment of our total population.
Person and Family Engagement (PFE): Patient stories, Engagement, and Perspective

“I was able to get in within 24 hours which usually isn’t an option and that really helps see that you do care about me as a person! Thank you.”

“Every time attending, the classes are giving me something positive to go home to think about, mainly myself. I’ll keep coming back.”

“(CBI staff) helped me get my meds cheaper.”

“Life is great thanks to the staff at CBI.”

Community Bridges highly values patient satisfaction and feedback. There are several ways in which we gather patient and family insight to help improve our programs and services in a way that best serves our stakeholders. As a patient-centered medical home, we emphasize the inclusion of patients and their families in developing an integrated treatment plan.

CBI also collects anonymous patient satisfaction surveys on a regular basis. Our survey instrument comprehensively measures satisfaction with regards to access to care, quality of care, cultural competency, and facilities. The aggregate summaries are shared with the Board of Directors, Executive Leadership, and management staff monthly so that appropriate action steps can follow.

CBI also holds monthly F/ACT Family Forums as per evidence-based practice guidelines providing psycho-education and other support as needed. Patients are welcome to come with their natural supports or supports can come alone. The agenda is to review general ideas without addressing specific patient issues or needs, creating an environment of education and milieu of connection. We strive to help community members or natural supports understand what F/ACT teams are, and how to navigate the behavioral health system as well as answer their questions with a focus on decreasing the sense of loneliness or separation. As one of our staff members describe it, “The topics are endless, and the goal is meaningful!”

One of our supportive transitional housing programs for homeless pregnant and parenting women with substance use and behavioral health conditions, Center for Hope, hosts monthly Family Nights where families of the residents join for a night of socializing/counselling.

Additionally, CBI strongly believes in a peer-based recovery model and employs a workforce of individuals who have lived through the process of recovery, an invaluable aspect of our model of care.

One of our staff members share:

Patient presented with Opiate Use Disorder IV, Significant Trauma.

“He came to us very ambivalent, referred by probation and drug court, and had been through residential treatment couple of times previously. He resided at a transitional living facility and completed all levels of treatment. He also completed a job program, got his peer support certificate, transitioned into his own apartment with a roommate, got employment and is now a Program Supervisor. He is doing very well and has maintained sobriety since August 2018 and continues to attend 12 step meetings in the community. He reports managing his symptoms of anxiety and depression by utilizing the coping skills he has learned and gaining the social skills to find support in a large sober community. Oh, and he successfully graduated drug court and probation!!”
Community Bridges is dedicated to moving in the direction in which the healthcare industry steers with their patients’ best interests at heart. This means adopting necessary IT infrastructure, having an integrated health record system, and participating in Arizona’s Health Information Exchange - Health Current. These tools have enabled staff at all levels to use meaningful data to drive change and improve outcomes.

As a result of the Practice Innovation Institute (Pii) initiative, we have done extensive work to build our medical neighborhood to identify specialists that we refer our patients out to on a regular basis, streamlining the referral process and setting expectations with regards to patient information sharing and transition of care. We started tracking hemoglobin A1c testing frequency for our patients with an A1c greater than 7.0% and as a result we now have defined evidence-based testing protocols and are focusing on increasing our testing for diabetes control as per protocol. The Pii workplan has guided CBI’s internal efforts related to disease management, onboarding the Health Information Exchange (HIE) and building systems to measure and track progress.

CBI has also built a comprehensive service system inhouse, providing different levels of care within the same umbrella making it a true health home for its patients. Not only do we offer evidence-based clinical services, we also provide wrap-around services that address our patients’ social determinants of health such as housing and navigation needs. We have done extensive work to build working relationships with several community stakeholders and partnered with local police departments and first responders, justice system, probation, and community-based service providers.

CBI’s leadership recognizes the hard work that the staff put in and rewards with recognitions, continuous training and development, internal hiring, etc. to decrease burnout and increase job satisfaction. This ultimately results in better patient care and outcomes.

Through Quality and Performance Management, Community Bridges strives to sustain our improvement efforts. Our communication structure is setup to include multidisciplinary workgroups that meet regularly to discuss change and improvement, allowing all pertinent departments to share input. CBI also has systems setup to keep all levels of staff engaged, all the way from leadership to frontline staff.

CBI uses data for improvement at all levels –

- High level aggregate data reports at board and executive leadership level to make informed strategic decisions
- Trending data reports and site level dashboards at senior leadership and managerial level to track changes
- Patient-level data at practice level to make actionable changes

CBI is in the process of building out our strategic quality management plan to include routine internal audits and share the findings with appropriate staff to guide improvement efforts. Ongoing trainings and staff development are a big part of CBI culture, playing a huge role in sustaining improvement.
Community Partners Integrated Healthcare Exemplary Practice Performance Summary

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**

![CPIH IP Admit Reduction](image1)

*Data Source: Pii*

**Figure 2: Reductions in ED Visits**

![CPIH ED Visit Reduction](image2)

*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.*
We at Crisis Preparation and Recovery, Inc. (CPR) are an Arizona state licensed, Title XIX certified behavioral health outpatient and crisis services healthcare organization that has been providing innovative, effective, and compassionate service since 1995. We pride ourselves on being a unique and diverse organization that is not only dedicated to helping our members “survive”, but to “thrive”. CPR’s well trained and experienced professionals continue to allow us to meet a variety of needs whether you are an individual in need of our service or an organization that is seeking a partnership with a behavioral health organization.

We offer a variety of services including outpatient counseling, medication management, crisis interventions, SMI evaluations, CISM trainings, and disaster/crisis management consulting. We at CPR partnered with Mesa Fire Department in Arizona to create 3 Medical Mobile Units to answer the low emergency calls and treat patients in Mesa and neighboring Apache Junction. These CCU teams in their beginning were staffed by a paramedic and a CPR clinician that accompanied the Mesa Fire Dept Captain. The CCU team also included a behavioral health specialist that allows the patient to have enhanced patient care and provide mental health care quicker and in the home of the patient in order to enhance the overall quality of care provided to members in need.

The creation of the CCU teams is seen as our way of streamlining the delivery of medical services and reducing the utilization of ED’s in the community. The mission of the CCU is to reduce the number of unnecessary hospital visits, reduce transportation costs and appropriate care in an expedient manner. We strive to provide care efficiently and skip the costly and often timely step of taking patients to the emergency room that can escalate in costs for the patient. Creating an alternative where patients can be seen in the comfort of their homes and provided care by skilled behavioral health professionals is the foundation of community paramedicine in behavioral health and EMS services. We are excited that we have been able to create and sustain a model that provides immediate and appropriate care to members in our community. With the implementation of our CCU team we have seen a diversion rate of 78%.

The Four Directions Integrative Wellness program is another demonstration of our innovative and integrative approach to improve the overall health of our members. Keeping with an integrative model we placed an emphasis on nutrition, physical fitness, and counseling for our members. This approach allows us to continue a consistent focus on patient and family engagement by educating our members on the importance of managing their chronic health issues as well such as diabetes, high cholesterol, high blood pressure and weight. The FDIW is a continuous and ongoing 8-week program that is offered to those interested within our patient population. It is outlined into 3 sections: nutrition, physical fitness and ACT therapy where immediate feedback is received to create ongoing improvements to our program. Improving our patient’s health literacy has led to healthy outcomes on measures that we have targeted and gives patients the empowerment to become more participative in their individual care.

We have also partnered with Cigna to pioneer a referral process that allows primary care physicians the ability to create referrals through one agency. This process has granted us the opportunity to be able to view the electronic system and retrieve key information regarding the patient. We are then able to manage the referral and ensure that contact is made with the patient within twenty-four hours and an appointment created within three days. We have been able to also expand our medical neighborhood in that if the
patient is unable to do intake at one of our locations, they can be seen by another behavioral health agency comparable to ours.

Our success is derived from the buy in from our staff, working alongside like-minded agencies, dedication to enhance the care provided to our community, and grassroots work to receive feedback and respond to it. Each program has had input from a multi-disciplinary approach with a continued focus on the community needs. Empowering each voice has led to the sustainability and growth of each of our programs.

We have been diligent in creating a culture where the patient and family are engaged and empowered. We conduct annual patient satisfaction surveys and have demonstrated that we are committed to making changes and transforming our workflows to meet the needs of our patient population. Patients and families are given a voice and the clinicians and support staff act on that feedback immediately.

At CPR we encourage organizations that are interested in our model to first ensure they have a solid working relationship with the payer. Listen to the need of the moment and find the opportunities to fill in the gaps. Get to know you members and the population that you serve as well as creating and maintain key relationships in the community. Recognize and embrace the village mentality. Our health village is the product of our collaborative effort that at its core is patient centric and person focused care.
Desert Senita Community Health Center Exemplary Practice Performance Summary

Desert Senita Community Health Center (DSCHC) is a Federally Qualified Health Center (FQHC) with three practice sites, located in the rural community of Ajo, Arizona, forty-three miles north of the Mexican border. DSCHC has 12 providers and cares for more than 2,500 people, approximately 75% of the population of Ajo. We live by the mission of providing quality, local, and affordable health care for all, regardless of patients’ ability to pay. Our patient population has health disparities entrenched in a variety of socioeconomic challenges, geographic isolation, and limited access to quality care. More than 33% of our patients live below the federal poverty level and have a high incidence of obesity and diabetes.

As a Patient Centered Medical Home (PCMH), we are committed to providing services that meet the pressing healthcare needs of our community, including preventative, acute, and chronic care for children, adolescent, adult, and elderly patients. There has been growing bodies of evidence not just locally but nationally that supports consistent measurement regarding performance in that it leads to better patient outcomes. DSCHC is dedicated to aims and performance measures that continuously address clinically meaningful, patient centered outcomes that best meet our population needs. One of the strategic priorities of DSCHC is to target diabetes health outcomes as it is impactful to our patient population. Uniform Data Services (UDS) reported a high incidence rate of overweight and obese patients. The highest visits to the clinic were for hypertension and anxiety disorders among adults.

At Desert Senita we recognized that our population included a high proportion of overweight and obese patients, with many adult visits to DSCHC related to hypertension and anxiety disorder. To address these community-wide health challenges, we brought patient community representation to key decision-making roles, including a majority membership on our Board of Directors. Our leadership shaped DSCHC’s response to Ajo’s high rates of obesity and hypertension. Two initiatives came to life through involvement of patients in the Board of Directors and community partners – The Edible Ajo School Yard (EASY) and Bike Ajo.

Our outreach department facilitated the transformation of school grounds into vegetable gardens to create the Edible Ajo School Yard (EASY) program. The program is designed to engage students in focusing on their health and activity through growing produce for the Ajo Unified School District cafeteria. Students in grades pre-k through six participate in in the growth and development of the produce and introducing them to produce that may not be offered in our own home. DSCHC’s dietician and behavioral health providers reinforce the importance of healthy eating and increased activity. In addition to EASY, the behavioral health staff partnered with the Ajo Community Garden to create a healing labyrinth to promote stress reduction, meditation, aromatherapy and “food for the soul.”

Community organizations, including the University of Arizona’s College of Public Health, worked with DSCHC to create this fun, inter-generational activity program. The Bike AJO program provides 40 bikes and helmets that are available to patients and families. Bike AJO provides licensed certified instructors (LCIs) who supervise bike rides for those interested on a regular basis. This program is now in its 3rd year and has expanded into an after school program that has now allowed it to reach both middle and high school students.
The Practice Innovation Institute (Pii) practice transformation consultant (PTC), working with DSCHC, aided in linking the established programs to meaningful clinical outcomes. It has been shown that programs such as these provide an exceptional value to an impoverished, medically underserved community. For example, DSCHC noted a gradual decline in body mass index (BMI) in some age groups since the implementation of the school garden activity. Provider education has been an ongoing continuous effort to teach new providers who are unfamiliar with requirements of FQHC’s to record education at each patient visit. One of our next steps is to formalize our data collection to continue to track BMI, hemoglobin A1C, and weight loss measures.

Children who exercise and eat more fruits, vegetables, and whole grains show health benefits, such as a lower BMI score. Every semester we at Desert Senita hold a “Health Safari” at the school where the staff collects and tracks student’s height and weight. The data from the Health Safari show the number of students in the High Risk for Health Risks category has decreased from 35.1% to 26.3% from spring 2015 to spring 2018. The number of overall students in the Normal Weight category has increased from 43.2% to 53.3% during the same time period. Through optimizing our care team and continuous use of our pre-visit planning tool we have been able to meet our target for BMI in adolescents.

We have begun to research and evaluate a variety of fitness challenges to involve family and community participation. Our Garden Program will be expanded to include healthy cooking class events with traditional community cuisines in mind. The health center will be participating in the Ajo Sustainable Community group to promote diabetes prevention and healthy eating habits, supporting the expansion of our diabetes education program. What makes our public health initiative successful is that it was founded to prevent and educate on the health threat of diabetes and obesity, the staff utilized innovative and practical solutions that best served the patient population and the programs were implemented due to community involvement.
Horizon Health and Wellness Exemplary Practice Performance Summary

**Horizon Health and Wellness (HHW)** successfully targeted and achieved results stemming from evidence-based protocol adoption and interventions intended to affect performance on HEDIS clinical measures, reduce hospitalizations and unnecessary testing.

**Horizon Health and Wellness** is a non-profit 501(c)(3) integrated health care agency licensed by the State of Arizona to provide an array of inpatient, outpatient and residential services in Pinal, Gila, and Yuma Counties as well as habilitation services in the counties of Cochise, La Paz, Maricopa, and Santa Cruz. We offer a full range of mental health services for all ages and stages of life. In addition to behavioral health, we also provide primary care and preventative health services. Our mission is to provide Integrated Health Care that addresses the whole person and promotes wellness using best practices to enhance the quality of life of the individuals, families and communities it serves.

**Horizon Health and Wellness** has thirteen locations and eighteen TCPI enrolled clinicians. We completed and graduated the five phases of transformation on April 26, 2018. We serve a predominantly white, population, with a payer mix trending toward Medicaid as primary for most of its 4500+ UDS eligible reported members. English is the reported primary language for the majority of our membership.

**Horizon Health and Wellness** aggressively targeted improvements on Aims 3, 4 and 5 through adoption of evidence-based protocols for HEDIS and clinical quality measures, interventions that focused on reducing emergency department and inpatient hospital encounters, and processes to reduce duplicate or unnecessary testing. In the table below, we show improvement over the baseline period in the listed eight measures.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Year 1 Change</th>
<th>Year 2 Change</th>
<th>Most Recent 12 Months Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult CT Scans</td>
<td>-29.4%</td>
<td>-52.9%</td>
<td>-47.1%</td>
</tr>
<tr>
<td>Adult Smoking Cessation</td>
<td>142.1%</td>
<td>204.3%</td>
<td>151.0%</td>
</tr>
<tr>
<td>Adolescent Well Child</td>
<td>113.5%</td>
<td>46.7%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>50.0%</td>
<td>36.4%</td>
<td>166.7%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>0.4%</td>
<td>8.3%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>
| Comprehensive Diabetes Care - HbA1c Control | 90.9% | 75.0% | 36.4% | }

Our practice implemented changes to workflows and processes to achieve these improvements, and the interventions are detailed in the **Hospitalization Prevention Initiative** and the **Unnecessary Testing Prevention Initiative**.

The **Hospitalization Prevention Initiative** was implemented starting in August of 2017, with some adjustments in the following months. This initiative targeted all clients in the first 30 days following a hospital discharge. A team of care managers were assigned to provide specific engagement services following a client’s discharge to support the client in ensuring they meet with a medical provider within seven days of discharge and provide additional information, resources and supports to the client that may help the client refrain from readmission and obtain better preventative care. Data demonstrate a downward trend in readmissions and inpatient stays (see Figure 1).
The **Unnecessary Testing Prevention Initiative** was implemented starting in October of 2017 to reconcile all data and more accurately identify clients in need of an A1C test, prior to the data being given to the care manager for follow up with the client and their PCP. At that time our Primary Care Physicians were utilizing the electronic health record E-Clinical Works, and our psychiatrists were utilizing Claimtrak. To collect evidence of all A1C tests for clients diagnosed with diabetes collected by prescribers outside of our agency, our care managers received a daily report from Claimtrak that identified missing test results. The care manager would then review the report, review data from Health Current (Arizona’s health information exchange) and collected the results from the provider’s assigned PCP and enter the data into Claimtrak. If there was no known A1C test in the past 365 days, the care manager would notify the client that they should visit their PCP to have the test ordered and performed. While this process did consider labs ordered by our psychiatrists, and did attempt to collect reports from other prescribers, it was labor intensive and did not use the reporting capabilities of E-Clinical Works and missed much of the test results that were present in E-Clinical Works. As a result, our dataset was incomplete, and several clients were asked to have an A1C test completed unnecessarily. A new report was developed which compared data from Claimtrak, ECW, and Health Current and combined the reports to more accurately reflect if the client needed an A1C test. Because of the new combined report, we identified many more A1C test results and are now able to focus on a much smaller group of clients who have not likely received the test.

*Example: (clients who are diagnosed with a serious mental illness and diabetes) When we looked only at Claimtrak we found that 48 of our 121 clients needed an A1C test. When we considered only ECW and Health Current, we found 35 of the 121 clients needed an A1C test. (See Table 1). However, with the combined reports we determined that only 17 total clients still needed the test. Looking at the reports separately would have resulted in care managers asking 49 of the 121 clients to get an A1C test unnecessarily (see Table 1 and Figure 2).*

**Figure 1. Readmissions and Inpatient Stays by Month**
Table 1. Clients with Diabetes and a Serious Mental Illness – HbA1c Test Needed and Complete by Source

<table>
<thead>
<tr>
<th>Clients diagnosed with Diabetes and a Serious Mental Illness</th>
<th>Claimtrak ONLY</th>
<th>ECW/HC ONLY</th>
<th>Combined Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C test in previous 365 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients Needing A1C test</td>
<td>48</td>
<td>35</td>
<td>17</td>
</tr>
<tr>
<td>Clients with Complete A1C test</td>
<td>73</td>
<td>86</td>
<td>104</td>
</tr>
<tr>
<td>Percent Compliant</td>
<td>60%</td>
<td>71%</td>
<td>86%</td>
</tr>
<tr>
<td>Total Clients in Sample</td>
<td>121</td>
<td>121</td>
<td>121</td>
</tr>
<tr>
<td>Number marked as complete on only 1 report</td>
<td>31</td>
<td>18</td>
<td>49</td>
</tr>
</tbody>
</table>

Exhibit 2 Clients with Diabetes and a Serious Mental Illness – HbA1c Test Needed by Source

Our aggressive adoption of evidence-based protocols has resulted in improvements in clinical outcomes, reduction of unnecessary tests and procedures, and has led healthcare cost savings. We are an exceptional FQHC servicing the needs of our clients by continually improving access to care for rural and at-risk populations.
EMPACT was founded in 1987 by Ilene Dode, Ph.D., with the vision of an agency that could address life threatening behaviors by providing prevention, treatment, and emergency services. EMPACT-Suicide Prevent Center’s original name was Emergency Mobile Pediatric and Adolescent Crisis Team. We were one of the first behavioral health agencies that offered in home counseling services to our community. We have also had our program “Survivors of Suicide” support program since the inception of our agency. At EMPACT-SPC we are proud that we offer comprehensive behavioral health services to children, adults, and families. We continue to be active in our community by providing prevention programs, training, outreach and advocacy. We have also created partnership with local police, fire, schools, places of worship and other agencies to promote a safe and resilient community.

Here at EMPACT-SPC we have established and continue to maintain mobile crisis teams for the community that we serve. Our mobile crisis teams consist of a master level and bachelor level clinicians who are experienced in crisis intervention. Our mobile crisis teams’ objectives are to provide assistance, support and resources to our clients and to those who support them in their time of need. These services are available twenty-four hours a day for the entirety of the year. Services are provided to those who wish to receive these volunteer services.

We have 14 mobile teams that operate out of Tempe, Glendale and San Tan Valley. They respond to approximately 700-900 dispatches a month. They are responsible for creating stabilization of people within the community at a rate of 75%. Mobile crisis teams are critical in de-escalating crisis situations and serve as an important component to our law enforcement and supporting agencies. They empower and advocate for the clients while also evaluating them for life threatening behavior such as suicide and homicide. Mobile teams from EMPACT-SPC are able to make treatment recommendations, transport as necessary and assist law enforcement with life threatening behavior. With this ability we have also seen an impact for patients who have been accused of drug-related crimes by breaking the cycle of addiction and treating the source of the criminal behavior.

Substance abuse is one of the most serious public health crises our nation faces, and Arizona is no exception. The success of our mobile crisis team and other programs within our agency is derived from the vision of our senior leadership and the dedication of our staff. When strategizing a program to implement we ensure that there is a multi-disciplinary approach and that each voice is heard. Communicating and partnering with other agencies with a shared vision has led to a continued effort to provide the necessary resources and outreach our community desperately needs.
It is our mission to create a culture where the patient and those that support them feel empowered to be an integral part of their own individual treatment plan. Each patient voice is instrumental in creating the foundation for continued sustainability for the programs offered in our community.

We remain committed to be a pioneer in behavioral health and an advocate for the community in which we are honored to serve. For organizations that are seeking to offer similar services that we do we encourage you to empower all levels of staff within your agency and seek out opportunities where there is a gap. Ensure that there is a strong partnership with the payer where both parties recognize and embrace the patient voice.
Marc Community Resources, Inc. Exemplary Practice Performance Summary

Marc Community Resources, Inc. (Marc) is a not-for-profit organization located in Mesa, AZ. We have been providing a comprehensive continuum of educational, vocational, daily activities, affordable housing, community living, outpatient services, psychiatric intervention, in-home supports and other related programs for people with intellectual disabilities, developmental delays (ID/DD) and behavioral health challenges since 1957. We serve more than 4,500 individuals and families in pursuing the highest level of independence, based upon individual choice, inclusion and community integration. Additionally, we provide behavioral health services to approximately 3,500 members. The basic demographics of the behavioral health members served include many members who suffer from Seriously Mental Illnesses (SMI) along with members receiving General Mental Health (GMH/SU) services.

Our bold aim is to reduce hospitalizations by focusing on the improvement of social determinants of health (SDOH) for members in the community. Our Community Transition Program (CTP) identifies high risk, high utilization and high cost members transitioning from hospitals into the community. CTP uses an evidenced-based practice known as “critical time intervention” which means providing resources for what the member need when they need it. CTP provides intensive support services aimed to keep members out of the hospital or to ensure they use the lowest levels of care. Our CTP team is led by a clinical director and employs support staff such as Resource Coordinators and Recovery Coaches. A Recovery Coach supports approximately 22 members at any given time.

Social determinants of health drive healthcare outcomes such as admission rates. In response, our CTP team provides multi-faceted interventions to address areas of SDOH such as housing, nutritional assistance, employment assistance, etc. Services are provided primarily by a team of Peers. Our CTP program is designed to place emphasis on community interventions and provide resources at the time of need.

Our CTP is a high value resource because it reduces overall healthcare costs and expenses to the system by serving members in the community and reducing utilization of hospitalizations. Recovery Coaches partner with members to connect them to essential community resources, coordinate doctor visits, promote medication adherence and facilitate the reunification with family or other critical supports. Additionally, Recovery Coaches help secure services and resources for the member to avoid hospitalization.

Through our CTP program, we saw an increase in the percent of patients with ongoing employment support correlated with a decrease in patients being hospitalized in 2018.

<table>
<thead>
<tr>
<th>Ongoing Employment Support</th>
<th>1st Quarter of 2018</th>
<th>2nd Quarter of 2018</th>
<th>3rd Quarter of 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16%</td>
<td>29%</td>
<td>32%</td>
</tr>
</tbody>
</table>
As illustrated in the table above the data demonstrates that we have increased in the percent of members receiving services in the CTP program, with ongoing employment support during 2018, which directly correlates to an improvement in social determinants of health.

We demonstrate positive health outcomes related to SDOH in our Mercy Care Value Based Contracting as evidenced by the following results:

- Mercy Care (Medicaid health plan) data - 2017-July 2018 decrease in psychiatric hospital admissions of 44% (from 47 per 1,000 at baseline to 26 per 1,000). This resulted in an estimated savings of $141,000.
- Decrease the utilization of mobile crisis team services by 51% (from 38 per 1,000 at baseline to 19 per 1,000)
- Maintain the percent of members who remain housed upon move in at 97%
- Increase in the percent of members who contribute to rent from 25% at baseline to 73%

Marc has received multiple awards from the City of Mesa and other community organizations for the exceptional services provided, including the Mercy RISE (Resilience, Innovation, Service and Empowerment) award which spotlights individuals who promote health and wellness, Non-profit of the Year award and ranks 14th in the Arizona Business Journal. We demonstrate high value to payers and members due to the range of services provided. Members experience an integrated and seamless service system.

In summary, we are a high performing agency; we generate value to funders and people served as demonstrated by outcomes the CTP program has achieved. CTP provides an intensive level of support services with the members that go beyond the traditional level of case management. We believe that if we provide resources to improve social determinants of health, when the need is identified, an overall reduction in behaviors associated with high admission rates is observed.
Maricopa County Correctional Health Services
Exemplary Practice Performance Summary

Maricopa County Correctional Health System (MC-CHS) achieved success on TCPI Aim 2 ("Build the evidence base on practice transformation so that effective solutions can be scaled"), Aim 4 ("Reduce unnecessary hospitalizations for 5 million patients") and Aim 5 ("Sustain efficient care delivery by reducing unnecessary testing and procedures"). These successes were achieved using evidence-based protocols like MAT (Medication Assisted Treatment) and Mosaic (intensive, holistic substance use treatment program), as well as through the use of the state health information exchange (HIE) to access clinical records of incarcerated persons to reduce duplication of tests and services, continue care and management of chronic conditions and to provide resources to those with a substance use disorder.

The Maricopa County Jail System is the fifth largest in the country and we book approximately 100,000 individuals each year. MC-CHS provides medical, dental, and mental health services for all individuals incarcerated within the jail system. Totaling 6 jail facilities and operating 9 clinics, we provide care including behavioral health, diet management, discharge planning, follow-up care, lab draws, medication administration, wound care, therapeutic interventions, and specialty clinics for infectious disease, obstetrics, optometry, orthopedics, physical therapy and surgery. Our population is broad and diverse and is defined by the demographics listed below.

- 23% of the individuals in MC-CHS facilities are dealing with chronic care conditions, such as diabetes, hypertension and heart disease
- At any one time, MC-CHS cares for between 30 and 40 pregnant patients
- MC-CHS conducts 400 withdrawal checks daily
- MC-CHS receives over 4,000 healthcare requests monthly
- The male to female ratio is 7 to 1
- The average daily population is 7,500 individuals
- Up to 8.2% of the total daily population are identified with SMI (Serious Mental Illnesses) and approximately another 16% have a significant mental health condition

Maricopa County Correctional Health Services has implemented programs to support improvements on TCPI Aims 2, 4 and 5. Our focus on interventions designed to reduce harm and deaths associated with opioid use not only highlights the evidence-based protocols we use to support the affected population, but also reduces the incidence of overdose resulting in hospitalization or death. Finally, research indicates the interventions we have adopted will result in cost savings in the communities and healthcare systems we serve.

Targeting the Opioid Crisis

Maricopa County Correctional Health Services has focused on harm reduction and death associated with opioid use through the adoption of interventions that improved outcomes for the affected population. This included using the HIE to identify relevant clinical information for persons entering jail and improve on continuity of care, coordination of care with community agencies to transition to MAT and/or residential treatment programs, expansion of Mosaic to include women and men, and adoption of a consent pilot to allow the use of substance abuse data and to better inform the treatment and management of affected members.
MC-CHS uses evidence-based screening and assessment tools to detect history of substance use (including opioid use disorder and substance use disorder). Individuals who started MAT prior to incarceration are permitted to continue their treatment while incarcerated. According to a recent report published in the *Journal of Addiction Medicine*, January 2018, Drs. Moore, Oberleitner, Smith, Maurer and McKee from Yale University reported the following:

“Inmates who were given methadone to treat their opioid dependence while in jail were less likely to be disciplined for bad behavior and more apt to continue their treatment after release, according to a state-funded evaluation of data by Yale School of Medicine researchers. The research, published online in the *Journal of Addiction Medicine*, revealed that inmates who had consistent methadone treatment before, during, and after incarceration were five times less likely to be re-arrested for a felony and 10 times less likely to be charged with a drug offense after release. By 30 days after their release, 41 percent were continuing their treatment in the community, compared to 10 percent of inmates who did not receive methadone in jail. The research also revealed that inmates had lower odds of being re-arrested and returning to jail if they continued treatment with the in-jail methadone provider, in this case the APT Foundation” (Moore, 2018).

MC-CHS introduced the distribution of nasal naloxone to opioid use disorder inmates that are exiting the correctional system in 2017. Since the start of the program, we have provided nasal naloxone education and medication to 995 patients in 2017 and 2,671 patients in 2018 upon their release from incarceration. Education to the inmate includes knowledge of the use of the medication and need to share with trusted family and/or friends upon release for application in case of overdose emergency. As inmates are exiting incarceration and connected to community resources, the education with use of this medication is reinforced by their MAT providers.

This intervention has been demonstrated to be efficacious in reducing opioid overdose death rates in communities where opioid education and naloxone distribution (OEND) was adopted. A 2013 study in Massachusetts found “observational evidence that by training potential bystanders to prevent, recognize and respond to opioid overdoses, OEND is an effective intervention, “ and “opioid overdose death rates were reduced in communities where OEND was implemented” (Walley, et al., 2013).

**People released from jail with Narcan in property at time of release**

<table>
<thead>
<tr>
<th></th>
<th>ESTIMATE 2019</th>
<th>JAN-19</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>995</td>
<td>36</td>
<td>2671</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4380</td>
</tr>
</tbody>
</table>

*Naloxone Distribution, Maricopa County Correctional Health Services, 2017-2019*
The Centers for Disease Control and Prevention reported in the Morbidity and Mortality Weekly Report in 2015,

“Providing naloxone kits to laypersons reduces overdose deaths, is safe, and is cost-effective. U.S. and international health organizations recommend providing naloxone kits to laypersons who might witness an opioid; to patients in substance use treatment programs; to persons leaving prison and jail; and as a component of responsible opioid prescribing” (Eliza Wheeler, 2015).

MC-CHS is also addressing the substance abuse through our Mosaic program. Located in the former “Tent City” in Maricopa Country, participants engage in classes in an air-conditioned dayroom, and are housed in living quarters adjacent to the classroom. Since moving to the new location, we have been able to add an additional 200 people to our Mosaic graduate list. In 2018, our program was the focus of an article that described Mosaic as, “…a seven-week curriculum, focused on the moderate to high risk jail population, teaches participants to deal with past trauma and gives them skills to replace the substance. The overarching goal is to reduce the likelihood they will return to jail” (Office of Communications, Maricopa County Department of Corrections, 2018).

When Mosaic was originally introduced, our program focused on women only, and the program was housed in a dormitory at the women’s jail. In 2016 a report overviewing Mosaic’s beginning stated it “…incorporates the use of gender-informed, evidence-based programming (including Start Now, Parenting Inside Out, and New Freedom curricula) and utilizes materials developed for this population alongside cognitive processing theory-based trauma and resiliency curriculum. To maximize [our] impact, Mosaic serves moderate to high risk women, focusing on individuals with co-occurring high needs, and [we have] developed a risk-needs-responsivity (RNR) model as the program’s foundation” (National Resource Center on Justice Involved Women, 2016). In 2018 the program expanded to include men as well as women. Participants were admitted based on several factors. A moderate – high risk proxy score, which measures risk of recidivism, was a consideration for participation. The table below illustrates the breakdown of MOSAIC participants by proxy score.

![Proxy Scores](proxy_scores_chart)

Additionally, applicants were considered based on a history of substance disorder. In the 2018 Mosaic class, 100% of participants had a history of substance disorder. (See table below)
Other factors considered for admission into the Mosaic program include history of homelessness and direct referral into the program by the legal system, judge or public defender, Adult Probation Department, Correctional Health Services, or patient-inmate request to participate. (See tables below)
Referrals Received

<table>
<thead>
<tr>
<th>Category</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal or Public Defender or Judge (LP/PD)</td>
<td>31</td>
</tr>
<tr>
<td>Patient Requested Participation (HNR)</td>
<td>387</td>
</tr>
<tr>
<td>Correctional Health Services (CHS)</td>
<td>3</td>
</tr>
<tr>
<td>Adult Probation Department (APD)</td>
<td>90</td>
</tr>
</tbody>
</table>

*Referrals Received by Category for Mosaic 2018, Maricopa County Correctional Health Services*

### Reduced Recidivism Rate for Mosaic Participants

Maricopa County-Justice Systems Planning and Information (JSPI) conducted an analysis for MC-CHS of the 2017 Mosaic participant data. Based on an analysis (using a control group) of 549 participants, 365 days post Mosaic release, there was a **20% reduction in recidivism** (return to jail for any reason), a robust reduction especially given the participant selection criteria of both SUD and moderate to high recidivism risk. The control group of 549 participants was comprised of incarcerated individuals who had a moderate to high proxy risk score and had a positive screening result for opioid use or other substance use in their history but did not participate in Mosaic. According to MC-CHS Mental Health Director Dawn Noggle, PhD, CCHP, “Mosaic brings together all the pieces of the individual’s care needs in one program.” Mosaic is a metaphor for the multifactorial components of the program and the multidimensional aspects of the participant’s clinical, behavioral and substance use history, unique personality and care needs. The 2017 recidivism data is extremely encouraging for future applications of this intervention in other correctional settings.

### Improvement Optimized Through Use of the Health Information Exchange

MC-CHS has actively engaged with Health Current to optimize our use of the health information exchange (HIE). Registered users of the HIE can access external clinical records of incarcerated individuals (with consent) to provide the most up-to-date accounting of the member’s needs. This reduces the need for testing for members with chronic conditions like diabetes, hypertension or asthma and permits the member to continue treatment protocols without a gap in care. Additionally, members who had started MAT prior to incarceration are permitted to continue that treatment in jail without losing the progress associated with the prior treatment. The bi-directional interface has a physical health portal and a CFR 42 Part 2 portal (Confidentiality of Substance Abuse Data), and our users have been collecting consents of incarcerated members to coordinate care with community agencies to support the “warm hand off” of members transitioning to MAT program and other clinical providers after exiting the jail system.
MC-CHS staff access the HIE portals manually and downloads patient records as well as uploads consent forms for CFR 42 Part 2 data. The current interface is set up such that we push data to the Part 2 portal once a patient leaves the jail facility. We are in the process of splitting the interface into two sections; physical health and Part 2 data. Patients who participate in the Mosaic program have their data housed in the Part 2 section of the HIE. The remaining patients’ information is placed in the physical health record.

Maricopa County Correctional Health System successfully targeted TCPI Aim 2, Aim 4, and Aim 5. Our success was characterized by using evidence-based protocols like MAT and Mosaic as well as through use of the state health information exchange. We were able to leverage the nasal naloxone distribution program, MAT, and Mosaic interventions to reduce hospitalizations resulting from opioid overdose secondary to substance use disorder. These solutions are effective and scalable to other correctional institutions. Additionally, we have effectively leveraged the HIE to maximize the care experience of incarcerated members to reduce duplicate and unnecessary testing and to provide continuity of care for chronic diseases and MAT therapies initiated outside the institution.

References:
Maricopa Integrated Health System Exemplary Practice Performance Summary

District Medical Group maintains a trusted relationship with Maricopa Integrated Health System and Family Health Centers, providing all physicians and mid-level staffing. DMG Comprehensive Health Center is an active participant of the Practice Innovation Institute (Pii), Arizona’s Practice Transformation Network.

Our organization is composed of a 325 medical bed hospital, a 289 behavioral health bed medical center, two behavioral health facilities, an outpatient specialty center and thirteen family health centers that are Federally Qualified Health Center Look Alike status. Maricopa Integrated Health System (MIHS) is public teaching hospital and safety net system in Phoenix Arizona. We have been serving the community for more than 140 years and have been providing care to over 16,500 inpatients and over 432,600 outpatients annually. We employ over 3,500 health care professionals and have partnership with 770 physicians and other advanced health care providers. We are an urban health care system serving all of Maricopa County. Close to 60% of our population are Medicaid recipients and 20% Medicare. The remaining 20% are uninsured or underinsured.

We are extremely proud of our overall accomplishments, particularly the re-verification as an adult and pediatric burn center by the American Burn Association and the American College of Surgeons, making us the only verified burn center in the state of Arizona and one of 58 verified burn centers nationally. Additionally, all our family health centers received the highest level of recognition from the National Committee for Quality Assurance’s Patient-Centered Medical Home program.

Given our large member population, it was imperative that we addressed the needs of the population as a whole. In line with TCPI overarching project goals and our organizations, both, regulatory and contractual requirements, we committed to building practice transformation on evidence-based solutions and improving health outcomes, ultimately reducing overall healthcare costs. Through such approaches we made significant progress toward system wide performance improvements.

The table below illustrates our continued commitment to quality improvement since 2015. Our FQHC Look-Alikes are part of the overall Healthy Communities Collaborative Network (HCCN). We outperformed other peer organizations in three of the UDS measures: Colorectal Cancer Screening, Dental Sealants, and Diabetes A1C. The improved clinical outcomes within these 3 measures reflect our organization’s goals. The strategy to address the diabetic population, described below, is the process we continue to follow in our continued pursuit for improving the health and clinical outcomes of our population.
Identification of the Problem and Plan for Improvement

Our population health priority focused on managing the high-risk diabetic patient given that 35% of our diabetic patients had poor glycemic control (HbA1C>9) and, furthermore, the implications of developing comorbid conditions. For every 1% reduction in HbA1c, there is a 40% reduction in risk for developing retinal, renal, and neuropathic diseases. Additionally, there is a 40% reduction in risk for developing myocardial infarction. We acknowledged that in order to optimize outcomes, diabetes care needed to be individualized for each patient, taking in consideration the multiple social determinants of health factors affecting our patient population.

Many of our patients have social determinant of health (SDOH) barriers such as access to care, homelessness, and food insecurities. In addition to SDOH, we also have a large population with behavioral health conditions. Many of our patients were not completing their labs or returning for follow up visits. When patients did present to care there were often other pressing issues to address and we missed opportunities to close care gaps. Thus, our efforts to improve population health required a combination of system-level and patient-level approaches.

Once we identified the problem, we researched best practice and assembled a task team that developed a provider-led, patient-centered multi-disciplinary protocol.
• IT developed a bulk ordering system in EPIC that applied
• rule-based logic to generate orders:
  – A1c’s based on clinical guidelines (every 3 or 6 months)
  – Microalbumin if > 1 year since last test
  – Lipid Panel if > 1 year since last lab test
  – Retinal Eye Exam if > 1 year
• Care Coordinators run a monthly report to identify diabetic patients with care gaps
• The orders route to PCP for review and authentication
• Bulk communication is sent to patients to notify them of gaps and request they contact office to schedule appointment to address care gaps.
• Monthly reports identify those patients who have not responded to outreach or scheduled gap closure appointment.
• Additionally, report is generated to identify patients who requested contact via the patient portal (MyChart) but have not read their MyChart message; the team will then conduct follow-up contact via phone or mail.
• Additional support for the initiative is provided by pharmacy, diabetes educator, clinic RN, MA, schedulers, administration and quality.

**Quality Metric results**

In July of 2018, through the Plan, Do, Check, Act process improvement methodology and Situation, Background, Assessment, Recommendation (SBAR) technique, we rolled out our patient-centered diabetes outreach initiative.

By November 2108, we saw an 8% improvement; we were able to reduce uncontrolled A1C’s from 35% in Jan to 28% in Nov. See graph below.
Even more surprising was the unexpected increase in patient adherence.

For Active Patients on DM registry with A1c (9 and above) who had an A1c ordered during the audit quarter:

<table>
<thead>
<tr>
<th>Audit Timeframe</th>
<th>Num/Den</th>
<th>% Test Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Qtr (Jul – Sep 2018)</td>
<td>490/1240</td>
<td>39.5%</td>
</tr>
<tr>
<td>3rd Qtr (Oct – Dec 2018)</td>
<td>1024/1380</td>
<td>74.2%</td>
</tr>
<tr>
<td>1st Qtr. (Jan-Mar, 2019)</td>
<td>766/1032</td>
<td>74.4%</td>
</tr>
<tr>
<td>2nd Qtr. (Apr– June, 2019)</td>
<td>1111/1499</td>
<td>74.0%</td>
</tr>
</tbody>
</table>

We believe this increased adherence is due to our frequent outreaches to the patient to remind them of the importance of following up on gaps in their care as well as discussing outstanding health maintenance items with staff at daily huddles.

Currently we are piloting an Integrated Behavioral Health program in three of our family health centers for patients with two or more chronic health lacking ability to manage their self-care due to life stressors such as anxiety and depression.

The patients are connected to a behavioral health counselor for solution-focused interventions and support such as functional analysis, cognitive behavioral therapy, motivational interviewing and teaching coping mechanisms for emotional wellness. This approach focuses on the whole person, as behavioral health is a major component for both self-management and medical supervision of the chronically ill patient. We are ultimately planning future integration in all our ambulatory care clinics.
MomDoc Exemplary Practice Performance Summary

MomDoc has been caring for women throughout the Phoenix metropolitan for over 40 years. We provide one-of-a-kind contemporary care for women that ensures each woman receives focused, undivided attentive care, and receives dedication and commitment from their provider. We are noticeably different from other practices in the way we greet our patients. Rather than the industry-standard front desk, our patients are welcomed into our Living Room and guided throughout their visit by a MomDoc Concierge (a trained Medical Assistant).

We are well-known for our leadership in the medical community, with our physicians serving in roles like OBGYN Department Chair at various hospitals and even Chiefs of Staff. Our Chief Executive Officer is currently the Chair of the Budget & Government Reform Committee at the Arizona Chamber of Commerce & Industry and is actively involved in many community organizations. Our entire staff is actively involved in community charitable events, participating in March for Babies each year and raising money and awareness for breast cancer research and other notable causes.

At MomDoc we focus on bringing joy to the workplace through several unique programs. In 2017, MomDoc launched MomDoc Learn!, an educational program for personal development of employees. Ten classes were offered throughout the year:

<table>
<thead>
<tr>
<th>1. Leadership</th>
<th>6. The MomDoc Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. MomDoc Culture</td>
<td>7. Workplace Skills</td>
</tr>
<tr>
<td>3. Español</td>
<td>8. Creating Happiness</td>
</tr>
<tr>
<td>4. Personal Finance</td>
<td>9. CPR Certification</td>
</tr>
<tr>
<td>5. Food &amp; Fitness</td>
<td>10. MomDoc 2018 Roadmap to Greatness</td>
</tr>
</tbody>
</table>

Employees were compensated for taking the classes and not only received their hourly pay for the duration of the class, but they also were given a $0.10/hour raise beginning with the paycheck following the completion of the class. (Exempt employees received a $200 bonus for attending)
This program included $224,016 dollars of potential raises. Investing back into our employees.

- 100% of Office Manager/Director retention that attended and took this class.
- Roughly 20% of employees that attended 5 or more classes have been promoted since 2017.
- Those same employees averaged attendance of 75% of classes offered.

The data suggests that attendance correlated with engagement which led to continued investment in the engaged employees. The program was great to identify engaged employees who have been retained since.

MomDoc Learn! evolved into what we still standby today which is ACE.

**A: Accountable.** At least once per day, do something to hold each other accountable for having a positive work environment. When a coworker is complaining about something, ask them to share it directly and privately with the party that the complaint is about. If they feel that does not resolve the issue, ask them to share it directly with someone who has a management role that can address it. Please then go a step further and ask them to share something positive regarding the person or concept that the complaint is about. The exchange of a negative thought for a positive one is a proven technique in improving mental health.

**C: Compliment.** At least once per day, share a genuine compliment with a colleague. Lift their spirits and ours by noticing the wonderful things they do and say and verbalizing it. Complimenting is a great way to improve relationships with those around us and improve our view of them.

**E: Express appreciation.** At least once per day (and hopefully many times per day), express appreciation to someone you work with. Feeling appreciated at work comes from those around us. If we are appreciating each other, regularly sharing our genuine gratitude for the support we give one another, we foster a positive environment and a positive self-image.

At MomDoc we believe that employee satisfaction leads to employee retention, provider satisfaction and ultimately patient satisfaction. Programs such as these, are easily replicable in other organizations at little to know cost. We believe that our employees are our most valuable assets and will continue to engage them and show our appreciation for them through programs such as these.
MVP Kids Care Exemplary Practice Performance Summary

**MVP Kids Care (MVP Kids)** is a multi-provider pediatric practice in Phoenix, Arizona, with three locations serving the West Valley in Maricopa County. MVP Kids has one location with socioeconomic disparities and another site that serves a geographic area with limited pediatric resources. Services are provided with an emphasis on safety and evidence-based practices that reduce costs, eliminate waste, and provide preventative healthcare that focuses on population health.

MVP Kids’ leadership evaluated the practice’s priorities and we identified the following areas of focus to ensure we are achieving bold aims that also align with the TCPI primary drivers:

- **Patient & Family Centered Care Design:**
  - Improve patient and family access
  - Use of electronic health records via patient portals
- **Continuous Data Driven Quality Improvement:**
  - Increase well-child checks
  - Reduce unnecessary emergency department (ED) visits
- **Sustainable Business Operations**
  - Financial sustainability
  - Efficiency of operations (staffing)

During the back-to-school and flu season of 2018, we identified the need to provide open access to appointment availability and we surveyed our staffing ratios to ensure we could deliver care with the increased access to appointments. In order to ensure that the staff were engaged, we had proper resources, and could therefore deliver excellent patient care, we identified the need for several more staffing positions, and we proceeded to fill those positions. These new staffing positions included new providers, nurses, a triage nurse, medical assistants, patient care coordinators, referral specialists, front desk staff, and a quality person to monitor and track system initiatives. We started with a core group of 30 staff members and have now expanded to around 50 staff members. We offer 24/7 call service, our providers have complete access to the EMR after hours, we have added weekend appointments and extended office hours during the week with additional appointment slots, and we make full use of HIE.

Our team leads are tasked with delegating and monitoring their teams with an emphasis placed on working on patient panel reports and high-risk registries. Our staff make approximately 2,400 calls per month to patients paneled to the practice, highlighting those patients needing well child visits and immunizations, in an effort to get patients in for well child visits and immunizations. The first full month of this process began in July 2018. Our clinician saw 1,054 more patients in July 2018 than we saw in July 2017, and July is typically our slowest month (Table 1 shows a comparison of each month side-by-side for the past 3 years; Table 2 demonstrates a steady increase in our patient panels). The month of August resulted in an even larger volume of patients.
Table 1. Comparative Patient Volumes (MVP Kids Care’s internal data)

<table>
<thead>
<tr>
<th>VOLUMES</th>
<th>18-May</th>
<th>17-May</th>
<th>16-May</th>
<th>18-Jun</th>
<th>17-Jun</th>
<th>16-Jun</th>
<th>18-Jul</th>
<th>17-Jul</th>
<th>16-Jul</th>
<th>18-Aug</th>
<th>17-Aug</th>
<th>18-Aug</th>
<th>Yr to Date 2018</th>
<th>Yr to Date 2017</th>
<th>Yr to Date 2016</th>
</tr>
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<tbody>
<tr>
<td>Volume</td>
<td>3705</td>
<td>3605</td>
<td>2822</td>
<td>3382</td>
<td>3091</td>
<td>2833</td>
<td>3782</td>
<td>2731</td>
<td>2807</td>
<td></td>
<td></td>
<td></td>
<td>24256</td>
<td>25088</td>
<td></td>
</tr>
<tr>
<td>Volume MV</td>
<td>845-22%</td>
<td>913-25%</td>
<td>839</td>
<td>807-24%</td>
<td>769-25%</td>
<td>780</td>
<td>875-23%</td>
<td>727-27%</td>
<td>825</td>
<td></td>
<td></td>
<td></td>
<td>6332</td>
<td>7180</td>
<td></td>
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<tr>
<td>Volume LV</td>
<td>458-12%</td>
<td>514-9%</td>
<td>66</td>
<td>448-13%</td>
<td>535-11%</td>
<td>67</td>
<td>451-11%</td>
<td>506-11%</td>
<td>76</td>
<td></td>
<td></td>
<td></td>
<td>2176</td>
<td>362</td>
<td></td>
</tr>
<tr>
<td>Volume AV</td>
<td>2424-63%</td>
<td>2378-66%</td>
<td>1920</td>
<td>2130-63%</td>
<td>1987-64%</td>
<td>1986</td>
<td>2475-65%</td>
<td>1998-62%</td>
<td>3908</td>
<td></td>
<td></td>
<td></td>
<td>15728</td>
<td>15928</td>
<td></td>
</tr>
</tbody>
</table>

*Side-by-side monthly comparison to previous years shows significant increase in volume of patients being seen by MVP Kids (overall volumes listed at top, and then broken down by site location).

Table 2. Number of Mercy Care (Medicaid Health Plan) Patients Attributed to MVP Kids Care

The clinics subsequently implemented the “Slide Up Schedule” that was used during the back-to-school and flu season as a permanent schedule, because it was so effective. This has created an avenue for patient access to our providers and, as a result, we have seen a decrease in the number of patients utilizing the urgent cares and Emergency Rooms (a decline in the use of ED visits is demonstrated in Tables 3 & 4). We also have a patient portal where patients can make appointment requests, increasing access to care for families that prefer to use technology instead of the phone system.

A systematic process has been implemented at all 3 of our locations. Data will continue to be evaluated to determine where improvements can be made and to identify areas of opportunity, and our process can be easily replicated and modeled in other practices.

Table 3. Avoidable ED Visits/1,000 – Emergent, but PCP Treatable (can be treated in a PCP Office) *Mercy Care (Medicaid Health Plan)
Our leadership has implemented a daily patient productivity level that is monitored in weekly productivity reports. The expectation is to have each provider care for at least 22 patients per day. This report is available to all providers and is part of the analytics presented at each provider meeting.

We have made great strides in achieving exemplary practice status by meeting Patient and Family Engagement (PFE) goals and TCPI Aims 2 and 3. By adding new staff, providers, appointment slots, and implementing a Quality Department, our practice has been able to accommodate patients’ needs, increase patient volumes and access to care, as well as simultaneously reducing ED visits. Additionally, the emphasis on the TCPI primary drivers has significantly improved the number of encounters, thus ensuring financial sustainability and success in value-based models. Our model has shown to reduce unnecessary ED visits which reduces costs to all payors as well as paneled members. Our sample of ED visit reduction is based on Mercy Care membership, which have an average cost of $449 per ED visit, which is replicated across all plans we serve. We also utilize the CareQuotient population health tool to monitor improvements across multiple diagnostic groups, utilization reports, and HEDIS measures.
NATIVE HEALTH Exemplary Practice Performance Summary

NATIVE HEALTH is a federally qualified health center (FQHC) located in Phoenix, Arizona that strives to provide the best health care available to urban American Indians, Alaska natives, and other individuals who generally experience barriers to holistic, patient-centered, culturally sensitive health and wellness services. NATIVE HEALTH currently provides a wide range of programs including primary medical, dental, behavioral health, WIC, and community health and wellness programs. Our demographics include approximately 50% Medicaid patients and over 25% uninsured. Our population consists of those often affected by social determinants of health and poverty. We serve everyone, including special populations like urban Indian groups, refugees, migrant workers and the homeless. The practice has 3 sites providing medical, behavioral health and psychiatry services. Two of the sites also provide dental care and one provides perinatal care. We have an additional site providing primary care only. We have approximately 10 medical providers, 3 dental providers, 10 behavioral health providers, 1 psychiatry provider, and part time perinatal providers.

In 2017, our unique patient census for 2017 was between 9-10K patients. A specific difficulty in our population was the management of late stage or progressive pathology, coupled with language barriers and limited access to care, food, and medication. **Our goal was to improve the health of all individuals regardless of age, gender, race or sexual orientation or identity.** Our mission was to address the social issues that obfuscate improvement of our patients’ mental and physical health. Our bold AIMS /performance that makes us a high value practice to payers and patients are **AIM 3 Reduce Unnecessary Hospital Use and AIM 4 Reduce Costs.** While we wanted to and did address all quality measures focused on by our payers, as shared, the most robust improvement is visible is the reduction of emergency department (ED) utilization and hospitalization. This practice was able to demonstrate a:

- 9.4% reduction in ED visits in Year 1 and
- 27.1% reduction in Year 2 compared to baseline. This resulted in an estimated reduction of 360 visits with a cost saving$148,138 in Year 1 and 997 visits and
- $409,941 cost savings in Year 2.

Inpatient admissions,

- Demonstrated a 3.9% reduction in Year 1
- A 29.1% reduction in Year 2 compared to baseline.
- An estimated 36 avoided admissions and $177,356 cost savings in Year 1
- There were 257 admits and $1,265,232 savings in Year 2,

This data was compiled based on attributed analysis of Mercy Care claims data.

To achieve our goals, we used electronic health record (EHR) data, claims data and health information exchange (HIE) data to identify the high-risk population(s) and patients recently discharged from nearby
hospitals. We developed a care management program as a responsibility of Clinical Case Managers, so we could continue to identify high risk patient’s areas of risk. Clinical case managers were supported by a team of individuals at numerous levels of training to overcome staffing limitations, ensure everyone is working at the top of their license and allow outreaching staff to better engage patients. Unfortunately, one challenge we faced was that many patients in our population are transient and phone numbers change frequently so we still missed many patients.

- WIC called newborn parents
- Diabetes educators called diabetics
- Case managers called patients who missed referral appointments
- Nurses called patients that haven’t had mammograms or colonoscopies
- Medical Assistants called patients who have missed labs
- Front desk staff called for appointment reminders and missed appointment rescheduling

A key barrier we identified to improving care was access to mental health providers. One particular example was a patient with diabetes who was uncontrolled who revealed she didn’t take her medications because “she would be better off dead”. **This supported the mission to provide mental health in tandem with physical health services.** As such we enhanced utilization of integrated behavioral health specialists embedded in the medical clinic to provide immediate assessments, intervention, and coordination of care with psychiatry and psychology.

We built on this to **implement interdisciplinary huddles** with mandatory attendance with medical providers and support staff, psychology, psychiatry, integrated behavioral health, dental, and community health and wellness programs. Huddles were used to take a proactive approach to identify high risk patients before the day started so we could coordinate care for patients to be seen by all necessary teams when they present for their appointment. We developed a Certified Diabetic Educator and dietitian program for enhanced patient education on nutrition, as well as glucometer and insulin education. This created better engagement for patients and reduced clinician visit burden.

Our improvement strategies reduced our unfilled appointment rate from approximately 50% to 30%, and improved productivity from 55-60% to 70-90%. These data further demonstrate that this approach to enhanced quality is financially viable in both the short and long term. Throughout the year the Medical Director focused on provider education by writing and giving lectures on up-to-date standards of care for high cost disease states. These lectures were given to staff at all levels of training to improve provider care delivery and support staff outreach. Lecture topics included, but were not limited to: DM2, HTN, HLD, CKD, MI, post stroke, HIV/STI, vaccinations, Breast CA screening, and Colon CA screening.

Another tactic used at NATIVE HEALTH was to **encourage uncontrolled and high-risk patients to have rapid follow up to capitalize on successes of short-term motivation**, so the successes could be maintained. All of our staff participated in the patient follow-up, including the case manager, diabetes educator, community health workers, and clinical staff. Patient successes and setbacks were shared daily at huddles. This rapid follow up also allowed patients to digest information and have clarifications upon follow up, giving the patients the opportunity to validate the accurate and debunk the misinformation that is often found on the internet. Placing a limit on medication refills without follow up also provided an opportunity to identify patients whose disease control was degrading between refills.
Additionally, our patients have numerous financial limitations and barriers that affect access to care and medication. Our Medical Director approached partners in industry to provide educational material for staff, get copay assistance cards, as well as other patient assistance tools. Additionally, discounted rates were negotiated with imaging and lab facilities to reduce the cost of imaging and labs affecting cash pay patients and patients with high deductible plans. To further enhance care, we began the process to start a 340b pharmacy program for discounts for our uninsured.

In summary, to improve patient care and outcomes NATIVE HEALTH implemented interdisciplinary huddles, care coordination, utilization of health IT, open access and same day scheduling, provider engagement and empowerment, and additional programs for patient education which together yielded a meaningful improvement in patients’ lives and healthcare costs. Each item is the embodiment of countless hours of work. These improvements are due to the staff working together to provide the best quality of care to the patients served.
North Country HealthCare Exemplary Practice Performance Summary

North Country HealthCare (NCHCAZ) is a federally qualified community health center that provides high-quality, comprehensive medical services in 14 communities throughout Northern Arizona. Dedicated to improving the health and well-being of our patients and communities, we offer a variety of services such as family medicine, obstetrics and gynecology, pediatrics, dental care, behavioral health services, telemedicine, health screenings, and more.

Our primary care offices are strategically located in medically underserved rural areas and near major tourist destinations such as the Grand Canyon, Painted Desert, San Francisco Peaks and Meteor Crater. NCHCAZ also provides educational and academic training programs for students pursuing a career in healthcare. NCHCAZ serves a predominantly white population, with a payer mix trending toward Medicaid at 37% as primary for most of our 51,800+ Uniform Data System (UDS) eligible reported members. English is the reported primary language for greater than 90% of the served population.

Working with the Practice Innovation Institute (Pii), Arizona’s CMS Transforming Clinical Practice Initiative (TCPI) Practice Transformation Network (TPN), we completed the five phases of transformation on April 10, 2018.

<table>
<thead>
<tr>
<th>Quality of Care Measures</th>
<th>ELIGIBLE POPULATION YEAR 1</th>
<th>SAMPLED POPULATION YEAR 1</th>
<th>YEAR 1 PERCENTAGE</th>
<th>ELIGIBLE POPULATION YEAR 2</th>
<th>SAMPLED POPULATION YEAR 2</th>
<th>YEAR 2 PERCENTAGE</th>
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<tbody>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan 3 - 17 Years</td>
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<td>7797</td>
<td>41%</td>
<td>8078</td>
<td>8078</td>
<td>54%</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan 18 Years and Older</td>
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<td>35651</td>
<td>72%</td>
<td>36155</td>
<td>36155</td>
<td>63%</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
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<td>91%</td>
<td>24334</td>
<td>24334</td>
<td>92%</td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma</td>
<td>269</td>
<td>70</td>
<td>77% of sample, 20% of eligible population</td>
<td>261</td>
<td>261</td>
<td>85%</td>
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</table>

Targeting Aims 2 and 3 to Improve Clinical Outcomes

North Country HealthCare wanted to improve clinical outcomes by following evidence-based medicine guidelines and increasing access to care for our patient population. This included 1) targeting improvement on UDS Quality of Care Measures for BMI, tobacco cessation and appropriate use of asthma medications; and 2) applying PCMH guidelines for management of diabetic members with HbA1c greater than 9 to improve rate of eye exams and routine testing of HbA1c for affected members.
North Country HealthCare UDS Compiled 2016-2017 data for Quality of Care Measures

We implemented a policy of scheduling the member with their assigned panel provider for all routine, preventative and screening exams to standardize documentation associated with Quality of Care measures. Additionally, our staff routinely conducts a focused chart review prior to each visit, and audits based on diagnosis and screening tests associated with the chief complaint(s) and patient problem list. In the table above, NCHCAZ’s applied model of patient empanelment and pre-visit chart audit resulted in measured improvements in the Quality of Care measures. In the tables below, we illustrate the month over month trend for BMI Screening and Follow-Up and Tobacco Use Screening and Cessation for our general population year to date in 2018.

For members with Type 2 Diabetes and an HbA1c value greater than 9, caregivers followed evidence-based guidelines for testing and monitoring of fasting glucose and for preventative screenings indicated for the population. This included diabetic eye exams and quarterly testing for patients with elevated A1c values. In
the tables below we illustrated how, NCHCAZ follows patients with elevated A1c values, the rate of testing for affected members, and the frequency of routine eye exams for diabetic members. For the period evaluated 08/2017 - 08/2018, we performed equal to or better than the network average for these metrics.
Ongoing Improvement and Program Sustainability
We are committed to continuous improvement and we have completed trainings with our staff empowering team members to innovate. In February 2019, we implemented newly designed workflows and processes to further improve on the metrics identified in this report. It is anticipated that the 2018 UDS report will reflect last year’s quality improvements, and 2019 will continue NCHCAZ’s trend toward practice transformation and improved quality outcomes.

North Country HealthCare successfully targeted TCPI Change Package Aim goal 2 (build the evidence base on practice transformation so that effective solutions can be scaled) and 3 (improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients) with changes to the care team workflow and documentation intended to demonstrate evidence-based practices to reduce gaps in care, optimize time spent with patients during every visit and to improve the health outcomes for our patients.
OrthoArizona Exemplary Practice Performance Summary

OrthoArizona (OAZ) is a physician owned private practice, comprised of a team of orthopedic specialists and primary care physicians specializing in all areas of orthopedic care including sports medicine, spine, shoulder and elbow, hand and wrist, hip and knee, foot and ankle, podiatry, pediatrics, trauma, industrial injuries and workers' compensation. OAZ has over 20 offices spread across the Phoenix Metropolitan area with more than 70 orthopedic specialists, each focused on quality care and exceptional customer service. Since 1994, we have been providing comprehensive orthopedic care of the highest quality to our community with extraordinary compassion.

OrthoArizona achieved success on TCPI Aims 2 and 3 by improving health outcomes and care processes and reduction of unnecessary hospital use through innovative use of evidence-based protocols and progressive infrastructure including shared services that are nontraditional in orthopedic care practices. By implementing changes to workflow and increasing the resource infrastructure around best practices, we have improved comprehensive care for our patients, resulting in decreased overall spend per episode of care, and reducing the need for post-acute care utilization.

Evolving our Practice
OrthoArizona’s mission is to provide comprehensive orthopedic care of the highest quality to our community. To meet our mission, OAZ physicians utilize evidence-based medicine to ensure delivery of effective and optimal care that supports our patient promise.

In 2016, we decided to voluntarily participate in CMS’ Bundled Payment for Care Improvement Initiative (BPCI). This program is designed to improve patient outcomes by putting an end to fractured care throughout the 3 months following a major surgery. Over the life of our involvement in the program, our organization built an infrastructure and processes to further support best practices and evidence-based medicine. Although our participation in this program only involves a subset of traditional Medicare patients undergoing a Major Joint Replacement of the Lower Extremity (approximately 1500-1700 patients annually), we have created processes that drive improvements in care for the entire population.

OrthoArizona started care transformation by targeting changes to how we look at patients. In the initial phase of BPCI we came to realize that to meet our goals in creating a seamless episode we would have to look at each patient individually and holistically.

Our initial infrastructure for success started with the foundation of:

- Hiring dedicated Nurse Case Managers (NCM)
- Creating modifiable risk factor guidelines based upon research
- Establishing a Steering Committee to oversee and evolve program
- Championing Physician engagement

Case Management
Our dedicated Nurse Case Managers help our BPCI patients navigate through their episode of care from three weeks preoperatively through surgery as well as the three-month post-surgical window. Through education, discharge planning, and support these patients gain confidence, knowledge about their procedure, expectations of their recovery and support for questions or concerns.
The benefits of this extra layer of patient touch are twofold. First, case managers are tracking utilization management and outcomes. Second, the patient has a single touch point who acts as advocate and conduit to patient and all their providers.

**Modifiable Risk Factor Guidelines**

A pillar for success in BPCI is the holistic treatment of the patient. OrthoArizona believes optimization preoperatively leads to better outcomes post-operatively. Our committee knew it would be important to create appropriate surgical guidelines that would also address modifiable risk factors. Review of evidence-based research drove our Steering Committee to establish 3 guidelines that align with best practices and support getting the best possible outcome for our patients. These modifiable risk factors include:

- Hemoglobin A1c < 7.5
- Body Mass Index < 40
- Nonsmoker within 3 weeks of surgery

Along with setting these guidelines, our committee also created a blinded process for indication review of complex cases. This process drives unbiased conversations about care and plans for best outcomes.

**Steering Committee and Physician Engagement**

This committee is comprised of physicians from all regions of the organization. Monthly committee meetings review CMS program and timeline updates, internal updates or needs, performance trending, financials and high spend case studies. Updates are sent out after all meetings to the entire organization. The communication of updates and participation of all regions of our organization leads to carryover education to non-committee physicians and teams.

**Proven Success**

Three years into the program, data demonstrates our infrastructure and practices have succeeded in transforming our practice for the better. Following best practices such as preoperative optimization, patient education, physician and patient engagement along with case management have led us to a sustained reduction in cost per case. At inception, OAZ cost per episode was more than $21,000 on average (Q1 2016) per Major Joint Replacement of the Lower Extremity. As of most recent data from CMS (Q1 2018), our average episode spend is around $18,500 (Figure 1). Additionally, OrthoArizona’s readmission rate in this population is most often below the set benchmark of 5%. Over the life of our program a reduction in utilization of skilled nursing for patients has gone from 24% to most recently 10% (Figure 2). We have also noted a significantly decreased need for home health care with utilization rates dropping from 62% to 20% (Figure 3).

**Figure 1. Average Cost/Case**
Evolvement
Since program inception at OrthoArizona, we have upgraded our solid infrastructure to ensure we evolve with health care and our patient's needs. Recent innovative additions to the program in the last 12 months include adding a program manager and an integrated health and wellness program. The Program Manager has the primary responsibility to analyze claims and real time data trends to identify opportunities for improvement. The Program Manager works closely with the organizational leaders and physicians to guide program changes, provide regular communication on updates, and act as a resource for education about changes to the program or processes.

OrthoArizona recognized it was not enough to have guidelines for modifiable risk factors. It was also important to our organization that we address those risk factors with our patients to improve their health in preparation for potential surgery on non-surgical management of their orthopedic issues. As such, we have also proudly added a shared service line practicing integrated health and wellness that fits a great need in our organization, Bundled Payment for Care Improvement Initiative (BPCI) and non-BPCI patients.
Integrated Health and Wellness Services
It is our goal to provide the best possible outcome with the fewest complications. To meet those goals, OrthoArizona has adopted safe surgical parameters that can be modified prior to surgery to minimize our patient’s risk and maximize the outcome. Studies have shown that certain parameters put patients at an increased risk for complications and have proved to lead to infection and other problems following surgery. To assist with optimization, we implemented a health and wellness line.

OrthoArizona provides a level of integrative healthcare combining the latest research in evidence-based medicine in combination with complimentary therapies to optimize our patients’ results. We work with patients to understand their concerns and we take the time necessary to understand their needs as fully as possible.

OrthoArizona’s health and wellness team provides an individualized comprehensive treatment to help improve BMI and metabolic health to support comprehensive care for optimizing outcomes for our patients’ orthopedic conditions. Our comprehensive care plan including the four pillars for long term success utilizing evidence-based medicine including FDA approved anti-obesity medication when clinically indicated, nutritional recommendations, improvement in physical activity, and assist with behavioral changes to help improve outcomes for long term success.

We have found that when we take the time to listen to patient’s goals, needs, and concerns, we are able to adapt our knowledge and understanding to their beliefs and goals to the best of our ability, while maintaining sound medical practice principles.

Going Forward

Although we have built a sound and beneficial infrastructure, we know that healthcare is forever evolving. To continue to achieve success in value-based programs and create the best possible outcomes for our patients we have visionary goals for our practice. These include:

- Expanding our shared service lines to include more helpful branches of medicine that align with health and wellness
- Growing our Case Management team to support more patients
- Adding to our guidelines to include additional modifiable risk factors
- Applying appropriate guidelines to other subsets of elective procedures

OrthoArizona anticipates continuing to grow and adjusting our practice for the better of our patients and musculoskeletal medicine.
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

<table>
<thead>
<tr>
<th>Eligible Members</th>
<th>Hypertension</th>
<th>ESRD</th>
<th>Diabetes</th>
<th>COPD</th>
<th>Chronic Kidney Disease</th>
<th>Coronary Artery Disease</th>
<th>Congestive Heart Failure</th>
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</thead>
<tbody>
<tr>
<td>8118</td>
<td>3607</td>
<td>48</td>
<td>1407</td>
<td>827</td>
<td>457</td>
<td>552</td>
<td>247</td>
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<tr>
<td>8118</td>
<td>44.4%</td>
<td>0.6%</td>
<td>17.3%</td>
<td>10.2%</td>
<td>5.6%</td>
<td>6.8%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Members</th>
<th>Substance Abuse</th>
<th>Schizophrenia</th>
<th>Bipolar Disorder</th>
<th>Anxiety and Depression</th>
<th>Alcohol Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>8118</td>
<td>3678</td>
<td>4564</td>
<td>5300</td>
<td>6178</td>
<td>1770</td>
</tr>
<tr>
<td>8118</td>
<td>45.3%</td>
<td>56.2%</td>
<td>65.3%</td>
<td>76.1%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

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 Clinical evaluation, Utilization, Potential physical limitations and Social 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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Omega</th>
<th>Varity</th>
<th>West Valley</th>
<th>MACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Hospital</td>
<td>-20%</td>
<td>-38%</td>
<td>-14%</td>
<td>-36%</td>
<td>-29%</td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>-20%</td>
<td>-13%</td>
<td>-55%</td>
<td>-42%</td>
<td>-25%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>-20%</td>
<td>-20%</td>
<td>-4%</td>
<td>-55%</td>
<td>-42%</td>
</tr>
<tr>
<td>Employed</td>
<td>+5%</td>
<td>+23%</td>
<td>+13%</td>
<td>+100%</td>
<td></td>
</tr>
<tr>
<td>PCP Visits</td>
<td>+10%</td>
<td>+23%</td>
<td>+57%</td>
<td>+24%</td>
<td></td>
</tr>
<tr>
<td>Jail</td>
<td>-10%</td>
<td>+22%</td>
<td>-40%</td>
<td>+10%</td>
<td>+2%</td>
</tr>
<tr>
<td>A1c Test</td>
<td>57% of pop</td>
<td>87% of pop</td>
<td>97% of pop</td>
<td>99% of pop</td>
<td></td>
</tr>
<tr>
<td>Retinal Eye Exam</td>
<td>49% of pop</td>
<td>75% of pop</td>
<td>93% of pop</td>
<td>100% of pop</td>
<td></td>
</tr>
</tbody>
</table>
Pediatrics of Queen Creek (PQC) provides high quality comprehensive primary health care and education to patients and families, lasting from birth to adulthood in the east central and southern Arizona. Our patient population has 39% on AHCCCS Medicaid.

Taking seriously the need to assist families to navigate the healthcare system and find needed community resources, we added a Care Coordinator position to our team. This means that the patient’s needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

Collecting and analyzing data from various internal and external resources such as Phoenix Children’s Care Network (PCCN), health plan gaps in care notices, and hospital networks, has allowed us to identify gaps in care, hospital admissions and unnecessary Emergency Department use for our most vulnerable patients. Our Care Coordinator reviews the data and outreaches to patients for education and to schedule follow up appointments. In addition, our Electronic Health Record system (Athena) send emails and text messages before and after scheduled appointments and our staff does outreach calls.

These efforts have shown great results in TCPI Aims 3 and 4. Based on Mercy Care data we have shown reduction and cost savings in these areas.

**Aim 3**

Reduction of ED Utilization (Mercy Care data)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline</th>
<th>Year 1 Avoided Visits</th>
<th>Year 2 Avoided Visits</th>
<th>Year 3 Avoided Visits</th>
<th>Q15 Avoided Visits</th>
<th>Total Avoided Visits</th>
<th>Year 1 Extrapolated (78)</th>
<th>Year 2 Extrapolated (50)</th>
<th>Year 3 Extrapolated (12)</th>
<th>Q15 Extrapolated (27)</th>
<th>Total Episodes Reduced (85)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>530</td>
<td>20</td>
<td>48</td>
<td>1</td>
<td>11</td>
<td>89</td>
<td>32</td>
<td>50</td>
<td>12</td>
<td>12</td>
<td>95</td>
</tr>
</tbody>
</table>

Reduction of Unnecessary Hospitalizations (Mercy Care Data)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline</th>
<th>Year 1 Avoided Visits</th>
<th>Year 2 Avoided Visits</th>
<th>Year 3 Avoided Visits</th>
<th>Q15 Avoided Visits</th>
<th>Total Avoided Visits</th>
<th>Year 1 Extrapolated (11)</th>
<th>Year 2 Extrapolated (2)</th>
<th>Year 3 Extrapolated (23)</th>
<th>Q15 Extrapolated (12)</th>
<th>Total Episodes Reduced (62)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>98</td>
<td>10</td>
<td>15</td>
<td>21</td>
<td>11</td>
<td>57</td>
<td>11</td>
<td>16</td>
<td>23</td>
<td>12</td>
<td>62</td>
</tr>
</tbody>
</table>
Aim 4

Cost Savings ED (Mercy Care Data)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Mercy Panned Members</th>
<th>Self-reported Members</th>
<th>Average Cost</th>
<th>Year 1 Cost Savings</th>
<th>Year 2 Cost Savings</th>
<th>Year 3 Cost Savings</th>
<th>Q1 Cost Savings</th>
<th>Q15 Cost Savings</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>611</td>
<td>620</td>
<td>$449</td>
<td>$14,368</td>
<td>$22,450</td>
<td>$449</td>
<td>$5,388</td>
<td>$42,655</td>
<td></td>
</tr>
</tbody>
</table>

Cost Savings Hospital Reduction (Mercy Care Data)

In order to meet the ever-changing needs of our patients, PQC reviews and streamlines processes on an ongoing basis. We have created a OneNote Notebook and utilize Microsoft OneDrive to share and document Workflow changes with the entire office for Policies and Procedures of Care. Using AthenaHealth has allowed us to digitize the office making referrals and ordering of prescription more streamlined.

We believe that our single strength is our people. The members of our practice, from front office personnel to the physicians that provide care, possess the same philosophy towards work. We provide bi-weekly training to all staff on workflow policies and procedural changes. We are proud to have an unrelenting attitude of service and uncompromising excellence in care toward our patients; providing all of our services with personal attention.
Pendleton Pediatrics Exemplary Practice Performance Summary

Pendleton Pediatrics (Pendleton) is located in the metropolitan Phoenix area with seven clinicians that care for children with a variety of physical and behavioral health needs. With a focus on meeting each child’s unique needs, we have collaborated with Dignity Health Dental and offer free dental screenings for children six days per month in office. We also offer car seat checks and are in process of establishing a collaboration with a local pediatric psychiatrist to see mutual patients once monthly out of our office. In addition, we have established a collaborative partnership with Arizona’s Children Association (ACA) and now have a full-time behavioral therapist in office to assist with patients who present with concerns regarding behavior, interpersonal relationship issues, trauma, anxiety, depression, etc.

Pendleton Pediatrics focuses on meeting the full spectrum of needs for each patient. Partnering with other care providers through medical neighborhood agreements and using Memorandum of Understandings (MOU), we have been able to promote and provide integrated care. Partnerships with Southwest Human Development and Arizona Children’s Association has been integral in reducing inpatient hospital visits for both physical health and behavioral health services and the subsequent cost savings as reported by the Practice Innovation Institute (Pii) (Table 1).

Table 1: Reductions in Inpatient Admissions and Resulting Savings

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Admits/1,000</th>
<th>% Change from Baseline</th>
<th>Avoided Events</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>187</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Year 1</td>
<td>116</td>
<td>-38.0%</td>
<td>32</td>
<td>$195,874</td>
</tr>
<tr>
<td>Year 2</td>
<td>94</td>
<td>-49.7%</td>
<td>51</td>
<td>$311,094</td>
</tr>
<tr>
<td>Year 3</td>
<td>101</td>
<td>-46.0%</td>
<td>41</td>
<td>$247,723</td>
</tr>
<tr>
<td>TOTAL</td>
<td>NA</td>
<td>NA</td>
<td>124</td>
<td>$754,691</td>
</tr>
</tbody>
</table>

To further engage patients and families, we have updated our website to include relevant links, education materials and other resources and have implemented a Social Determinants of Health Tool that is given to every family at every visit to help us determine what other needs may exist. We implemented an intervention/tools packet for each potential concern that includes resources such as adult health clinic locations, food banks, bus schedules and additional community resources.

Through patient and family feedback, we addressed patient access to care by establishing a more frequent visit schedule for high risk patients, such as those with diagnoses of autism, ADHD, asthma and those in the welfare system and extended office hours and same day sick appointments during the week for all of our patients. Our office is open on Mondays and Thursdays from 8am to 8pm and on Tuesday, Wednesday and Friday from 8am to 5pm, and patients can reach us after hours for urgent concerns. We believe that by extending our office hours we have been able to meet both the HEDIS measures for Well Child Visits in the first 15 months and in the first 3-6 years of life (see Table 2 as reported by Pii).
Table 2: Improvements in Well Child Visits

<table>
<thead>
<tr>
<th>Time Period</th>
<th>W15</th>
<th>W36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>42.9%</td>
<td>52.2%</td>
</tr>
<tr>
<td>Year 1</td>
<td>65.5%</td>
<td>56.5%</td>
</tr>
<tr>
<td>Year 2</td>
<td>60.5%</td>
<td>64.5%</td>
</tr>
<tr>
<td>Year 3</td>
<td>90.0%</td>
<td>74.8%</td>
</tr>
</tbody>
</table>

Our full-time Care Manager (RN) pulls gaps in care reports for immediate referral needs, providing referral resources in notebooks for parents, getting them signed up on the patient portal and scheduling follow up appointments.

Challenges were addressed on a regular basis with monthly staff meetings, tracking problems and resolutions as well as monthly meetings with office manager, care manager and all providers. We tracked challenges and resolutions, following up on success or failure of changes made and adjusting accordingly. New forms and tools have been used to address some challenges. We have worked hard to establish relationships with outside providers to allow for integrated care for our patients (i.e. dental team, behavioral health and psychiatry). Consideration of even the smallest team input has allowed for successful change and growth over time.

Pendleton Pediatrics was successful in the implementation of these changes because of continued feedback and consideration of all members of our team. We have looked at processes that already existed within our practice and streamlined or fully documented them in order to perfect their use on a day to day basis. Taking one step at a time, we focused on the needs and benefits for the patient and the entire community that cares for them. We continue to strive to embody our practice’s vision in every positive change.
Phoenix Medical Group (PMG) is a multispecialty group with 3 locations in the Phoenix metropolitan area. Our specialties include Internal Medicine, Pulmonology, Endocrinology, Sleep Disorders and Podiatry. We serve a wide variety of patients where 25% are on state Medicaid. Our efforts are to put the patient at the center of everything we do. PMG has reduced hospital and emergency department use for the population we serve, while promoting preventative care and timely follow up care.

Our providers have directed that we make it a priority to have their schedules full. Their focus on patient care and delivery is best met during patient appointments. In order to meet this request, we have updated workflows and job responsibilities in a concerted effort to promptly follow up on every hospital admission and emergency department (ED) visit promptly. Also, by reaching out to patients that have missed appointments, are behind on annual wellness visits/HEIDIS, or have not been seen in the past 12 months. Using reports from Health Current (Arizona’s HIE), health plans, neighboring hospitals, and EHR/Practice Management systems, patients are promptly scheduled for follow up visits with their PMG providers.

At PMG we use multiple outreach process for appointment reminders, that include phone calls, emails and text messages. All patients are contacted 1-3 days prior to their scheduled appointments. We closely manage our paneled patients. In addition, we have implemented a no-show policy to help hold our patients accountable to their care and encourage them to come to their scheduled appointments. All staff are part of the care team and involved in patient care and compliance efforts. From the scheduling department, front desk, referrals, physicians, to the case management team, every effort is made to meet each patient’s care needs and to identify those that are non-compliant. We utilize community resources and payer case managers to help our non-compliant patients better comply with treatments to support their health care needs. If we find we have exhausted all efforts and we are still not able to engage a patient, we work with them to direct them to more appropriate care for their individual needs.

Our efforts led to remarkable performance in Aims 3 and 4: reduction in hospital and ED use and associated cost savings, as reported by the Practice Innovation Institute (Pii) (see Charts 1 and 2 below). In addition, we have reduced our patient no-shows over 10% within the last year (see Chart 3 below).

Chart 1: Aims 3 & 4: Reduction in ED Visits (PH and BH)
Chart 2: Aims 3 & 4: Reduction in IP Admissions (PH & BH)

Data Source: Practice Innovation Institute (Pii)

Chart 3: Reduction in No Show Rates

Our Phoenix Medical Group providers wanted their schedules full. Finding and implementing solutions to meet this request with proactive and prompt patient follow up, not only lead to provider satisfaction, but also lead to better patient care. In addition, this helped us to better meet the requirements of the health plan for prompt patient follow up after hospital use and subsequent utilization cost reduction. By simply implementing an intentional ongoing outbound outreach process, using tools and reports provided by our system, hospitals, health plans and the Arizona HIE we have been, and continue to be, successful in our healthcare delivery. This is a simple change with huge results that can be replicated in any practice.
Piller Child Development Exemplary Practice Performance Summary

Piller Child Development (Piller) is a pediatric multidisciplinary outpatient therapy practice. Our practice has three locations in the greater Phoenix metropolitan area. Over 45 occupational and speech therapists serve approximately 1500 clients a week. Patients range in age from birth through 18 and consist of children with various developmental disabilities, illnesses, or injuries that result in loss of function or independence. The company has been servicing patients for almost nine years. We proudly grew from 4 patients and one therapist to one of the largest pediatric therapy practices in the fifth largest city in America. This growth occurs because of our transformative practice.

By including patients and families in care planning and delivery, we provide evidence-based treatment across all therapies that result in better patient outcomes and more cost-effective treatment. Our leadership and therapists developed and revised care plans, streamlining and documenting workflows that engage patient and families in quality improvement initiatives based on evidence-based practices in the area of occupational therapy.

Working together, our therapist and patient/family establish meaningful goals for treatment. Each of our therapists focuses treatment on developing relationships with the patient and family to discover the values and beliefs of the patient and family. Our therapists take time each session to talk with parents and patients to include them within the treatment process. Before goals are established, our therapists spend one on one time with parents discussing their needs and goals for therapy. Goals are developed collaboratively with the patients and families. Treatment is centered on these values and goals to increase patient engagement and follow through with treatment recommendations. Every one of our therapists believes in the importance of developing a relationship with the provider and family. When the patient trusts our providers, they are more likely to follow through with recommendations. Our relationship-based care is the cornerstone of providing high quality service and allows our patients to make continual improvements towards independence.

Our therapists take a team approach to treatment. While working with their own caseloads, therapists are familiar with other patients seen in the office. Therapists frequently treat together and are consistently engaged in collaborative conversations. In addition, we offer structured times for team meetings where therapists work within their disciplines and across disciplines to ensure the best care coordination for the patients. Our office space is set up to encourage cross collaboration within disciplines and between disciplines. Our team-oriented approach provides support for learning and advancing clinical skills, which provides accountability for therapists to continually work to improve their practice, knowledge, and skills. We promote a patient-centered approach to care where therapists are continually involved in discussions about how to meet the needs of each individual patient. The nature of pediatric therapy often leads to frequent patient encounters for months at a time. Our team approach helps prevent patient burn out by continually collaborating for new treatment ideas. By working together, our therapists are equipped to provide high quality, patient centered interventions.

Cost and Utilization - We are a multi-disciplinary practice that provides therapy services within one location. As a result, clients can receive multiple services on the same day at the same location and access services at a lower overall cost. Although therapy is typically billed as units, our same day services can result in a reduction of transportation costs, including possible out of pocket costs to the client, by reducing the total number of trips required for services. The table below shows estimated cost savings by
using a multi-disciplinary clinic with all services at the same location compared to a multiple single discipline therapy clinics.

<table>
<thead>
<tr>
<th></th>
<th>Single Service per Day over 6 months at three sessions per week</th>
<th>Multi-discipline service (3 services in one day one day per week) over 6 months</th>
<th>Savings for multi-discipline clinic over 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive Time</td>
<td>15 min each way/30 min round trip</td>
<td>2,340 minutes</td>
<td>1,560 minutes</td>
</tr>
<tr>
<td>Co pay Cost</td>
<td>$20/service/day</td>
<td>$1,560</td>
<td>$1,040</td>
</tr>
<tr>
<td>Transportation Cost</td>
<td>10 miles round trip/$0.54 per mile</td>
<td>$421.20</td>
<td>$280.80</td>
</tr>
</tbody>
</table>

In addition, due to the combination of services, we are able to reduces no shows and cancellations. Our no shows and cancellations on average, for clients utilizing a same day service model, are approximately 25% less than those utilizing a multi-day service model.

**Evidence-Based Practice** - We provide evidence-based research and defining best practices for therapeutic interventions. Our therapists have an ethical requirement to provide evidence-based interventions, and this expectation is taken very seriously at Piller. Evidence-based interventions demonstrate effectiveness of treatment methods to target areas of difficulty, which in turn results in decreased costs. Our unique approach to evaluating therapists’ use of evidence-based practice ensures that the provided interventions are the most effective. We use the procedure outlined below to evaluate occupational therapy interventions. Results of the data analysis were used to evaluate evidence-based practice and inform quality improvement activities for the organization. Our step-by-step approach to evaluating the effectiveness of occupational therapy interventions is comprised of the following four steps:

2. Examine the treatment performed within that setting.
3. Interventions from the clinic are matched with the current published evidence of effective treatment interventions.
4. Through our quality improvement process, we implement updated and clinical practice guidelines based on these results.

Our method has been published in an occupational therapy practitioner magazine with results of a retrospective cohort study for occupational therapy interventions for the treatment of coordination delay (Piller & Candler, 2015). Through this study, we are able to determine the most commonly used interventions at our facilities. These interventions matched the interventions found in the literature for effective occupational therapy interventions in the treatment of coordination delay. Therefore, our therapists could say with confidence they were implementing evidence-based practice.
Performing evidence-based treatment is critical for best practice of therapy services. However, it is also important for therapy interventions to demonstrate effectiveness in reaching client goals and improving function. We also implemented retrospective studies to examine the effectiveness of interventions performed within our clinics. Two studies are provided to indicate the effectiveness of interventions performed at Piller Child Development. The first provides evidence of the effectiveness of occupational therapy on the treatment of coordination delay. Pretest and posttest standardized assessment data were analyzed with non-parametric statistics to determine if the change was statistically significant for three motor subtests on a motor skills assessment. The intervention utilized was established via the text mining study that developed into clinical practice guidelines for intervention of occupational therapy services for children with coordination delay. The results of the study revealed that the intervention was statistically significant in improving fine motor integration skills and bilateral coordination skills, indicating that the provided intervention is effective in improving motor skills.

Table 2. Effectiveness of Occupational Therapy Interventions on Motor Skills for Children with Coordination Delay

<table>
<thead>
<tr>
<th>Pair</th>
<th>Interventions</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td>BOT-2 Initial Fine Motor Precision - BOT-2 Second Fine Motor Precision</td>
<td>-0.315</td>
<td>3.270</td>
<td>0.383</td>
<td>-1.078</td>
<td>.448</td>
<td>-.823</td>
<td>.413</td>
</tr>
<tr>
<td>Pair 2</td>
<td>BOT-2 Initial Fine Motor Integration - BOT-2 Second Fine Motor Integration</td>
<td>-1.411</td>
<td>3.926</td>
<td>0.459</td>
<td>-2.327</td>
<td>-0.495</td>
<td>-3.071</td>
<td>.003*</td>
</tr>
<tr>
<td>Pair 3</td>
<td>BOT-2 Initial Bilateral Coordination - BOT-2 Second Bilateral Coordination</td>
<td>-2.507</td>
<td>4.021</td>
<td>0.471</td>
<td>-3.445</td>
<td>-1.569</td>
<td>-5.326</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*Statistically Significant
A second study examined the practices of occupational therapists in the treatment of handwriting difficulties, a common reason for referral to occupational therapy. This study also utilized a retrospective review of daily documentation to provide evidence as to interventions used for the treatment of handwriting difficulties and a retrospective pretest-posttest to determine the effectiveness of the interventions on improving motor skills. Again, results of pretest-posttest analysis revealed statistically significant differences, indicating effectiveness of interventions.

**Figure 2. Evidence-based Interventions Utilized in the Treatment of Handwriting Difficulties**

| Table 3. Effectiveness of Handwriting Interventions to Improve Visual Motor Skills |
|---------------------------------|----------|
|                                  | Mean     | n  |
| Pretest                          | 15.33    | 21 |
| Posttest                         | 17.90    | 21 |

| Negative Ranks                  | -        | 6  |
| Positive Ranks                  | -        | 13 |
| No Change                       | -        | 2  |
| Wilcoxon Signed Ranks Test Z    | -2.039   | 0.04* |

The two study examples demonstrate the effectiveness of interventions utilized by our therapists. The analysis of daily documentation provides an easy method for the organization to review routine practices for evidence-based practice and quality improvement purposes. We provide this information to current clients, potential clients, and referring providers to demonstrate that the interventions utilized are targeted, evidence-based, effective, and cost-efficient in the treatment of children.

**Cost Effectiveness from Evidence-Based Practice** - Evidence-based practice allows clinicians the ability to choose the best intervention to meet the client’s needs. By choosing the best interventions, the result is decreased cost in healthcare. Rehabilitation fields, such as occupational and speech therapy, have little research on the effectiveness of interventions, comparison of interventions, or the best frequency and duration of interventions. We would like to be able to compare costs of therapy services to national averages for care. However, due to the limited research on effectiveness and frequency, there are little to no data on average costs of pediatric therapy services by discipline. Organizations such as the American Occupational Therapy Foundation have listed this as a research priority for the field of occupational therapy in order to establish cost effective therapy services. We have embarked on the journey of establishing solid practice guidelines, including evidence-based interventions and duration and frequency of services, in an attempt to provide cost-effect interventions targeted to meet the client’s needs. We have just begun the process of collecting data on the costs of therapy based upon established practice guidelines as well as
the duration and frequency of therapy. We continue to develop this process as part of our transformation plan.

**Patient Engagement** Outpatient pediatric therapy can be a lengthy process with average weekly visits being 50 or more for each patient. It is essential to ensure continued compliance with the ongoing treatment so the client completes the course of treatment and prevents relapse or regression, which can often result in longer duration of treatment. Relationship is the key to engaging patients and families within the treatment process. Our therapists take time to get to know the patients and families, spend time in ongoing treatment to understand their changing goals, and ensure patients and families understand the treatment process. Every session is devoted to one-on-one treatment with the client and time to discuss with parents and family members. Patient satisfaction feedback indicates that families appreciate the engagement. Below are a few quotes from surveys:

“[] feel so fortunate for how much work they did with my son. He made huge improvements in fine and gross motor skills and in his executive functioning.”

“My son loves [therapist’s name].”

**Continued Development** - As evidenced from the success of the research projects for occupational therapy interventions, our organization identified that the processes and workflows we implemented for our occupational therapists would be useful in replicating and further developing for our speech therapists and speech therapy interventions and procedures. We are actively working toward completion of those steps.

Currently we have completed a quality improvement analysis to determine the time between assessments. In this analysis we identified the need for a standard operating procedure to reassess speech therapy clients on an annual basis. This has not yet been rolled out. In the fourth quarter of 2018, we began gathering data from informal speech therapy assessments on a bi-annual basis – every six months. Adding the formal assessment data will add to the data needed for a more complete retrospective analysis and for daily documentation.

We are confident that the use of additional data will lead to further improvement and quality outcomes for patients in our care.

**Summary** - We are an example of an exemplary multidiscipline ancillary practice. We provide patient centered facilities that promote health, well-being, and independence through patient and family centered care while providing a supportive environment for therapists to work. Support is provided through management and teamwork, proper equipment and space, and access to resources and evidence. We partner with other practices in their medical neighborhood and professional organizations (e.g. American Occupational Therapy Association, American Speech and Hearing Association, etc.) to promote practical methods for implementing best practice, evidence-based practice, and promoting health and wellness among patients to increase patient outcomes while decreasing costs.

**References**

Pulmonary Consultants Exemplary Practice Performance Summary

Pulmonary Consultants (PCOM) achieved success on TCPI Change Package Aims/Goals 2 (build the evidence base on practice transformation so that effective solutions can be scaled) and 3 (improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients) through innovative use of evidence-based protocols to support improvement on clinical measures via changes to workflow and documentation processes. PCOM leveraged training from the Practice Innovation Institute (Pii) Practice Transformation Consultant (PTC) consultant and the electronic health record (EHR) vendor to identify gaps in workflow to facilitate improvement in visit note documentation, medication reconciliation, referral linking, immunization tracking and chronic disease management to improve health outcomes for their patients.

Pulmonary Consultants (PCOM) is a physician owned private practice located inside of Banner Heart Hospital in Mesa, Arizona. Operating in the valley for over twenty years, our physicians at PCOM are board certified pulmonologists trained in the diagnosis and treatment of conditions which include COPD, asthma, tuberculosis, Valley Fever, pneumonia, lung nodules and chest infections. Additionally, we are skilled intensivists who manage critically ill patients on life support with organ system failure. PCOM also provides care in Sleep Medicine, managing conditions including sleep apnea with evidence-based treatments for sleep complaints involving pulmonary function. Pulmonary Consultants has an active panel of over 49,400 patients. The payer mix is mostly Medicare Parts A, B and C, along with a significant volume of dual eligible and commercial insurance members.

Evidence-based Care in Practice
Pulmonary Consultant targeted Aims and 3 with changes to the patient encounter visit and documentation intended to demonstrate evidence-based practices to improve the health outcomes for PCOM patients. Quality improvement training and education supported care team members to have positive performance improvements as detailed in the table below. Specifically, routine monitoring and improved documentation for clinical quality measures tracked for the Quality Payment Program were reflected in the improved performance percentages for each provider who attested in 2018. In prior years, PCOM struggled with the Physician Quality Reporting System (PQRS) and Meaningful Use and had accumulated several negative adjustments in Medicare reimbursements. This was significant for our practice whose payer mix is predominantly Medicare and Medicare replacement plans.

New workflows and additional staff training resulted in improved documentation that supported capture of the clinical measures outlines in the table below. (QPP 2017 Clinical Quality Measures)
Following the process improvement of 2017, our clinical team embraced additional modifications to workflows and clinical documentation to further capitalize on the benefits of preventative screenings and disease state monitoring to improve health outcomes for our patients. In 2018, areas for improvement were identified and included tracking and documentation of pneumonia vaccine status, as this is very significant to a pulmonary disease patient population. Further, we incorporated services from Health Current, Arizona’s health information exchange (HIE) including implementing a referral process that employs the use of direct secure mail (Continuity of Care Document) to communicate with collaborating clinicians in the medical neighborhood with the intent of expediting referrals and reducing duplicate test ordering. Additionally, we incorporated HIE Alerts of admissions, discharges and transfers to their patient intake and monitoring process to promote swift follow up for patients with hospital encounters. Shown in the table below are the Clinical Quality Measures reported for Pulmonary Consultants for 2018 demonstrating improvement in seven categories, and excellent performance on two additional metrics not reported in 2017.

<table>
<thead>
<tr>
<th>Clinical Quality Measures</th>
<th>2018 Practice Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Influenza Immunization NQF 41</td>
<td>40.36%</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (NQF 0028)</td>
<td>89.80%</td>
</tr>
<tr>
<td>Pneumococcal Vaccination Status for Older Adults NQF111</td>
<td>39.98%</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record (NQF 0419)</td>
<td>95.85%</td>
</tr>
<tr>
<td>Preventive Care and Screening Body Mass Index (BMI) Screening and Follow-up NQF 0421</td>
<td>54.49%</td>
</tr>
<tr>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet NQF68</td>
<td>77.78%</td>
</tr>
<tr>
<td>Diabetes: Medical Attention for Nephropathy NQF62</td>
<td>58.80%</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%) NQF 001</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
**Pulmonary Consultants** successfully targeted Aims 2 and 3 with changes to the patient encounter visit and documentation intended to demonstrate evidence-based practices to improve the health outcomes for PCOM patients. The quality improvement training and education supported care team members to have positive performance improvements that resulted in better outcomes for the patients. In addition, routine monitoring and improved documentation for clinical quality measures tracked for the Quality Payment Program resulted in improved performance percentages for each provider who attested in 2018.
Resilient Health is a not-for-profit healthcare company with 18 locations throughout Arizona. With 230+ employees who are passionate about providing exceptional care, 179 employees provide direct care to our participants. Our services support over 3,000 children, individuals, and families throughout Arizona who experience mental health and substance use disorder challenges, including the SMI population.

To ensure good stewardship of public dollars and create high value for our payers and participants, Resilient Health places a high emphasis on the TCPI service delivery Aim 2 - Improving Clinical Outcomes through focused and effective AIM 2 Clinical Processes - evidence-based practices for responding to trauma and building resilience. We call our patients “Participants” because they are an integral part of their successful experience. Using evidence-based practices and innovative resiliency-building techniques, our participants receive a treatment experience that differs from the typical experience. Our participants’ improvements have been in 19 of the 20 areas identified in the DLA-20 over the course of six months.
The most substantial improvements include:

As we further refine our innovative treatment experience, we expect to see the outcomes from the DLA 20 continue to increase.

*Figure 1: Resilient Health’s Treatment Plan*

Resiliency implies a more durable, even a permanent level of skill building when compared to “treatment” which typically has a connotation of fixing and thus vulnerable to deterioration. It is important to us that each person who walks through our doors walks out with tools that will help them continue to experience success in life.

We feel that trauma, which often has a direct correlation to mental health and substance use disorders, can be addressed and resiliency achieved through five basic pillars during their treatment. This experience focuses on a trauma- responsive service array that includes a combination of non-verbal interventions and verbal interventions.
RI International (RI) is not-for-profit service provider that delivers an array of crisis and outpatient recovery-based services in 50 programs across five states and New Zealand. Our services are broken down into four key business units: Crisis, Health, Recovery and Consulting; supporting RI’s mission of empowering people to recover, succeed in accomplishing their goals, find meaning and purpose in life, and reconnect with themselves and others. We proudly delivered 54,668 episodes of care in 2018; a number slightly above the number of unique individuals served during the year given some individuals received care in multiple programs. We are often recognized as an international thought leader in behavioral healthcare for the team’s lead role in the development of the Zero Suicide initiative, Crisis Now exceptional practice standards, the focus on inclusion of individuals with lived experience (peers) in the workforce starting in the early 2000’s and the first living room model of crisis service delivery in 2003.

RI International achieved success on TCPI AIMS 3 and 4 by reducing hospitalizations and demonstrating an overall reduction in healthcare costs. We leverage relationship with first responders to eliminate incarceration as an alternative to connecting to accessible quality mental health crisis services. We focus on throughput (the time it takes to get services) when individuals are dropped off at our crisis facilities to ensure we provide timely accessible mental health crisis services and a level of service that encourages law enforcement to connect people to this cost effective level of care in lieu of more expensive emergency department assessments that often lead to inpatient care.

We use a data-driven, peer and family-informed approach to increase the value of services to individuals and communities through a culture of continuous quality improvement. We infuse patient and family engagement into every aspect of the organization. We have been a pioneer in the advancement of a peer workforce, design of what is now seen as standards of crisis care and physical environment advancements within the living room and retreat models. Our commitment to peer involvement includes ongoing dialog and survey feedback from individuals served. Additionally, we employ nearly 1,100 team members in the programs and over half identify themselves as having lived experience; working in a multitude of roles that include dedicated peer positions, management, and organizational leadership roles. We take pride in ensuring that the patient and family voice is rippled throughout the agency.

Using technology such as electronic bed boards, we have an efficient workflow process from the time a member enters the door; allowing us to serve more members which avoid unnecessary E.D. visits, hospitalizations and incarcerations. These efficiencies reduce overall system costs, reduce hospitalization, increase conversion rates (when a member moves from involuntary status to voluntary for treatment) and improve overall patient satisfaction.

Recovery Innovation Crisis Program

Our crisis program in Peoria, AZ, is a Recovery Response Center (Crisis Stabilization Program). The program served 5,298 individuals in 2018 with 82% arriving in the back of a police car. Through a culture of person and family engagement, we “never say no” to first responder referrals. We have accepted over 14,000 consecutive referrals from law enforcement where individuals are brought into care instead of being dropped off at an emergency department (ED) where individuals wait for care and incur ED related health care expenses that are typically avoidable (over 96% of individuals served did not require a referral to an ED.
after arrival last year). Through our “never say no” campaign we have eliminated unnecessary hospitalization and delays in accessing needed care. The graph below shows the increase in our total admissions and law enforcement drop offs over a four-year period that held steady last year.

By increasing the number of drop-offs at our facility, we effectively reduce ED drop offs and AIM #3 in reducing hospitalizations. Additionally, our efforts positively impact AIM #4 of reduce health care costs, by infusing patient and family voice throughout the organization and through the use of technology, which prompted the following outcomes:

- We have partnerships with law enforcement to accept all referrals which increased the number of drop off at the facility by 96% from 2014 to 2018;
- Using electronic bed boards we have immediate access to bed status and have a process to ensure increased throughput which increased capacity and reduced the need for ED visits and inpatient hospitalizations which allowed the program to serve 35% more individuals with the existing resources;
- We are able to serve an increased number of individuals in mental health crisis served in the facility by 35% from 2014 to 2018; and
- Our Joint Commission safety and quality review performance is exceptional with only one finding during the last one site review.

In May 2018, we reviewed the previous year's data and averaged a 70% conversion rate from involuntary to voluntary and 159 conversions per month which resulted in a total of 1,910 conversions during the last 12 months (May 2017 through April 2018). During the year, our average length of stay was closer to two days and RI experienced a lower rate of escalation to the subacute facility. This roughly translates into a $47,750,000 avoided cost if all individuals experienced a typical inpatient length of stay (estimated at 25 days and assuming a $1,000 daily total); a figure that is 4 times the annual funding for RI’s crisis stabilization and subacute facility. A lack of crisis facilities in a community does push individuals to EDs which come with their own costs which the National Association of State Mental Health Program Directors (NASMHPD) cites (from Wake Forrest Study) at $2,264 cost to the ED per episode for an individual with a mental health
challenge. In 2013, the National Institute of Health cited an average emergency department cost of $1,233 which is avoided for 96% of individuals we serve in our crisis stabilization program. In 2018, this would translate into an emergency department savings of $6,271,137 when compared to models in which all individuals are first medically cleared via an emergency department assessment. The ability to take direct law enforcement drop-offs eliminates these ED costs as well as the corresponding delay to accessing care.

**Transforming Clinical Practice Initiative**

Working in partnership with the Practice Innovation Institute, we have quickly progressed through all 5 phases of transformation and graduated TCPI on January 11, 2019. By embedding patient and family engagement that promote health outcomes, we demonstrate notable reduction in costs and unnecessary hospitalizations. Additionally, we are actively engaged in a value-based contract focused on coordination of care, follow up with the behavioral health provider within 7 days of intervention and we are proud to report a score of a 100% in 2018.

RI operates as a national leader in areas of Zero Suicide and Crisis Now consensus exceptional practice standards as co-leads of these National Action Alliance for Suicide Prevention initiatives. The RI-developed data table (interactive model) below represents the data currently being used to guide crisis system design on the National Association of State Mental Health Program Director’s (NASMHPD’s) Crisis Now.com website. The model includes real Maricopa County healthcare cost and capacity impact to inform the national model that is now in place. Evolved data are defined to mean that the program has moved from the baseline in which a system meets mental health crisis needs solely through emergency departments and acute inpatient beds to one in which is evolved: incorporating a full continuum of crisis services that include mobile teams, crisis stabilization chairs, subacute beds and acute inpatient in ratios that align with the typical levels of clinical need of individuals who experience a crisis (please see graphic above, RI Peoria Crisis Center, for breakdown of over a decade of statewide Level of Care Utilization (LOCUS) data for individuals engaged by mobile teams, crisis facilities or in EDs). RI has done this research, analyzed the data in collaboration with Medicaid and other state agencies and then made the models and tools publicly accessible to all with the NASMHPD website to advance these cost saving quality improvement efforts throughout the nation.
As can be seen from the Calculator, the **Crisis Now** program can drastically reduce the number of inpatient beds needed and move more services to lower intensity settings, such as crisis beds, crisis observation chairs, and mobile teams. If the results shown were achieved, it would result in more individuals served (103,200 vs. 70,176) while reducing costs by 52%. Although this calculator is focused on projections for communities, the graphic represents assessed impact of crisis service implementation in Maricopa County where RI International is one of three crisis stabilization service providers.
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.

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.
St. Elizabeth’s Health Center TCPI Exemplary Practice Performance Summary

St. Elizabeth’s Health Center (SEHC) is a faith-based Federally Qualified Health Center (FQHC) located in Tucson, Arizona, providing primary medical, dental care, behavioral health, nutrition, services to Medicare, Medicaid and uninsured patients. We serve a population of approximately 8,000 members with 11 primary care providers and 8 specialty providers in 1 location. Our goal to achieve NCQA Patient-Centered Medical Home recognition, which we accomplished in December 2017, intensified our focus to provide the best care possible for our fragile and underserved population.

Our practice exemplary performance was achieved by focusing, initially, on meeting and exceeding the Health Center’s Uniform Data System (UDS) national measures. Utilizing our electronic health record, we generated population health reports to identify care gaps within our population. In conjunction with feedback from clinical team, work group designations, PDSA cycles, and weekly/monthly meetings, our practice successfully met or exceeded the national UDS targets for several of the measures. As chart above illustrates, in 2015, cervical cancer screening was at 31%, which was below threshold of the 2016 UDS national average. In 2018, for 3 consecutive quarters, we met or exceeded the stretch goal by achieving 70%, meaning 8% above the UDS target. Colorectal cancer screening measure, in 2015, we met or exceeded threshold at 32%. In 2018, we maintained an average of 68%, which is 8% above the threshold. Additionally, Coronary Artery Disease, Diabetes Control, and Asthma Pharmacologic Therapy are 3
measures showing continuous improvement and are currently *Meeting/Exceeding UDS Thresholds or Meeting/Exceeding UDS Targets*.

Furthermore, we reduced emergency department (ED) and inpatient visits (IP) by improving care coordination processes for closing the referral loop and outreach processes for inpatient discharges. We reduced ED visits for three consecutive periods, the most recent showing a 31.5% decrease compared to baseline. Additionally, we achieved reductions in IP admissions for the same three consecutive periods, the latest showing a 29.0% decrease compared to baseline (see Table 1 and Figure 1 below). Estimated cost savings from ED visit reduction totaled $965,000 (using an average cost per ED visit of $449). Similarly, using an average cost per IP admission of $5,761, the estimated savings from reduced IP admissions totaled $2.5 million.

**Table 1/Figure 1 – Reduction in ED Visits/IP Admits**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Year 1 Change</th>
<th>Year 2 Change</th>
<th>Most Recent 12 Month Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits</td>
<td>-11.7%</td>
<td>-25.1%</td>
<td>-31.5%</td>
</tr>
<tr>
<td>IP Admits</td>
<td>-13.6%</td>
<td>-22.9%</td>
<td>-29.0%</td>
</tr>
</tbody>
</table>

Staying true to our vision of person and family-centered care design, we expanded our focus to another population to address the emerging opioid national crisis. According to the Arizona Department of Health Services, between June 2017 and May 2018, Pima County had 1,359 reported cases of opioid overdoses, with 15% being fatal. With state and national emergency called on opioid utilization, our executive leadership, pledged to prevent and combat use disorders, opioid overdoses, and related deaths.

Applying our regular improvement methodologies, our initial step was to obtain feedback from the rest of the practicing providers which meant holding multiple, consecutive meetings to gain consensus/buy-in, not only, on such undertaking, but also, to inquire as to the process, expectations, deliverables. Using the Arizona’s Opioid Prescribing Guidelines as our tool, we began the transformation processes which included:

- Revise policy and procedures for opioid treatment to correspond with CDC and Arizona Opioid Prescribing Guidelines
- Update/develop forms such as opioid treatment agreement, informed consent, pain assessment and documentation tool (PADT), and opioid risk tool (ORT)
• EHR modifications: create opioid document, assigned scanned documents to auto-populate flowsheet, create custom flowsheet view, add naloxone to EHR custom med list, create quick texts for provider documentation
• Collect and maintain substance use treatment resources, relevant to the patient population served (use of internal behavioral health and collaboration with external providers)
• Create a registry for established patients on long-term opioids and apply risk mitigation strategies (EHR based)

**Figure 2 – Use of Multiple Prescriber Comparison**

![Graph showing comparison between Sep 2017 and Sep 2018 performance for use of multiple prescribers/pharmacies.](image)

The graph reflects a comparison between Sep 2017 performance and Sep 2018 performance. In two of the 3 HEDIS measure elements, our practice performed slightly better than the PTN performance. Similarly, between June 2017 and May 2018, Arizona saw a 17% decrease in opioid overdose cases.

**Figure 3 – Use at High Opioid Dosage Comparison**

![Graph showing comparison between Sep 2017 and Sep 2018 performance for use of opioids at high dosage.](image)
We continue to work with providers and patients in reducing the number of patients who are taking high dosage of opioids. Figure 3 reflects our continuous improvement initiative as our PTN had a greater reduction than our organization. Given the size of our population, a 17% decrease is a step in the right direction.

Consideration for patient needs and desired health outcomes, along with provider buy-in, we designed a treatment plan to mitigate the patients’ risks while on the medication, which included a tapering plan and alternative treatment options. Through this process, we identified patients whose complexity was significantly greater due to their other physical health or behavioral health diagnoses. For these patients we continually assessed the need to transition patients to a behavioral health provider and/or a medication assisted treatment (MAT) provider when appropriate.

Our practice continues to develop and enhance quality improvement efforts with the inclusion and feedback from patients. Patient engagement is key to the continued success of our practice and services. As such, we collect patient experience surveys on an annual basis. The survey includes categories such as access, communication, and self-management and care coordination. Key indicators:

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Performance</th>
</tr>
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<tbody>
<tr>
<td>Recommend SEHC</td>
<td>97%</td>
</tr>
<tr>
<td>Provider Listens</td>
<td>95%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>93%</td>
</tr>
<tr>
<td>Education about Improving Health</td>
<td>95%</td>
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Finally, we have success in managing relations with value-based contracts, most recently joining Equality Health who will provide additional assistance in managing value-based relationships. We are confident that practice transformation, leading to improvement in health outcomes and cost savings, is an achievable aim.
Sun Life Family Health Center (Sun Life) is a not-for-profit Federally Qualified Health Center (FQHC) organization providing healthcare in Arizona in the areas of Apache Junction, Casa Grande, Chandler, Eloy, Coolidge, Florence, Maricopa, Oracle and San Manuel throughout 12 locations with 63 clinicians on the Sun Life team. We are the largest provider of primary health care services in Pinal County and are governed by a Board of Directors representing the patients and communities served. Sun Life serves over 47,000 patients, 28% of whom are children. What makes Sun Life different is our unfailing concern for the well-being of our patients, and our willingness to provide the best possible experience for every person that walks through our doors.

Commitment to close patient Care Gaps was made and observed closely over a 7-month period. I was the first clinician to recognize the impact these care gaps made on key clinical AIMS in the practices. Instilling a new way of seeing patients, while improving two major AIMS (preventative visits and reducing unnecessary tests) it became my mission and sparked the creation of the “Healthcare Team Integration” program. This new program would mean that each patient would have all their clinical needs and care gaps addressed by either their primary PCP team or a team of collaborating clinicians at each scheduled or walk-in visit. The program would bring back “Patient Centered and Whole-Person” care once again.

Healthcare Team Integration and Practice Standardization is supported by the implementation and integration of AZARA Healthcare (AZARA DVRS) and eClinicalWorks (ECW), our Data Retrieval/Population Management and Electronic Health Record (EHR) programs. We practice healthcare delivery one patient at a time. Our ongoing transformation and progress are assisted by the implementation of Lean Six Sigma change management tools that help us create process improvement and instill team empowerment. Quality Improvement and Risk Management programs were also integrated, along with the use of our Uniform Data System (UDS) measures and Patient Family Engagement initiatives through council participation by patients. Each practice site also implemented a practice manager to oversee and maintain our continually evolving program.

Proof of Program Effectiveness was shared by using and modeling my own Gynecology practice data and outcomes with the Sun Life practice teams. My next step was to replicate the program across all disciplines in the Sun Life organization. To assist me in making this happen, I met with clinicians in a 1:1 in-service to share the protocols and assist them with the paradigm shift. This process is also a part of all onboarding of new hires. My pilot program produced measurable improvement with appointment follow-ups and produced a systemic redesign of the care delivery system for walk-ins or patients making same day appointment requests. The team members in each practice are able to see their monthly improvements with the use of AZARA and ECW data integration. Through the implementation of the AZARA DVRS Dashboard and Individual practice graphs, the Healthcare teams have the ability to see real time data to assist in making process improvements immediately.
AZARA Healthcare Dashboard (AZARA DVRS key Care Gaps measures) for Sun Life Family Health Center

**Continued Training** of clinicians and support staff on AZARA DVRS and expanding ECW capabilities into their practices gives Sun Life patients a seamless experience when they walk through the practice doors. My program has laid a path for realignment on how Sun Life practices healthcare delivery with real-time closing of clinical, especially chronic, care gaps.

**Areas of Demonstrated Performance Excellence** related to the TCPI aims are:

AIM 2 Clinical Outcomes: **Diabetes**

AIM 2 Clinical Processes: **Preventative Visits, Cervical Cancer Screening, Care of High-Risk groups** as evidenced in the graphs below.

**Supporting Data Graphs** below show improved clinical outcomes with preventative visit adherence to **Cervical Cancer Screening, Child Weight Screening / BMI program, and Hypertension Controlling High Blood Pressure** which brought about the closing of care gaps in these areas. Q4 2018 demonstrates the improvement that took place after the implementation of the **Healthcare Team Integration program**.
This Cervical Cancer Screening graph shows the Quarter trend in adherence to these Clinical Processes. The graph shows a 50% improvement between the start of the Healthcare Team Integration program during the Q1-2017 and Q2-2017 time period.

This Child Weight Screening/BMI/Nutritional graph shows the Quarter trends in adherence to this Clinical Outcome. The downward slope in the graph from Q1-18 at 46% down to Q3-18 at 12% represents a program transition and the start of a new wave of children in the program Q3-18 at 12%. The subsequent program adherence to the Child Weight Screenings and integration of the Integrated Healthcare Teams contributed to the second program wave only going down to 12% and making an 8% improvement between Q1-18 and Q1-19.

This Hypertension Controlling High Blood Pressure graph shows the upward trend in visits from Q4-2017 to Q3-2018. Q4-2018 was the introduction of new patients to the program. The adherence drop to 67% in Q4-2018 was minimal due to the Healthcare Team Integration program. With this said, this was able to recover and excel with patient adherence to 80% within the next 3-month Quarter.

Sun Life’s commitment to providing patient-centered care through our Integrated Healthcare Team approach is a benefit to payors and patients alike. The changes that were implemented to align with this commitment allow us to provide care that improves clinical outcomes and reduces unnecessary utilization of healthcare resources. We feel strongly about the changes and commitments that have been made, our leadership has made a commitment to share the cross-collaborative health team story with all clinicians and provide ongoing communication between clinicians within and outside of Sun Life Family Health Centers.
Terros Health (Terros) is an integrated health care provider with specialization in trauma-informed primary medical care and mental health care, substance use care, mobile crisis, and family services. Inspiring Change for Life is our compelling purpose, and in 2018 we helped more than 53,000 Arizonans on the path to better health and an improved quality of life. As a community health center and safety-net provider, we intend to create healthy communities while meeting our quadruple aim of excellent patient experience, empowered staff, quality health care outcomes, and controlled health care costs. We keep this aim in focus through our vision to provide extraordinary care by empowered people achieving exceptional outcomes.

In the last 50 years, we’ve grown into a leading healthcare organization employing more than 900 professionals across 17 locations. At Terros Health, we believe a person’s mind and body represent whole health. We join each patient on his/her journey toward healthy living, utilizing evidence-based practices that offer the most benefits to improved health and well-being. Our compassionate integrated care teams place the patient at the center of all we do.

Achieving healthy communities

Our approach to care: Extraordinary care begins by creating a medical home, a place where patients can come to meet all their health care needs. Terros Health is recognized as a Patient Centered Medical Home (PCMH), which means that we embrace a team-based health care delivery model. Our patients find that our providers and nurses work directly with peers, community health workers, counselors, case managers, behavioral health coaches, and other staff to coordinate care and communicate within our integrated setting and through our referral network.

To facilitate this dynamic communication and our approach to care from a whole health perspective, we have implemented a single integrated medical and behavioral health record.
Our investment in people: Our staff is our most valuable asset. We strive to cultivate joy at work by providing our employees with trainings, tools, a safe environment, and caring, competent leadership. We encourage our teams to have fun and connect with each other. During our spirit weeks throughout the year, we have themed days and dress up competitions that allow us to learn more about each other and offer a creative outlet for our staff.

Our focus on population health: At Terros Health, our formula to manage population health includes the following components.

1. **A systematic process to use data to inform our clinical interventions**: one example is that our care coordination team uses a report listing gaps in care to reach out to our patients and encourage them to complete the necessary preventative screenings. We also use data to educate our medical providers on our quarterly performance with respect to clinical measures.

2. **Education and training**: we train medical providers during their staff meetings on how to properly document their work in the EHR. We also created a population health calendar to rally the organization around a specific health topic on a monthly basis in order to increase awareness and improve the screening rate.

3. **Integration at the staff level**: we have strategically repositioned our population health staff within our service excellence department to enable this staff to become the bridge between quality and care delivery.

We have found that empowering our administrative and clinical staff to take an integrated team approach to assessing the quality of our care delivery yields improved health outcomes for our patients, particularly as they pertain to the Uniformed Data System (UDS) measures. UDS measures are a standardized set of clinical measures that Federally Qualified Health Centers (FQHC) and look-alikes use to report on their performance.

The TCPI bold aims/performance that makes Terros high value to payers and patients are, AIM 2 Clinical Outcomes- Asthma and Diabetes and AIM 2 Clinical Processes- Meeting evidence-based guide – Asthma and Diabetes. These AIMS are accompanied, as demonstrated below, by our diligent Clinical Measure efforts in the areas of improved Childhood Immunization, Body Mass Index and Colorectal Cancer Screening.

Following is data that demonstrates that we are generating the desired behaviors to continue to improve our performance on specific clinical measures.
Our core values of integrity, compassion and empowerment inform our approach to care, our investment in our employees, and our focus on population health, and in turn, these key factors provide a foundation for our improved clinical performance.
Wesley Community and Health Centers Exemplary Practice Performance Summary

Wesley Community and Health Centers (Wesley), since 1950, has provided community programs, services, classes, activities, and meeting spaces, for the primarily Hispanic families residing in south-central Phoenix. For many years, the primary activities included adult English and citizenship activities (including but not limited to amnesty programs). With the addition of a gymnasium in the 1970s, more programs were provided for children and youth, continuing that emphasis.

With the addition of Mother/Baby clinics in the 1970s/80s, the healthcare priority expanded in 2002. Centro de Salud health center began with volunteer physicians, primarily from the Banner Good Samaritan Hospital (newly named Banner University Hospital - Phoenix). These primary healthcare services and clinic began as “uninsured only”—all patients paying $20 per visit (increased to $40 after one year, when the patients commented that we should “charge more” for our excellent healthcare services). With an unexpected Federal stimulus grant from HRSA on March 1, 2009, this healthcare for “uninsured only” became a Federally Qualified Health Center (FQHC), providing healthcare to “underserved populations regardless of their ability to pay”.

We expanded our primary FQHC healthcare services at its original site, at 1300 S. 10th St. In November 2016, and we opened our newly expanded second healthcare site at the Golden Gate Community Center (1625 N. 39th Avenue). The Golden Gate Community Center is owned by Wesley and coordinates all services with 300 English Second Language (ESL) adult students, 150 children and youth in afterschool and summer programs, and community health programs.

Our health centers have partnership agreements with Banner University of Arizona Medical School/Phoenix, Arizona State University, Midwestern University, and Mayo Clinics, which often include residents, medical students, and volunteers from many health-related entities. Wesley is also a member of the Arizona Alliance of Community Health Centers (AACHC). Our clinical staff consists 2 physicians, 5 Nurse Practitioners, 4 full time and 1 part time and 5 Medical Assistants.

The bold aims/performance that makes our practice a high value to payers and patients revolves around AIM 2 Clinical Outcomes – Asthma and AIM 2 Clinical Processes - Meeting evidence-based guidelines – Asthma. Our goal for care of patients with persistent asthma is that all will be prescribed and be able to access and consistently utilize appropriate asthma controller medications (inhaled corticosteroids, long-acting bronchodilators).

When diagnosed with Asthma, all patients are given their prescribed Asthma medication list and referred by their clinician to the Wesley Community Asthma Program. We are connected with the GSKForYou Assistance program (https://www.gskforyou.com/) which is a website designed to help people who need assistance paying for their GlaxoSmithKline prescription medicines and vaccines. The patient fills out a needs assessment application and work with the Patient Care Coordinator or Patient Navigator to identify Asthma mediation needs and enroll in the GSK program. Services are provided whether the patient has insurance, a social security number or not, resulting in full compliance in Asthma Management for all Asthmatics. All medications are free of charge. All our Medical Assistants (MAs) are also trained on the intake protocols and processes of the Asthma Management Program and maintain this standardization over both campuses.
Through a team-based approach, Wesley focuses on bringing clinicians together to build evidence-based care models for effective patient solutions. Our model of care is built to focus on the improvement of health outcomes for our population. The patient centered care model is developed to address the needs of the patient from the moment they walk through the door (check in process) to the rooming and appointment process (medical assistant and provider involvement) lab process, referral process, and check out process. Our model is focused on closing the loop on patient needs using a team-based approach. From administration, to the front desk, to the clinical team: everyone is trained to understand how each step of the Patient Centered Care model works and what each team member’s role is within this model.

Our Uniform Data Service (UDS) report demonstrates our outstanding achievement in asthma care. All health center patients with a diagnosis of persistent asthma (whether mild, moderate, or severe) are evaluated annually for appropriate use of asthma controller medications. The state and national average for patients meeting this goal is 86%; Wesley Health Center consistently achieves > 92% with most years meeting 100% compliance. We pulled our data into AZARA DRVS, our population management software, to produce graphs below that show a visual picture of the data.

This graph shows our percentages since we implemented AZARA.
You will see that Wesley has an AVERAGE of 93% in 2018.
A Culture of Person and Family Engagement (PFE) drives and contributes to our performance. Our patient care coordinator, as with all our clinic staff, is dedicated to helping patients achieve health and wellness. By demonstrating our commitment to helping patients access care and various treatment options, we observe increased patient engagement with their individualized care plan as well as motivation to adhere to the plan—whether it is to continue treatment when effective, or schedule more frequent follow ups when optimal outcomes have not yet been achieved.
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