OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Care Transformation Advisory Committee
Meeting Agenda
October 5, 2015, 8:00 A.M. to 11:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

1. Introductions
2. Name change to Primary Care Transformation Advisory Committee
3. Finalize definition of PCMH
4. Discuss provider focus group results and barriers to transformation
5. Identify initiatives to reduce/eliminate barriers to transformation
6. Discuss opportunity to refine high-risk patient list provided by payers to practices
7. Update on SIM Measure Alignment Workgroup
8. Public Comment

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Care Transformation Advisory Committee
Meeting Minutes
October 5, 2015, 8:00 A.M. to 11:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Committee Members: Gus Manocchia, David Brumley, Tracey Cohen, Mary Hickey, Beth Lange, Ed McGookin, Andrea Galgay, Christine Grey, Darlene Morris, Deb Hurwitz, Pano Yeracaris, Kathleen Calandra, Mary Craig, Peter Hollmann

Not in Attendance:
Gina Rocha, James Fanale, Brenda Briden, Russell Corcoran, Maria Montanaro, Ed McGookin, Tina Spears

1. **Introductions**

2. **Joint Committee Summary**

   Sarah Nguyen, OHIC, reviewed the major points from the Joint Committee meeting on Thursday October 1, 2015.

   a. Discussion of overlapping topics between the Care Transformation and APM committees and alignment with other state initiatives
      i. Committee members specifically discussed alignment and representation from the Department of Health in these Affordability Standards conversations
      ii. Committee members recommended a wrap-up combined joint committee at the end of this process. OHIC will follow-up with Committee Members to schedule a date.
      iii. At the Joint Meeting, committee members, called out plan design as a specific topic for the APM committee as part of consumer engagement.
   b. Primary care transformation and ACOs
   c. Consumer protections
      i. Committee members discussed the importance of the patient perspective as the system moves towards ACOs. There should be consumer protections in place to protect patients from unnecessary restriction of care or selection of healthy patients.
   d. ACO governance and different ACO models
      i. Committee members discussed the fact that there are different models of ACOs, (e.g. physician led vs. institutional led). Additionally, some ACOs have a specific focus on primary care.

ii. Practices are worried that ACO care management dollars are not flowing to the practices. Committee Members emphasized the need for strong primary care representation in ACO governance structures.

e. Focus on Specialists and engagement of small practices
   i. Committee members discussed the difficulties associated with the engagement of small practices.
   ii. Committee members also noted that hospitals and specialists should be held accountable to targets as well.
f. Standardization and alignment of data, quality metrics, attribution etc.
   i. Committee members noted the need for better information if primary care is to succeed.
g. Strategies to accelerate movement towards "accountable care" and APMs
h. Incentives and disincentives for physicians (PCPs and specialists) and patients
   i. Committee members discussed the need to align incentives for specialists and hospitals and to have common goals across entities.

3. Name change to Primary Care Transformation Advisory Committee

Committee members discussed a potential name change to this committee – members felt strongly about keeping the original name of the committee because specialty and hospital care impact primary care transformation and will continue to be connected as the health care system moves towards more accountable care.

4. Finalize definition of PCMH

a. Cost Containment Strategies

OHIC has been working with a subset of the Committee to develop the cost containment strategies survey and has incorporated feedback from the payers, providers, CTC, and RIHCA. Committee members noted that before they could comment on this final version, they would need to see a document with a timeline of how all the OHIC requirements and funding model tie together.

Beth Lange, PCMH-Kids, noted that co-pays can be an adversarial component for the family and that as OHIC explores plan designs, they should be aware of the situation in pediatrics where parents are batching all questions for their well-child visit assuming that there is no co-pay for this visit. However, because physicians are doing education at this visit, they have to code parts of the visit as such and this triggers an unexpected co-pay for the parents.

b. Performance Improvement

Cory King, OHIC, updated the committee on the status of the performance improvement requirement. OHIC is working with the carriers to finalize the performance measures and is also working with the APCD to try to automate this process in the future.

Committee members requested that there be an in-depth discussion of these performance

improvement measures at the next Care Transformation meeting (October 22, 2015). Committee members also discussed the need for these measures to align with the SIM Measure Alignment Workgroup and the Data and Evaluation Workgroup of CTC-RI.

Sarah Nguyen, OHIC, noted that the current performance measures being examined are:

- Breast cancer screening;
- Adolescent well-care visits;
- Comprehensive diabetes care: eye exam (retinal) performed;
- Avoidance of antibiotic treatment in adults with acute bronchitis;
- Comprehensive diabetes care: medical attention for nephropathy;
- Use of imaging studies for low back pain;
- Antidepressant medical management: effective acute phase treatment; and
- Antidepressant medication management: effective continuation phase treatment.

Committee members noted that several of these measures are difficult to collect at the practice level and discussed the possibility of practices being able to report this data themselves, rather than having the carriers report the data, noting the concern of available practice resources. Committee members also discussed the possibility of having various levels of measures for different levels of transformation (process measures versus outcome measures).

c. Other Components of 2016 Care Transformation Plan

Sarah Nguyen, OHIC, briefly reviewed the other components of the 2016 Care Transformation Plan.

i. 2016 PCMH target
ii. 2016 baseline
iii. Stakeholder activities
    1. PCP educational campaign
    2. Care Manager Academy
    3. Care Management Coordination Workgroup
    4. Annual meetings
    5. Standard core measure set
    6. Community Health Team Pilot Expansion

5. Discuss provider focus group results and barriers to transformation

Megan Hall, who moderated all three of the provider focus groups presented the summary results of the focus groups. She noted that a more complete report will be coming in the next few weeks. Committee members were given a handout with the high-level summary results.

Committee members asked about the PCMH definition that were given to the provider participants. Megan Hall and Sarah Nguyen noted that participants were given a higher-level summary of the OHIC definition that included all three components (accreditation, cost containment, and performance improvement). Committee members responded that if future focus groups are implemented, it might be worth exploring using a summary of the NCQA definition to see if the reaction differs.

Megan Hall noted that the third focus group consisted of doctors who all had moved to the U.S. to become doctors and were the most unaware of PCMHs and ACOs and as such, their perspectives might be different from doctors who are born in the U.S. Please see the focus group handout for more themes and take-aways.

Committee members noted the following points and questions:

- Most of the provider participants in these focus groups were in small or micro practices – their perspectives may differ substantially from participants who are in larger practices. Additionally, the focus group participants' average age was 55 years – results may be different with a group of younger doctors.
- Do the demographics of these focus groups match up with the non-PCMH practices that are left in Rhode Island?
- If future focus groups are to be conducted, OHIC could consider doing a merged group with both PCMH and non-PCMH providers.
- Documentation associated with becoming and maintaining PCMH status is a barrier for both small and large practices.
- What is the quality performance difference between PCMH and non-PCMH practices in RI?
    - Neil Galinko, United, noted that at least, nationally, there wasn't an association between achieving NCQA Level III and high performance.

6. **Identify initiatives to reduce/eliminate barriers to transformation**

During this conversation, committee members made the following suggestions and notes:

- A value proposition for care transformation and PCMH needs to be developed which can include a statement about what it means to "not be a PCMH".
- The concerns of current PCMH practices should be addressed so that these practices can act as "ambassadors" to non-PCMH practices.
- CTC-RI has acted in the practice facilitator role but does there need to be more "hands-on" practice transformation to address the concerns raised in the focus groups?
- There could be an "administrative/technical" person as part of the Community Health Team model to help practices with the administrative side of becoming a PCMH and maintaining PCMH status.
- How will funding for additional administrative assistance be provided?

- Committee members discussed that some practices may not want to aggregate or become part of a larger organization and they may want to keep their independence – what type of supports could help these practices? The concept of a "PCMH geek squad" was discussed – this team could act as a shared resource among practices and could help with the more administrative side of PCMH accreditation.

Darlene Morris, RIQI, presented on CurrentCare hospital alerts and on RIQI's recently awarded Practice Transformation Network (PTN) grant. This grant would provide: practice transformation assistance towards NCQA or other recognition, with an emphasis on specialists and small practices, a physician leadership academy, care coordination and transition assistance through CurrentCare, assistance to practices looking to enter into value-based contracts (RIQI can only give technical assistance when the practices are not in value-based contracts), and performance measurement. OHIC will work with RIQI to better understand how this grant and the care transformation work can be integrated. Committee members also noted that there should be alignment between the PTN grant work and SIM as well.

Committee members were asked to consider whether CurrentCare hospital alerts should be formally included in the Care Transformation Plan.

7. Discuss opportunity to refine high-risk patient list provided by payers to practices

Sarah Nguyen, OHIC, noted that the discussion around the potential elements, format, and mode of delivery for the high-risk patient list will move to the Care Transformation Committee. Members suggested that a sub-committee be developed – OHIC will solicit names for that sub-committee.

8. Update on SIM Measure Alignment Workgroup

Cory King, OHIC, updated the Care Transformation Committee on the progress of the SIM Measure Alignment Workgroup – four meetings have been held to date and the group is currently discussing hospital measures with the next topic being behavioral health. The measures will be used for contracting purposes and it will be a menu of measures with a core set.

9. Next Steps

Committee members were given the topics and dates for the upcoming Care Transformation and APM Committee meetings. The next Care Transformation meeting is on October 22nd and the next APM meeting is on October 16th.

10. Public Comment

There was no public comment.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Care Transformation Advisory Committee

Fall 2015 Convening
October 5, 2015

Agenda

1. Introductions
2. Summary of Joint Committee Meeting
3. Name change to Primary Care Transformation Advisory Committee
4. Update on operationalizing definition of PCMH
5. Discuss provider focus group results
6. Identify initiatives to reduce/eliminate barriers to transformation
7. Discuss opportunity to refine high-risk patient lists
8. Update on SIM Measure Alignment Workgroup
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10/1 Joint Committee Summary

- Discussion of overlapping topics between the two committees and alignment with other state initiatives
- Primary care transformation and ACOs
  - Consumer protections
  - ACO governance and different ACO models
- Focus on Specialists
- Standardization and alignment
- Strategies to accelerate movement towards "accountable care" and APMs
- Incentives and disincentives for physicians (PCPs and specialists) and patients

Name Change to Primary Care Transformation Advisory Committee

- Committee, as charged by Regulation 2, is focused on primary care transformation and the strategies/initiatives needed to build a strong primary care infrastructure
- Does not mean that the Committee cannot discuss topics relating to specialty care and how this impacts primary care

Finalizing and Operationalizing the Definition of PCMH

- Cost Containment Strategies
  - OHIC worked with a subset of the Committee to develop the cost containment strategies survey
  - Incorporated feedback from the payers, providers, CTC, and RIHCA
  - Comments on the final draft due Monday October 12th
- Performance Improvement
  - OHIC is working with carriers to finalize the performance measures
  - Also working with APCD to try to automate this process in the future

Other Components of the 2016 Care Transformation Plan

- 2016 PCMH Target
- PCMH baseline calculation
- Stakeholder activities
  - PCP educational campaign
  - Care Manager Academy
  - Care Management Coordination Workgroup
  - Annual meetings
  - Standard core measure set
  - Community Health Team Pilot Expansion
- 2-Part Sustainable Funding Model

Provider Focus Group Results

- 3 Focus Groups
  - 2 groups with physicians not in a PCMH
  - 1 group with physicians in a PCMH
- Focus group demographics:
  - Total of 25 practicing physicians
  - Mean age: 55
  - Practicing for average of 23 years
  - Median size of practice: 3 physicians
  - Predominately white males
- See handout for a high-level summary

Discussion: What are the barriers to PCMH transformation and what are some strategies/initiatives to reduce these barriers?

High-Risk Patient List

- List used to identify those patients who are at high risk for future use of expensive health care services and who may be able to avoid the use of those services with intensive care management services
- Need for coordination of efforts and uniform standards around high-risk patient reports
  - Reports should be actionable and accessible
- Discussion topic: what are the potential elements in a high risk patient list and what is the mode of delivery?

SIM Measure Alignment Update

- Held 4 meetings to date
  - Measures reviewed:
    - Pediatric prevention
    - Adult prevention
    - Pediatric chronic illness care
    - Adult chronic illness care
    - Hospital (in progress)
- Approach
  - Measures will be used for contracting purposes
  - Menu of measures with a core set

Next Steps

Care Transformation

- October 22, 2015: 8-11am
- Agenda
  - Develop consensus on initiative to reduce barriers to transformation
  - Continue discussion on enhancing high-risk patient list
  - Discuss implementation of sustainable PCMH financial model
  - Discuss possible common contractual requirements

APM

- October 16, 2015: 8-11am
- Agenda
  - Discuss proposed 2017 and 2018 Aggregate and Non-FFS targets
  - Review current stakeholder activities to achieve 2016 targets
  - Discuss plan design options to promote APM adoption
  - Discuss potential unintended adverse consequences of Total Cost of Care contracting
  - Discuss proposed definition of Meaningful Downside Risk
  - Discuss plan initiatives to achieve APM targets

Physician Focus Group Report Outline

Submitted by The Providence Plan – 10.5.2015

This is a summation of the three focus groups with physicians regarding Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) carried out by The Providence Plan for the Office of the Health Insurance Commissioner. The focus groups occurred on August 6th, September 10th, and September 16th, 2015 and lasted between 60 and 75 minutes. Groups 1 and 3 were comprised of physicians who were not in a PCMH and group 2 consisted of 14 physicians currently in a PCMH.

Focus group demographics:

- Total of 25 practicing physicians
- Mean age: 55
- Practicing for average of 23 years
- Median size of practice: 3 physicians
- Predominately white males

Limitations:

- Small sample size, not enough to reach saturation
- Self-selected sample of participants might mean views expressed are more extreme than overall population of physicians
- The third focus group consisted of providers who all moved to the United States to become doctors. Their perspectives might be different from those of primary care doctors born in the United States.

<u>Enthusiastic participants</u>

Despite a literal road block on the main street leading to the building where the focus group took place, a rain storm and the first Patriots game of the season for the second focus group, only three physicians who RSVP'd did not attend these sessions. We also had an additional three participants who attended without sending an RSVP. Given the challenges often associated with recruiting physicians into research, this participation rate was noteworthy, and presumably attributable to physician's strong attitudes about the topic of care transformation.

Focus Group Themes

1) Our practice is already/was already acting as a PCMH.

2) There is too much bureaucracy and paperwork involved in becoming and being a PCMH.

3) Conflating being a PCMH with instituting and using an Electronic Medical Record (EMR).

4) PCMH model takes them away from interacting closely with their patients, affecting the physician patient relationship and not improving quality of care.

5) A loss of job satisfaction associated with transitioning to PCMH, adopting EMR, or joining an ACO.

6) Skepticism about the motives that are driving reforms, and suspect that third party payers are motivated by an opportunity to cut costs.

Conclusions:

It is difficult to make broad conclusions from three focus groups. However, the following statements ring true:

1) Some physicians feel that they had not been listened to about their concerns about current health reform practice changes.
2) Physicians want to be involved in these discussions about their practices. They want to be part of a bottom up approach to healthcare reforms.

Recommendations:

The Providence Plan is putting forth a set of process recommendations for moving forward, and leaving the question of substantive recommendations to the Office of the Health Insurance Commissioner and its partner organizations. We recommend:

1) Consider additional focus groups, especially with those already in PCMH practices.
2) Following up on these focus groups with a more in-depth survey, in order to get feedback from a broad group of physicians.
3) Find as many ways to include physicians in conversations about the future of their practices as possible, at the times that they are available (early morning or later in the evening).

Rhode Island Quality Institute

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A New Standard of Care

OHIC Care Transformation Committee
October 5, 2015

Topics

1. PCMH Definition & Cost Containment Strategies
2. Tools for Reducing Readmissions
    a) CurrentCare Hospital Alerts
    b) Care Management Alerts
    c) Dashboards
3. Summary of RIQI Grant Awards

OHIC PCMH Definition & Cost Containment Strategies

PCMH Definition & Cost Containment Strategies

- Within 12 months of seeking PCMH status under the Affordability Standards, Practice to implement cost containment strategies:
  i. Develop and maintain high-risk patient registry…;
  ii. Use data to implement care management, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;
  iii. Implement strategies to improve access to and coordination with behavioral services;
  iv. Expand access to services both during and after office hours;
  v. Develop service referral protocols…;
  vi. Develop/maintain an avoidable ED use reduction strategy.

Tools for Reducing Readmissions: CurrentCare Hospital Alerts

Overview – CurrentCare

RIQI Business Services

current care®

Secure repository containing clinical data across geographic, propriety and payer boundaries

CurrentCare & Care Management Alerts

Providers notified in real-time about patient Hospital encounters

CurrentCare Viewer

Providers view patient data via secure website

Provider Directory

Single Source of truth for Provider Information in RI

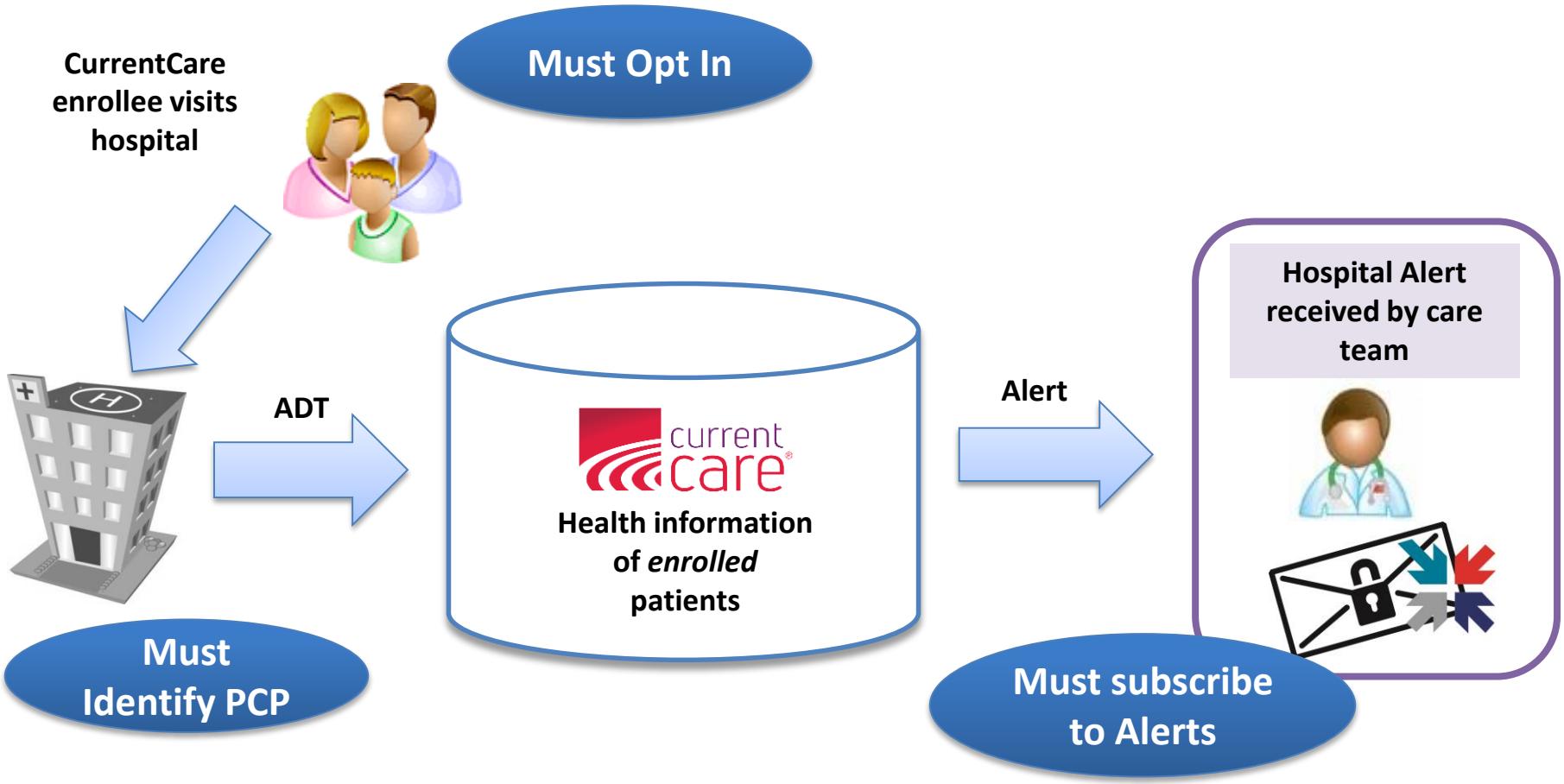
CurrentCare For Me

Consumers access and manage health data on Portal & on Mobile devices

Dashboards

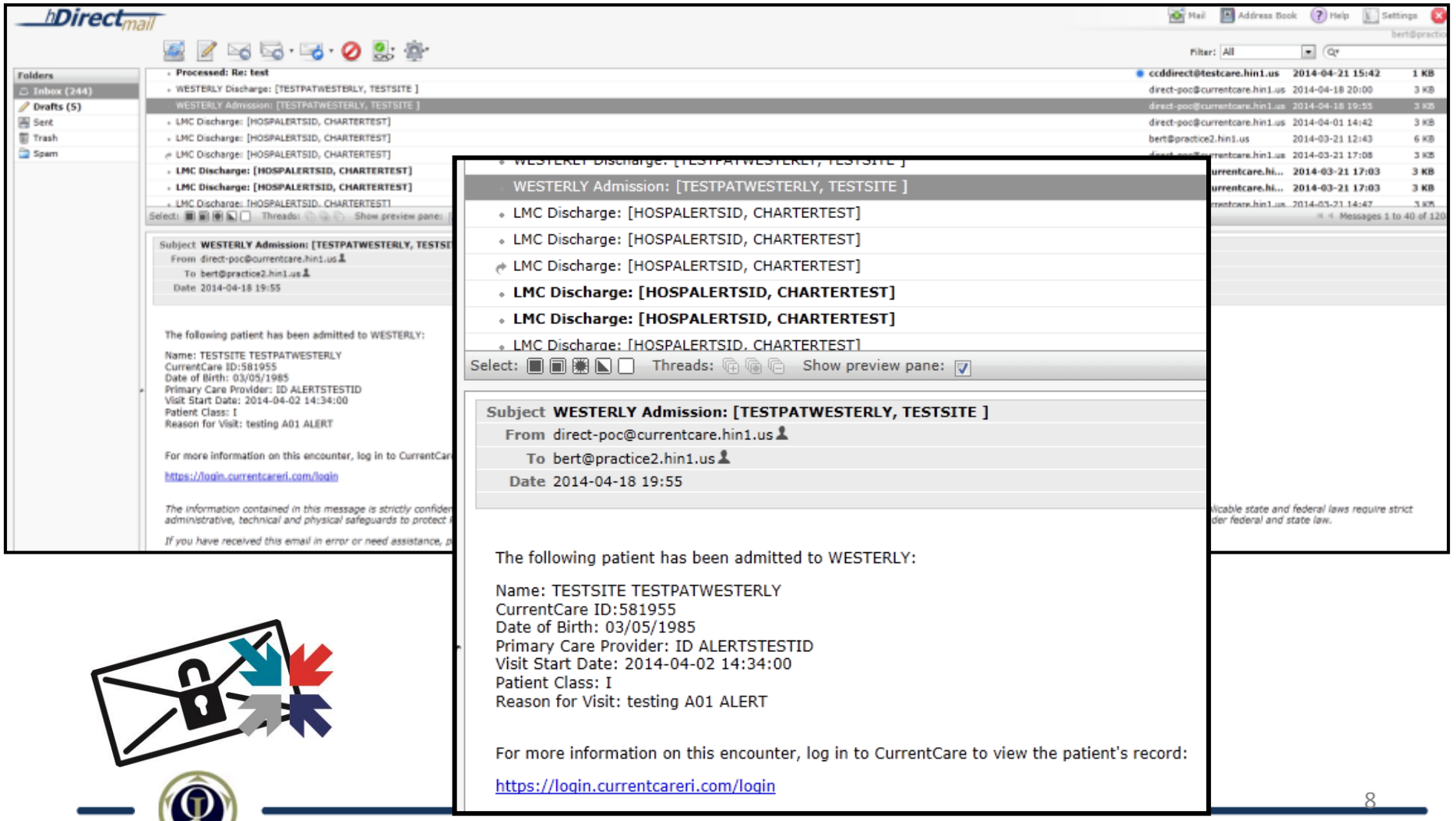
Real-time view of patients in hospital or ED

CurrentCare Hospital Alerts



Specialists can receive Alerts too!

About Hospital Alerts



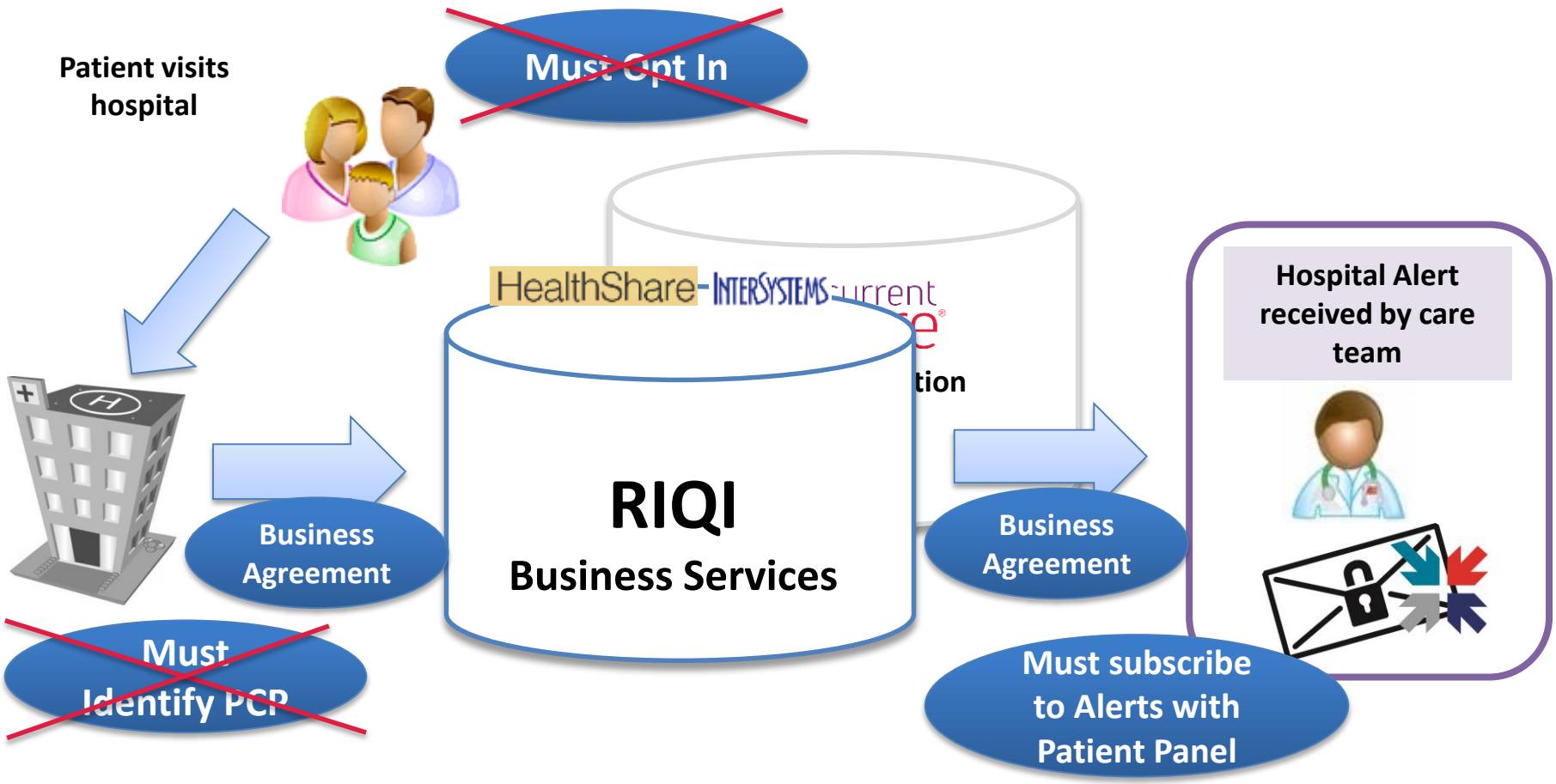
Hospital Alerts - Benefits

Sends real-time Hospital Alerts when an enrolled patient is admitted to or discharged from a hospital or emergency department

- Timely follow-up
- Reduce costly re-admissions
- Strengthen patient-provider relationship

Tools for Reducing Readmissions: Care Management Alerts

About Hospital Alerts



Specialists can receive Alerts too!

Care Management Alerts

- Alerts are sent to a provider for a set of patients when a specified event occurs
- Contracted service with a provider solely for treatment of their patient panel
  - No CurrentCare consent required
  - No PCP required on ADT feed from hospitals
- Specified events
  - ED and In-Patient admissions & discharges
  - Other events in the future

Care Management Alerts

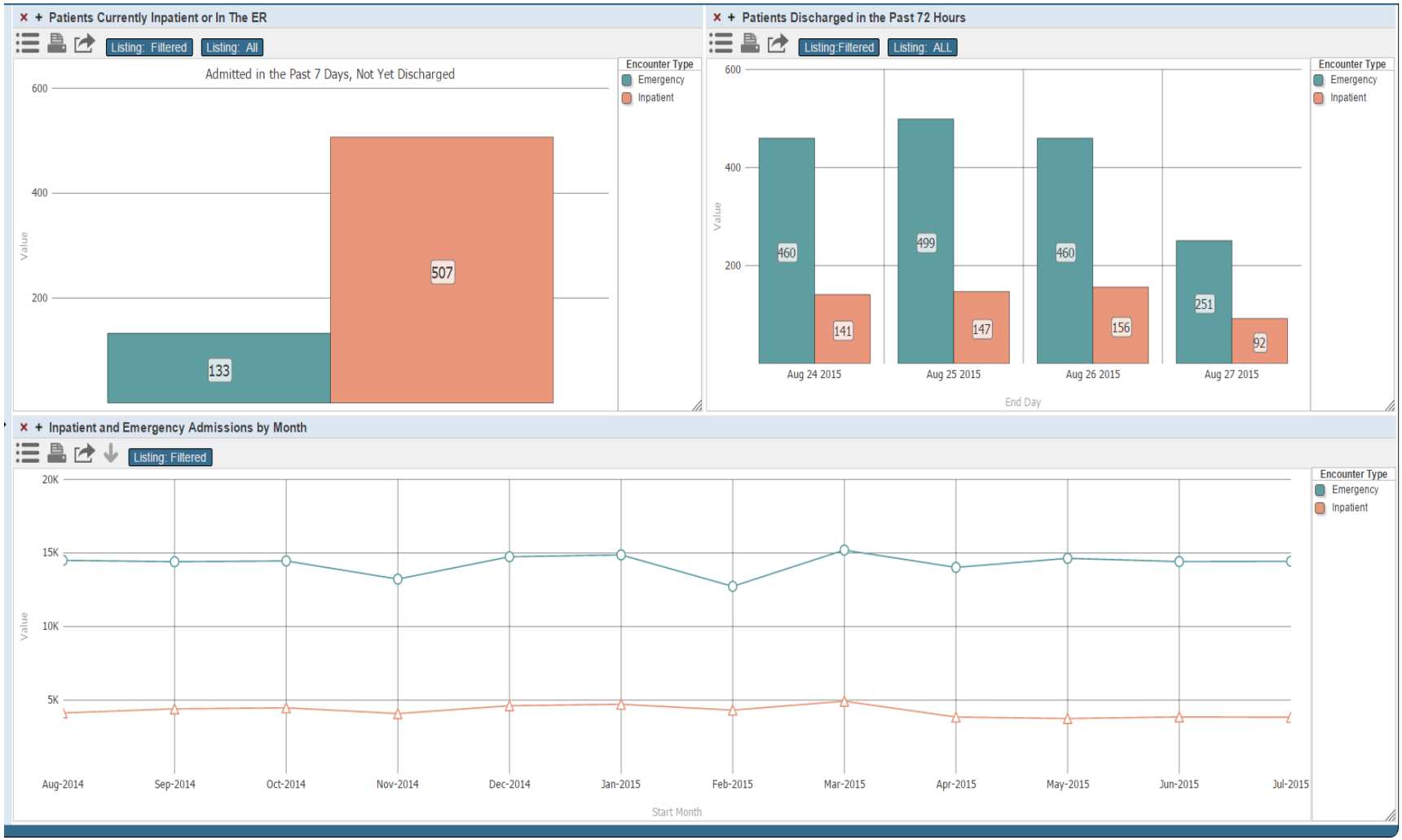
- How does it work?
- Provider creates and sends patient list to RIQI
- Patient can be on more than one list
- Provider can have multiple patient lists
- Each patient associated with address for receiving notifications
- Offered as a business service by RIQI under HIPAA treatment, payment and operations (TPO)

Care Management Alerts for Care Coordination

- Replaces need for hospitals to send fax notifications
- Provides control of which alerts are received
- Allows for better integration with EHR and Care Management Systems
- Reduces readmissions with prompt follow up
  - Save $$
  - Less risk (contract, liability)

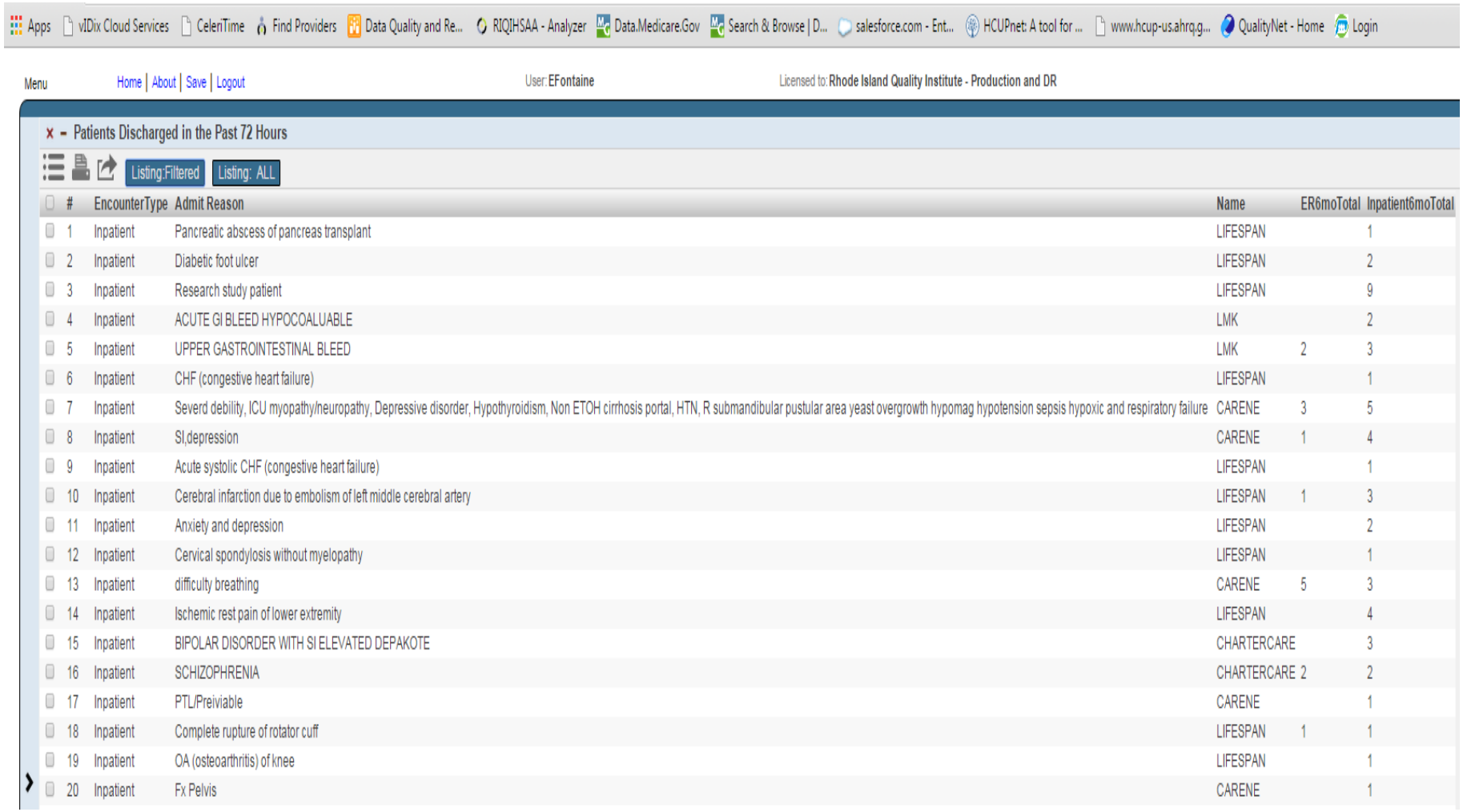
Tools for Reducing Readmissions: Dashboards

Dashboard of Hospital and ED Utilization



….. Data is updated every 45 minutes

Drilldowns Display Individual Patient Data



#	EncounterType	Admit Reason	Name	ER6moTotal	Inpatient6moTotal
1	Inpatient	Pancreatic abscess of pancreas transplant	LIFESPAN		1
2	Inpatient	Diabetic foot ulcer	LIFESPAN		2
3	Inpatient	Research study patient	LIFESPAN		9
4	Inpatient	ACUTE GI BLEED HYPOCOALUABLE	LMK		2
5	Inpatient	UPPER GASTROINTESTINAL BLEED	LMK	2	3
6	Inpatient	CHF (congestive heart failure)	LIFESPAN		1
7	Inpatient	Severd debility, ICU myopathy/neuropathy, Depressive disorder, Hypothyroidism, Non ETOH cirrhosis portal, HTN, R submandibular pustular area yeast overgrowth hypomag hypotension sepsis hypoxic and respiratory failure	CARENE	3	5
8	Inpatient	SI,depression	CARENE	1	4
9	Inpatient	Acute systolic CHF (congestive heart failure)	LIFESPAN		1
10	Inpatient	Cerebral infarction due to embolism of left middle cerebral artery	LIFESPAN	1	3
11	Inpatient	Anxiety and depression	LIFESPAN		2
12	Inpatient	Cervical spondylosis without myelopathy	LIFESPAN		1
13	Inpatient	difficulty breathing	CARENE	5	3
14	Inpatient	Ischemic rest pain of lower extremity	LIFESPAN		4
15	Inpatient	BIPOLAR DISORDER WITH SI ELEVATED DEPAKOTE	CHARTERCARE		3
16	Inpatient	SCHIZOPHRENIA	CHARTERCARE	2	2
17	Inpatient	PTL/Preiviable	CARENE		1
18	Inpatient	Complete rupture of rotator cuff	LIFESPAN	1	1
19	Inpatient	OA (osteoarthritis) of knee	LIFESPAN		1
20	Inpatient	Fx Pelvis	CARENE		1

Dashboards – Drilldowns are configurable

Standard Fields

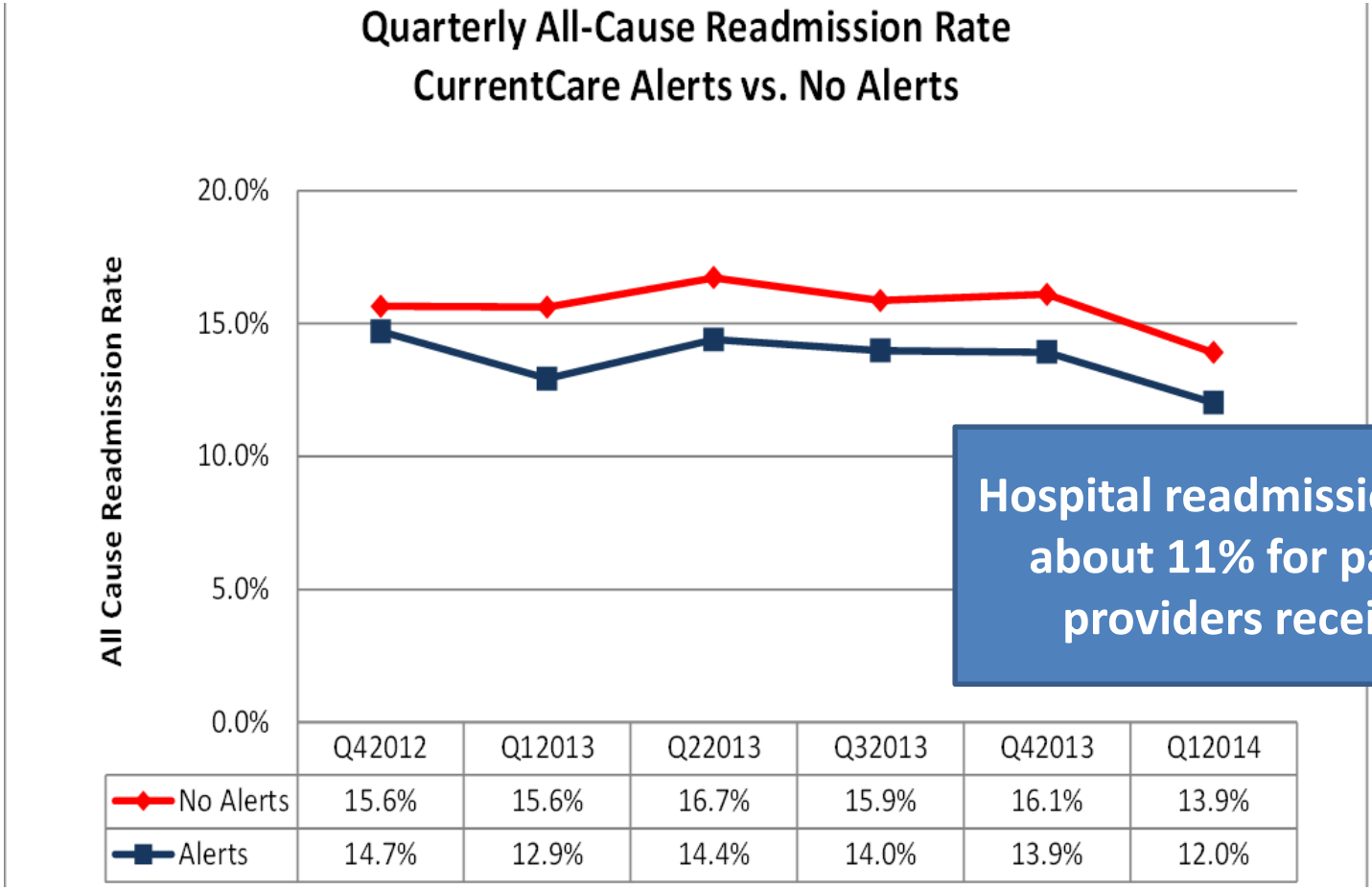
- **Patient Demographics**
  - RIQI ID
  - Name
  - DOB
  - Address
  - Home Phone Number
  - Cell Number
  - Work Number

- **Encounter Information**
  - Health Care Facility
  - Start and End Time
  - Encounter Type (ER or Inpatient)
  - Admission Reason
  - Discharge Location
  - Referring Clinician Name

- **Calculated Fields**
  - Number of ER visits within the past six months
  - Number of Inpatient within the past six months
  - More to follow, including predictive risk scores

….. Additional information provided by the practice can also be included on the list

RIQI Hospital Readmission Analysis

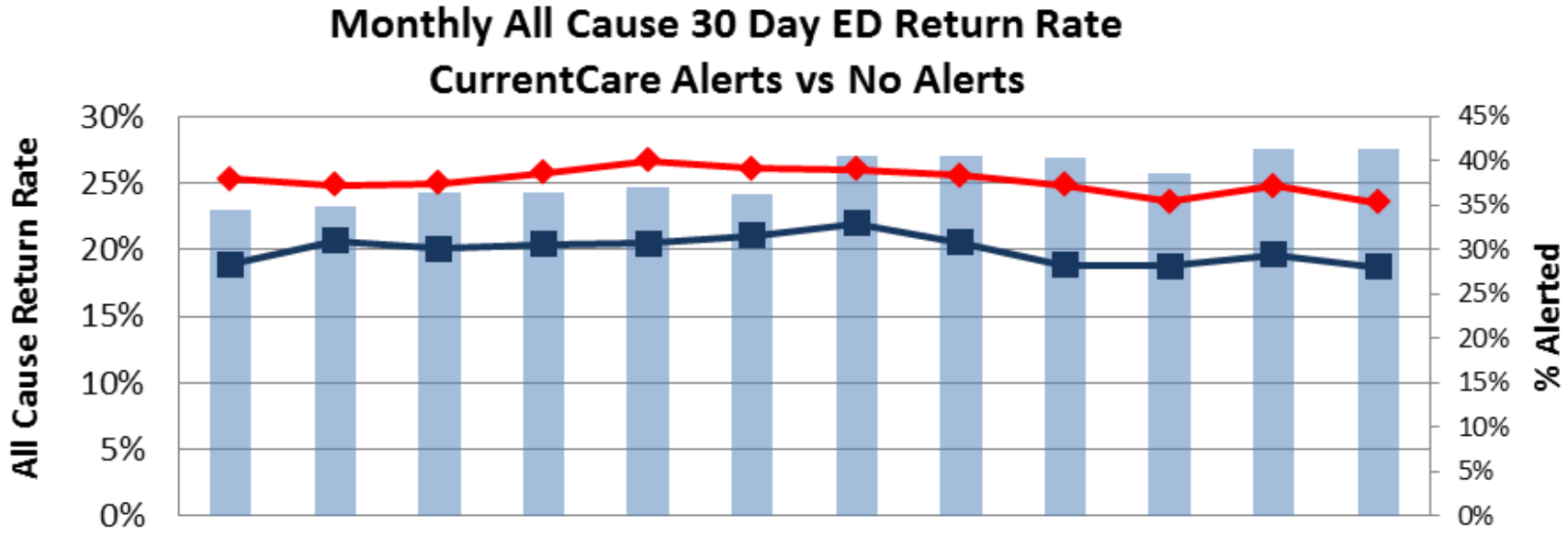


	Q42012	Q12013	Q22013	Q32013	Q42013	Q12014
No Alerts	15.6%	15.6%	16.7%	15.9%	16.1%	13.9%
Alerts	14.7%	12.9%	14.4%	14.0%	13.9%	12.0%

Hospital readmission rate lower by about 11% for patients whose providers received an alert

RIQI ED 30-Day Return Rate Analysis

30-day return rate lower by about 20% for patients whose providers received an alert



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
% Alerted	34.6%	34.9%	36.5%	36.5%	37.1%	36.3%	40.6%	40.6%	40.4%	38.7%	41.3%	41.4%
No Alerts	25.3%	24.8%	25.0%	25.8%	26.7%	26.1%	26.0%	25.6%	24.9%	23.6%	24.8%	23.6%
Alerts	18.9%	20.7%	20.1%	20.4%	20.5%	21.1%	21.9%	20.5%	18.9%	18.8%	19.6%	18.7%

Summary of RIQI Grant Awards

Summary of RIQI Grant Awards

- Four Grants received in 2015
  1. Advance Interoperable Health IT Services for Health Information Exchange (ONC)
  2. Community Interoperability and HIE (ONC)
  3. Transforming Clinical Practices Initiative (CMS)
  4. Rhode Island Foundation

Advance Interoperable Health IT Grant

- Project
  - Sharing Health Information For Transitions (SHIFT) in Care
- Purpose
  - Increase adoption and use of health IT tools and services to support exchange of health information
  - Improve care coordination
    - Enable the send, receive, find and use capabilities of health IT within and outside of the care delivery system
- Performance period: 2 years beginning July 27, 2015
- Award: $2.7M (RIQI to provide required $1M match)

Advance Interoperable Health IT – Partners and Goals

- Advance Health Information Transfer Between:
  - Primary Care Eligible Professionals (EPs)
  - Long term and post acute care facilities (LTPAC)
  - Individuals (patients and caregivers)
- Three Goals:
  - Adoption of technology and services that enable health information exchange
  - Exchange of Health Information
  - Interoperation of Data Systems
- Support and improve care coordination and transitions of care

Community Interoperability & HIE (ONC) Grant

- Project
  - Rhode Island Behavioral and Medical Information Exchange Project
- Purpose
  - Work collaboratively with behavioral health care providers at community mental health organizations to support and extend the use of secure, interoperable health IT tools and HIE services
  - Connect Butler Hospital to the HIE
  - Enable individual and community health improvement through collective impact
- Performance period: 1 year beginning Sept. 11, 2015
- Award: $100,000, no match required

Transforming Clinical Practices Initiative

- Project
  - Rhode Island Practice Transformation Network
  - CMS grant
- Purpose
  - Test 3-pronged approach to national technical assistance to enable large scale transformation
    - Aligned federal and state programs/resources
    - Practice Transformation Networks
    - Support and Alignment Networks (support PTNs)
  - RIQI to support 1,500 clinicians (PCPs and specialists) in RI region toward achieving common goals to meet the Triple Aim
  - Practices ‘graduate’ when they are prepared to enter into value-based payment arrangements

Transforming Clinical Practices Initiative

- Five components of RIQI's proposal:
    1. Practice Transformation assistance
    2. Rhode Island Clinician Leadership Academy
    3. Care Coordination and Care Transition Services
    4. Clinician Participation in Value-based Contracts and Payment Reform Efforts
    5. Performance Measurement, Reporting & Evaluation
- Performance period: 4 years beginning Sept. 29, 2015
- Award: $8.3M, no match required

Rhode Island Foundation Grant

- Manage High Risk List and Provide CM Dashboard
  - Support 30 practices, up to 10,000 patients
    - CTC collaboration effort
    - Staggered entry into the project based on limited resources
    - Randomized for fairness and best ability to evaluate effectiveness
    - Hope to get files directly from payers
- Performance period: 3 years beginning Oct. 2015
- Award: $500,000

Thank You

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@Cu are

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www.currentcareri.com

~~Proposed~~ Draft Rhode Island PCMH Cost Containment Strategies

September 27, 2015

The following standards must be met by primary care practices seeking PCMH designation from Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved 2016 Care Transformation Plan.

Practices that have received NCQA PCMH Level 3 designation will be deemed to have met all requirements listed below that are substantially the same as one or more NCQA PMCH requirements. OHIC will work collaboratively with CTC to identify those requirements that can be deemed.

Requirement #1: The practice develops and maintains a high-risk patient registry:

The practice must perform all of the following functions:			
Function	Year 1	Year 2	Year 3
1. The practice has developed and implemented a methodology for identifying patients at high-risk for future avoidable use of high cost services (referred to as "high-risk patients").	Required →		
2. Using information from a variety of sources, including payers and practice clinicians, the practice updates the list of high-risk patients at least quarterly.	Required →		
3. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors: a. assessment of patients based on co-morbidities; b. inpatient utilization c. emergency department utilization	Required →		

Requirement #2: The practice offers Care Management/Care Coordination Services with a focus on high-risk patients enrolled with the carriers that are funding the care management/care coordination services. Care Management/Care Coordination services include services provided by practice staff other than the designated care manager or care coordinator when services provided promote care management and care coordination and are provided under the direct supervision of the Care Manager or Care Coordinator.

The practice must perform all of the following functions:			
Function	Year 1	Year 2	Year 3
1. The practice has a designated resource(s) that at the minimum includes a trained licensed Registered Nurse or trained licensed RN or social worker care coordinator for pediatric practices to provide care management/care coordination services that focuses on providing services to high-risk patients.	Required →		
2. The practice has an established methodology for the timely assignment of levels of care management/care coordination service needed by high-risk patients based on risk level, clinical information including disease severity level and other patient-specific characteristics. The purpose of the assessment is to promptly identify which high-risk patients should be in the care manager's/care coordinator's active caseload at any point in time.	Required →		
3. The care manager/care coordinator completes within a specified period of time (from the time that the high-risk patient is placed in the care manager's/care coordinator's active caseload) a patient assessment based on the patient's specific symptoms, complaints or situation, including the patient's self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk. For children and youth, the care coordinator shall complete a family assessment that includes: a. a family status and environment	Assessment initiated within one week, with at least three contact attempts (if needed) within two weeks Assessment cCompleted within two weeks of caseload	~~Completed within two weeks of caseload assignment~~ Same as Year 1	~~Completed within one week of caseload assignment~~ Same as Year 1

The practice must perform all of the following functions:			
Function	Year 1	Year 2	Year 3
assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth & family), and b. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance and needs, and emotional/behavioral strengths and needs).	assignment unless patient is non-responsive to outreach		
4. Working with the patient and within two weeks of completing the patient assessment, the care manager/care coordinator completes a written care plan that includes: a. a medical/social summary b. risk factors c. patient-generated goals d. an action plan for attaining patient's goals	Required →		
5. The care management/care coordination resources update the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal, but no less frequently than semi-annually.	Required →		
6. For high-risk patients known to be hospitalized or in a SNF, the care management/care coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.	Required →		
7. The care management/care coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs.	Within 72 hours of discharge	Within 48 hours of discharge	Within 48 hours of discharge

The practice must perform all of the following functions:			
Function	Year 1	Year 2	Year 3
8. The care management/care coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status.	Within 72 hours of the ED visit	Within 48 hours of the ED visit	Within 24 hours of the ED visit
9. The care management/care coordination resources complete a medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person.	Within 7 days of discharge	Within 7 days of discharge	Within 72 hours of discharge
10. The care management/care coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks[1] referrals and test results on a timely basis for high-risk patients.	Required →		
11. The care management/care coordinator resources provide health and lifestyle coaching for high-risk patients designed to enhance the patient's/caregiver's self/condition-management skills.	Required →		
12. Practices shall provide patient-engagement training to care managers/care coordinators, as necessary, to achieve these requirements.	Required →		
13. The care management/care coordination resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient's level of risk.	Required →		
14. The care management/care coordination resources participate in team-based care meetings to assure whole-person care is provided to high-risk patients. For pediatric practices, participants in practice-initiated team meetings may include primary care and specialist providers, school liaisons, behavioral health providers, developmental	Required →		

[1] Consistent with 2014 NCQA PCMH recognition Standard 5, Element B, "tracking" here means that the practice "tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports."

The practice must perform all of the following functions:			
Function	Year 1	Year 2	Year 3
specialists, government support program representatives (e.g., SSI), and social service agency representatives.			
15. The care management/care coordination resources use HIT to document and monitor care management service provision.	Required →		
16. The care management/care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	Required →		

Requirement #3: The practice improves access to and coordination with behavioral health services.

The practice has implemented one of the following approaches to behavioral health integration
Function
1. To promote better access to and coordination of behavioral health services, the practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice's patients and there is an operational protocol adopted by the PCP and the preferred specialists for the exchange of information. The terms of the preferred arrangement are documented in a written agreement.
2. To promote better access to and coordination of behavioral health services, the practice has arranged for a behavioral health provider(s) to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s).
3. To promote better access to and coordination of behavioral health services, the practice is implementing or has implemented a co-located (or virtually located), integrated behavioral health services model that is characterized by licensed behavioral health clinicians serving on the care team; the team sharing patients, and sharing medical records, and the practice promoting consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences, and warm hand-off protocols.

Requirement #4: The practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am and 5pm).

The practice must perform the following functions:			
Function	Year 1	Year 2	Year 3
1. The practice have a written policy to respond to patient telephone calls within the following timeframes: a. For urgent medical/behavioral calls received during office hours, return calls are made the same day. b. For urgent calls received after office hours, return calls are made within 1 hour. c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	Required →	→	→
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day.	Urgent care	Urgent care	Urgent and routine care[2]
3. The practice has an agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving Emergency Department care.	Required →	→	→
4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access.	Required →	→	→
The practice must perform *at least 2* of the following functions:			
Function	Year 1	Year 2	Year 3
1. The practice has created a secure web portal that enables patients to: • send and receive secure messaging • request appointments • request referrals • request prescription refills • review lab and imaging results The practice clearly communicates to patients that the portal should not be used for urgent matters and that patients should call the practice under such circumstances.	All, but lab and imaging	All, but lab and imaging	All functions

[2] Consistent with the AHRQ definition contained within the CAHPS survey, routine care is defined to mean care that patients believe they need, but not "right away."

2. The practice has expanded office hours so that services are available at least two mornings or two evenings a week for a period of at least 2 hours beyond standard office hours.	N/A	Urgent care	Urgent and routine care
3. The practice has expanded office hours so that services are available at least four hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians, so long as the affiliated physicians are able to share medical information electronically on a near real-time basis through either a shared EMR system or by ready access to a patient's practice physician who has real-time access to patient's medical records.	N/A	Urgent care	Urgent and routine care

Requirement #5: The practice refers patients to referral service providers who provide value-based care.

The practice must perform the following functions:	
Function	
1. The practice has developed referral protocols for its patients for at least two of the following: a. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist; b. laboratory services; c. imaging services; d. physical therapy services, and e. home health agency services.	Year 1
2. Should one or more payers provide the practice with readily available, actionable data, t~~T~~he practice has used ~~readily available, actionable data from payers~~such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e., "high-value referral service providers") and prioritizes referrals to those providers.	Year 2