CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

"Using Technology to Improve Care for Patients with Chronic Conditions"

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Board of Directors Presentation | April 22, 2022

Care Transformation Collaborative of RI

Overview

12 month Telehealth Learning Collaborative - 21 practice sites

- 9 adult, 3 family, 9 pediatric practices
- Cohort 1: February 2021 – January 2022
- Cohort 2: May 2021 – April 2022

Goal: help primary care practices expand the use of technology, and…

- Help patients better manage chronic conditions
- Continue to provide access to care with in-person visits due to COVID-19

Incentives:

- Infrastructure payment ($15,000.00 per practice site)
- Incentive payment $7,000 (single practice) or $5,000.00 (per practice site for multi-site)

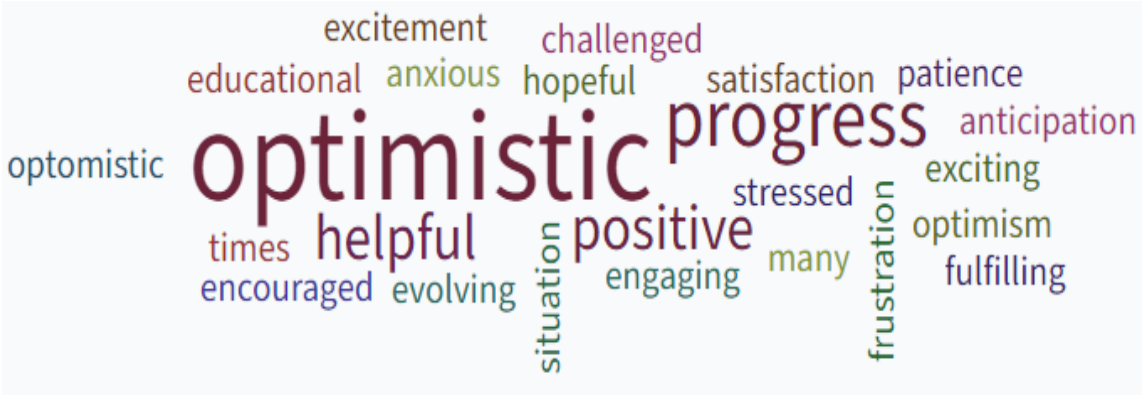
Support & Funding:

- CARES Act funding (infrastructure payment)
- UnitedHealthcare (quality improvement support & incentive payments)
- RI Department of Health
- Northeast Telehealth Resource Center (NETRC)

WORD CLOUD

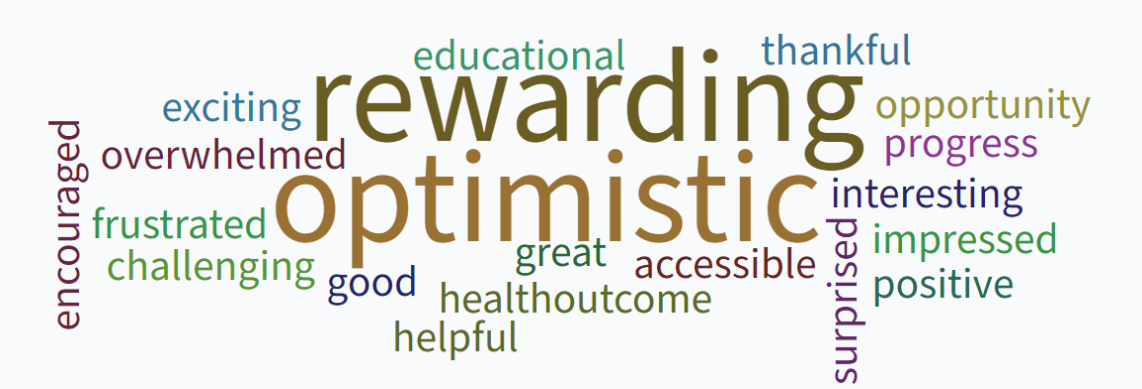
1st Meeting in May 2021

Aug 2021 Meeting



Nov 2021 Meeting

Jan 2022 Meeting



Participating Practices: Cohort 1

Practices	Focus
A to Z Primary Care	CHF
Barrington Family Medicine	Hypertension
Lincoln Charter Care Medical Assoc.	Diabetes
Coastal Medical	Cardiology
Encompass Family Medicine	Diabetes
Pediatric Primary Care at Hasbro	Asthma
Hasbro Medicine Pediatrics	Diabetes
Medical Associates of RI, Bristol	Hypertension
PRIMA Inc	ADHD
Richard Ohnmacht, MD	ADHD

Number of patients impacted: ~2,176

Participating Practices: Cohort 2

Practices	Focus
Anchor Medical Associates - Adult Medicine	Heart Failure
Anchor Pediatrics Lincoln	Anxiety
Barrington Pediatrics	Anxiety & School Failure
Kingstown Pediatrics	ADHD
Santiago Medical Group	Obesity

Number of patients impacted: ~500

Snapshot of Results

Telehealth :Pediatric

- Improved ADHD medication management, increase in 3-4 medication checks per year
- Decreased no-show rates (8%) with ADHD telehealth visits
- Patients adjusted to new process, reported positive experience

Remote Patient Monitoring (RPM):Adult

- For patients who consistently monitor their blood sugar (Glucose RPM), …saw an improvement in their glycemic control
- Improvement in HgA1C along with increased adherence to diabetes screenings

Phone Apps: Pediatric

- 42% of patients lost >5% of their body weight; >50% reduced their liver enzymes (ALT, AST); >20% reduced cholesterol and triglycerides; of 4 patients (prediabetes/diabetes) 75% decreased HgA1c by ≥5%
- Survey results showed some adolescents benefitted using a BH app

Results: Anchor Medical Associates

Telehealth for high-risk patients with Heart Failure

1. **Surveys re: patients & provider experience\barriers with telehealth**

2. **Leveraged data\telehealth = access to expanded care team** (IBH, PharmD, NCM & MD/DO/NP/PA)

3. **50%+ decrease in admissions in heart failure population**
   - Streamlined telehealth process
   - New integrated report
   - Standardized NCM templates
   - Expanded telehealth touchpoints with care team.

Anchor Heart Failure Telehealth Project – Overall impact
Snapshot of ER/Admission use over time.
Showing all High-Risk patients with dx of HF

Dept	2020 Q3+4						2021 Q3+4					
	Dx HF	Avg # Care Team Touch Points	Adm 1 Time	Adm 2+ times	Adm Visits	Avg # Care Team Touch Points	Dx HF	Avg # Care Team Touch Points	Adm 1 time	Adm 2+ times	Adm Visits	Avg # Care Team Touch Points
LIM	81	10	3	21	24	0.41	61	36	9	7	16	9.05
PIM	126	48	19	35	54	1.63	110	66	13	8	21	5.33
WMP	73	35	10	20	30	5.65	62	41	12	5	17	14.47
Anchor	280	93	32	76	108	2.56	233	143	34	20	54	9.61

Avg # Care Team Touch Points
*includes visits in office and/or telehealth phone/video with any provider

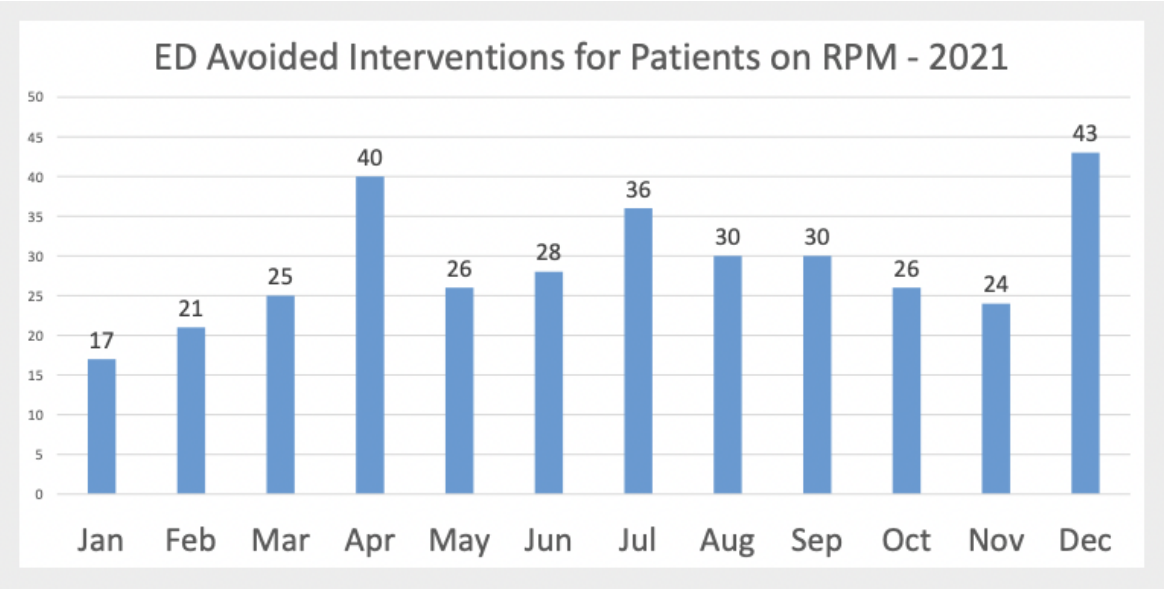
50%	Reduction in over all hospitalization when comparing time periods
73.68	Reduction in people with more than 1 hospitalization

Results: Coastal Medical

RPM Monitoring Expansion

Sustainability:

Cost Avoidance	
Total ED Cost Avoidance	$241,502
Total IP Cost Avoidance	$2,539,517
Total Cost Avoidance	**$2,781,019**



Outcomes:

- COPD: 286 Patients
- Diabetes: 335 Patients
- Heart Failure: 235 Patients
- Hypertension: 500 Patients

Patient & Practice Experience

Patient Experience

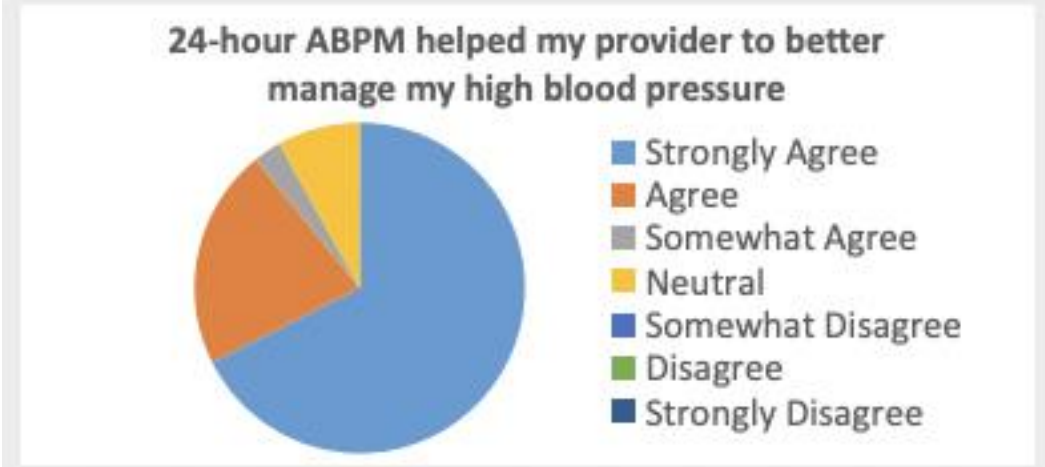
- 78% reported telehealth helped them get the care they needed/wanted
  - 89% would choose telehealth visit again for same reason
- Patient satisfaction surveys consistently demonstrated high “net promoters” scores across all programs.
  - Clinician satisfaction with RPM services similarly scored 4.29 out of 5 stars.

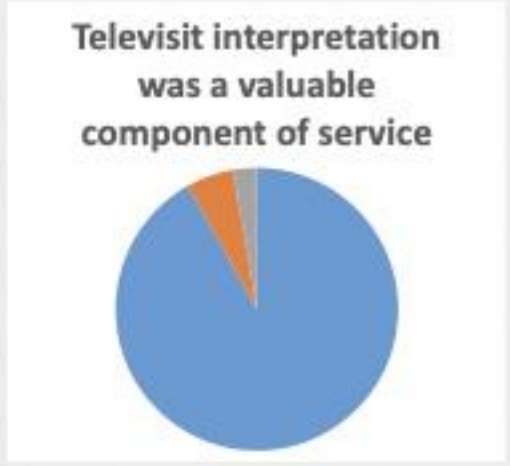
Practice Experience

- “Learning collaborative has shown that RPM has clinical value and potential to improve patient care. RPM can play an important role in the way we manage our patients with diabetes”
- “Improved patient experience by expanding access and response of the care team for our patients is an unanticipated triumph of this technology”

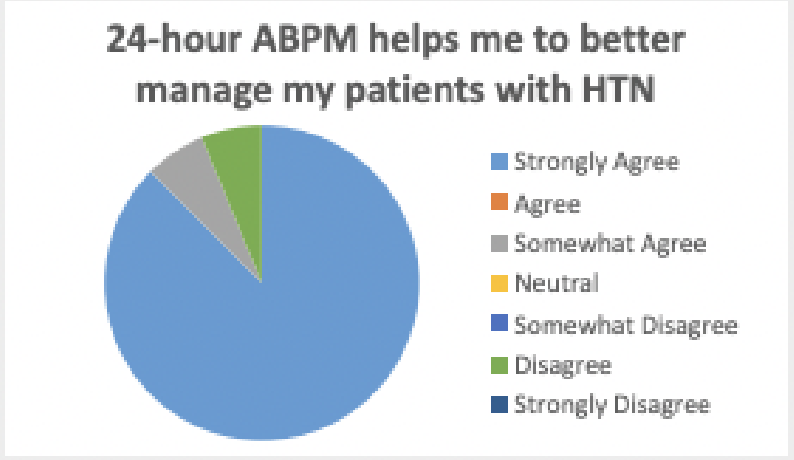
Experience: Medical Associates of RI

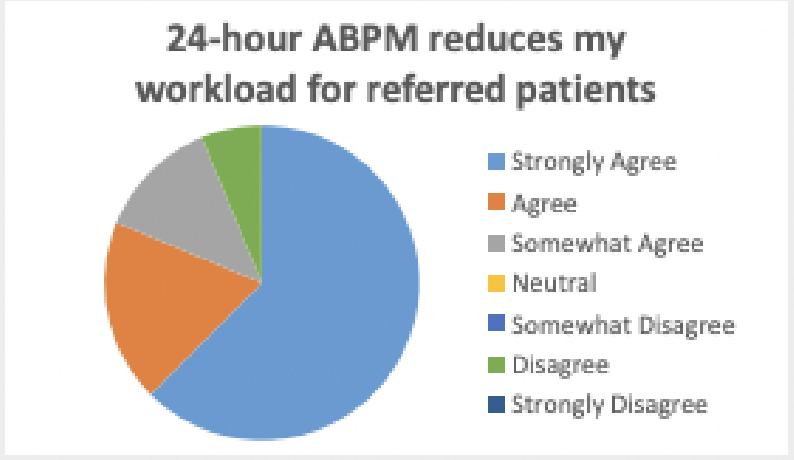
Patient Satisfaction





Provider Satisfaction





Sustainability

Remote Patient Monitoring

- Challenges with RPM reimbursement for adult medicine, zero RPM reimbursement for pediatrics
- Challenges with RPM equipment
- An efficient way to monitor blood sugar, which makes program sustainable from a personnel perspective
- Integration of a telehealth solution-RPM platform into EHR meant substantial cost savings and …without need to hire additional staff

Telehealth

- "Telehealth is here to stay, so it must be paid for"
- Video connectivity issues still often exist even with DOXY, so reimbursement for audio-only is imperative
- "Telehealth (for ADHD) will be offered for every other scheduled visit in the future, thus removing barriers of transportation, weather and extra time off for work for patients and their caregivers".
- "Patient does best with in-person training on how to use telehealth technology (need extra resources)"

Other

- Asthma-Nurse Educator Telehealth Visits … An RN must be a certified asthma educator to bill for theses services
- Lack of coverage for behavioral health apps

Lessons Learned & Recommendations

- **Primary care sees the value**
  - Demonstrated successful outcomes
  - Primary care wants to do more to leverage technology
  - Some will continue this work for patients with chronic conditions

- **OHIC workgroup influenced the State of RI telehealth policies**

- **Multi-payer approach by Health plans is needed for Remote Patient Monitoring (RPM)**
  - Learning Collaborative infrastructure payment allowed practices to test RPM technology; lack of multi-payer RPM payment makes it difficult to sustain
  - Health plans have made an investment in their Medicare Advantage population using national vendors to deliver RPM; (outside of Primary Care) - - this investment hasn't been spread to other project lines
  - Large practices/SoC have more resources and ability to invest in technology/resources

THANK YOU