



---

ADVANCING INTEGRATED HEALTHCARE

# Welcome

## Care Transformation Collaborative of R.I.

---

BREAKFAST OF CHAMPIONS  
SEPTEMBER 13, 2019

# AGENDA

---

- Integrated Comprehensive Primary Care; Model Enhancement and Payment
- Statewide Community Health Team Expansion Model for individuals and families
- Leveraging Cedar for multi-payer approach to children and families
- Feedback and further BOC agenda
- Table Top exercise

# Objectives for today

---

- Review CTC effort to further define and pay for an efficient and cost-effective model for integrated comprehensive primary care.
- Explain and obtain feedback on the evolution of CHTs to better serve substance-affected families.
- Review data/results current CHT network.
- Discuss how to leverage the Cedar program to increase connection to PCMH kids and support multi-payer CHT expansion.



---

ADVANCING INTEGRATED HEALTHCARE

# Integrated Comprehensive Primary Care; Model Expansion and Payment

---

# Patient-Centered Medical Home

---

- A “process” to support primary care transformation with a focus on patient, family, population health
- Recognition – NCQA, various state programs
  - Patient engagement through team-based primary care
  - Population health that is comprehensive, coordinated, data-driven
  - Increased access to care
  - Clear **accountability** for patient “panel”
  - Physician/practice **culture** change required
  - Integrate “**Quality Improvement**” efforts into practice
- Need ongoing support to develop and sustain infrastructure

# Clinical Strategy: Transformed Advanced Primary Care

---

## “Core Functions”

### PCP/Team – Patient/Family

High-Functioning Team-based care	Population Health	Data Driven Quality Improvement	Sustainable Business Operations
PCP training	Registries	Plan/Do/Study/Act (PDSA)	Payment reform
RN Care Mgr	High-Risk ID	Patient Voice	Systems of Care
MA Training	Technology		Infrastructure Support
Joy in Work (Pharmacist)	Actionable Patient Data		

# What Have We Learned?

## Principles of Successful ACOs

---

Brookings Nov 2014 (McClellan and Mostashari) Keys to success for “Physician led” ACOs

- Identifying and managing high-risk patients
- Developing high-value referral networks
- Using event notification
- Engaging patients
- To support comprehensive primary care add;
  - “Integrated behavioral health”
  - collaboration with community based health initiatives thru community health teams (CHTs) predominantly with Community Health Workers (CHWs)

# Clinical Strategy: Building the (Medical) Neighborhood

---

PCP/Team – Patient/Family/Community

Team-  
Based Care

Population  
Health

Data-  
Driven QI

Sustainable  
Business ops

Integrated  
Behavioral  
Health

PCP-Specialist Collaboration  
Hospitals/ ACOs  
Seamless Care  
Aligned Financial Incentives

Community Health  
Teams

Mental Health

Substance Abuse

Pain Management

Behavioral Change

Patient/Family Engagement

Clinical Collaborations

CHF, Palliative Care, etc.

Pain Management

Schools/ CBOs

Government

Health Plans

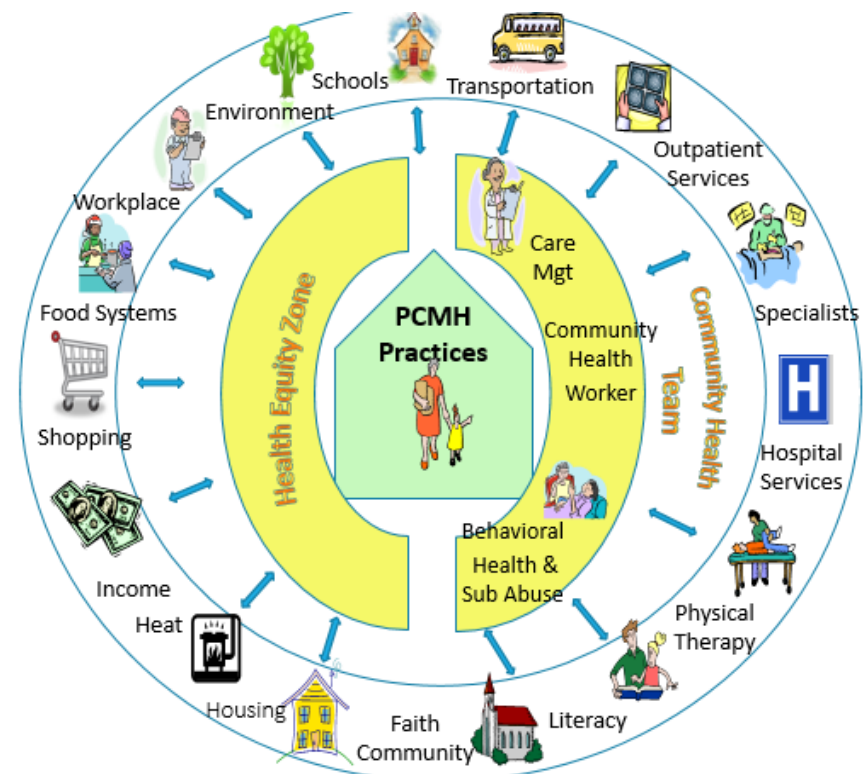
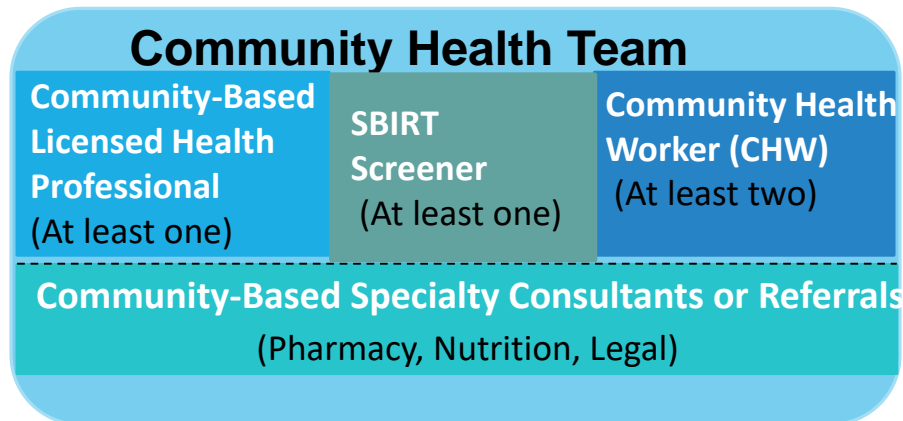
Employers



# Community Health Team Model: an extension of primary care

## Use care management processes to address

- Physical health needs
- Behavioral health/SUD needs
- Health education needs
- Social determinants of health needs



# Comprehensive Primary Care Sustainability

---

- Determine required core clinical services and move toward primary care capitation in standardized, systematic, aligned statewide manner. Meyers et al estimate for mixed adult practice \$45 PMPM.
- Need to develop a PMPM framework for innovations of Integrated BH and access to “Community Health” resources.
- Payments could include support for statewide CHT network as well as risk-adjusted payments for additional practice based resources. Combined responsibilities between health plans and capitated practices.
- PMPM for these added resources ARE definable.

# Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices



## Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices

David Meyers, MD<sup>1</sup>, Lisa LeRoy, PhD<sup>2</sup>, Michael Bailit, MBA<sup>3</sup>, Judith Schaefer, MPH<sup>4</sup>, Edward Wagner, MD<sup>4</sup>, and Chunliu Zhan, PhD<sup>1</sup>

<sup>1</sup>Agency for Healthcare Research and Quality, Rockville, MD, USA; <sup>2</sup>Abt Associates, Boston, MA, USA; <sup>3</sup>Balt Health, Needham, MA, USA; <sup>4</sup>MacColl Center for Health Care Innovation, Seattle, WA, USA

**BACKGROUND:** Broad consensus exists about the value and principles of primary care; however, little is known about the workforce configurations required to deliver it.

**OBJECTIVE:** The aim of this study was to explore the team configurations and associated costs required to deliver high-quality, comprehensive primary care.

**METHODS:** We used a mixed-method and consensus-building process to develop staffing models based on data from 73 exemplary practices, findings from 8 site visits, and input from an expert panel. We first defined high-quality, comprehensive primary care and explicated the specific functions needed to deliver it. We translated the functions into full-time-equivalent staffing requirements for a practice serving a panel of 10,000 adults and then revised the models to reflect the divergent needs of practices serving older adults, patients with higher social needs, and a rural community. Finally, we estimated the labor and overhead costs associated with each model.

**RESULTS:** A primary care practice needs a mix of 37 team members, including 8 primary care providers (PCPs), at a cost of \$45 per patient per month (PPPM), to provide comprehensive primary care to a panel of 10,000 actively managed adults. A practice requires a team of 52 staff (including 12 PCPs) at \$64 PPPM to care for a panel of 10,000 adults with a high proportion of older patients, and 50 staff (with 10 PCPs) at \$56 PPPM for a panel of 10,000 with high social needs. In rural areas, a practice needs 22 team members (with 4 PCPs) at \$46 PPPM to serve a panel of 5000 adults.

**CONCLUSIONS:** Our estimates provide health care decision-makers with needed guideposts for considering primary care staffing and financing and inform broader discussions on primary care innovations and the necessary resources to provide high-quality, comprehensive primary care in the USA.

**KEY WORDS:** primary care; workforce; team-based care; health care delivery.

**Electronic supplementary material** The online version of this article (<https://doi.org/10.1007/s11606-018-4530-7>) contains supplementary material, which is available to authorized users.

Received January 17, 2018  
Revised April 20, 2018  
Accepted May 30, 2018

J Gen Intern Med

DOI: 10.1007/s11606-018-4530-7

© Society of General Internal Medicine (This is a U.S. Government work and not under copyright protection in the US; foreign copyright protection may apply) 2018

### INTRODUCTION

There is broad consensus with regard to the value and principles of primary care in the USA and around the world<sup>1–3</sup>. As expressed by Starfield,<sup>1</sup> Bodenheimer et al.,<sup>2</sup> and more recently, the Patient-Centered Primary Care Collaborative,<sup>6</sup> primary care should be (1) person and family centered, (2) continuous, (3) comprehensive and equitable, (4) team based and collaborative, (5) coordinated and integrated, (6) accessible, and (7) of high value. Health system structures and processes needed to support these aims have also been identified, including meaningful use of information technology, population management, linkage with social services and community resources, and appropriate and adequate financing mechanisms.<sup>3,4,7–9</sup>

Team-based care is at the core of most strategies aimed at improving primary care.<sup>4,6–15</sup> Clinicians alone do not have the time and may not be best suited to meet all of the needs of their patients. A primary care team, with each member working collaboratively and performing to the full extent of their training, can more efficiently and effectively serve a practice's patients. Researchers have identified a wide variety of elements necessary to form an effective team, including leadership and culture, team size, staffing ratios, workflow, and communication<sup>9–12</sup> and called for expanded roles for nurses, medical assistants (MAs) and others on primary care teams.<sup>12–14</sup> Though not yet definitive, early evidence, especially around patient-centered medical homes (PCMHs), shows that team-based approaches have positive impacts on patient and provider outcomes.<sup>15–17</sup>

However, there is relatively little data on team compositions in U.S. primary care practices besides the number of physicians per practice.<sup>18–20</sup> Peikes et al. analyzed staffing patterns of 496 practices participating in the Comprehensive Primary Care initiative in 2012, reporting that 98% of them employed administrative staff, 89% employed MAs, 47% employed licensed practical nurses (LPNs), 36% employed registered

# Statewide CHT Network: Enhanced Model

---

Enhance current statewide Community Health Team (CHT) network serving high-risk adults by bringing an “integrated family health” approach to best serving individuals and families who are “high” or “rising” health risk due to significant social and/or behavioral health needs.

- Expand geographic reach and clients served through Aes.
- Support increased connection with PCMH kids and Cedar; add new level of coordination to ensure seamless hand-offs to best serving team for specialized support (Family Home Visiting, etc. as needed).
- Serve families affected by substance use (target those who do not meet requirements for services from Family Home Visiting or other existing programs).
- Tailor existing CHT services/configuration to meet needs of added target populations.

# Expansion Model: Relationships and Resources

---

- Primary Care Practices and Accountable Entities/ Systems of Care
- PCMH-Kids
- Women and Infant's Family Care Unit
- OB-GYN Providers/Practices
- MAT Programs
- DCYF - FCCPs
- RIDOH Programs - Family Home Visiting programs & MOMS-PRN
- Medicaid

# CTC Role

---

Ensure that the statewide CHT network complements system of care and health plan strategies and programs to mitigate SDOH

- Standardized data collection, including outcomes and program evaluation.
- Work regionally with community-based organizations/HEZ to improve integration efforts and “closing the loop” for referrals.
- Ongoing learning through best practice sharing and training with expanded stakeholders.
- Provide services that complement SOC efforts to manage complex patients. For example, those who would benefit from short-term in-home BH evaluation and services.
- Strengthening connection with MLPB for legal support and training.
- Expand ability to respond to referrals from non-PCP (OBGYN, ED/Hospitals) for “no wrong door” approach.
- Inform public policy, test and spread innovation.



---

ADVANCING INTEGRATED HEALTHCARE

# Statewide CHT Network: Data and Results

---

# CHTs address health and SDOH needs

---

Presently the model focuses on at-risk adults who meet the following criteria:

- 18+ years of age
- poorly controlled, high-risk, chronic conditions
- 2+ special healthcare needs (8+ medications, functional impairments)
- substance use disorder and at least one other co-morbid physical or behavioral health condition
- irregular access primary care (tx disengagement)
- 2+ inpatient or ED visits w/in 6 months
- unmet behavioral health or psycho-social needs



# CHT Referral Triage Tool

Mechanism by which PCPs identify high risk referrals to CHTs

## Higher Risk Drivers (3 Points Each)

0	<b>Utilization</b> (medical or psych): (15 Points Max) <input type="checkbox"/> IP admit in past 30 days <b>OR</b> <input type="checkbox"/> 30-day Readmission in past year <b>OR</b> <input type="checkbox"/> 2+ IP admits in past 6 months <b>OR</b> <input type="checkbox"/> 2+ ED visits in past 6 months <input type="checkbox"/> Health Plan High Risk Report – impactable costs actual or predictive > \$25,000
0	<b>High Risk of:</b> (6 Points Max) <input type="checkbox"/> IP admit/ ED visits in next 6 months <input type="checkbox"/> Significant decline in functional status/ need for LTC in next 6 months <input type="checkbox"/> Do you think it likely that pt will pass away in next 12 months or Palliative Care Referral Made?– (Levine Score or Palliative Care Screening Tool ≥ 4)

0	<b>Substance Abuse:</b> Actively using, newly sober, motivated to change (2 Points Total) <input type="checkbox"/> Alcohol <input type="checkbox"/> Opioid <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Other
0	<b>Mental Health DX</b> that is severe, persistent, and uncontrolled: (2 Points Total) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Major Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Debilitating Anxiety <input type="checkbox"/> Other

## Fundamental Risk Drivers (1 Points Each)

0	<b>Chronic Disease/ Co-morbidities</b> – <u>not well controlled/</u> not noted above (1 Point) <input type="checkbox"/>
0	<b>Functional Impairments</b> – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point Each) <input type="checkbox"/>

## Moderate Risk Drivers

0	<b>Poorly Controlled High Risk Chronic Disease</b> (2 Points Total) CAD <input type="checkbox"/> CHF <input type="checkbox"/> Diabetes <input type="checkbox"/> COPD <input type="checkbox"/> Chronic Pain <input type="checkbox"/> End stage disease: <input type="checkbox"/>
0	<b>RX Meds:</b> 8+ active prescriptions <b>OR</b> recent change in high risk meds (2 Points Total) <input type="checkbox"/>
0	<b>Disengagement:</b> significant, chronic condition(s) and (2 Points Total) <input type="checkbox"/> inadequate follow-up with PCP, or <input type="checkbox"/> not following care plan, or <input type="checkbox"/> specialty care without coordination
0	<input type="checkbox"/> <b>Disability:</b> significant Physical/ Mental/ Learning disability impacting reasons for referral (2 Points Total)
0	<b>Psycho-Social risk factors</b> which prevent adequate mgmt of high risk diseases (2 Points Each/ 6 pts max) <input type="checkbox"/> language/literacy <input type="checkbox"/> safety <input type="checkbox"/> homeless <input type="checkbox"/> poor supports <input type="checkbox"/> food insecurity <input type="checkbox"/> undocumented legal status <input type="checkbox"/> other

## Eligibility Determination for CHT

- >15 = High-Risk (offer CHT to patient)
- 8-14= Rising Risk (patient may meet criteria for CHT)
- <8 = Discuss referral with CHT before offering to patient

# CHT Evaluation completed by URI

(Oct 1, 2018-June 30, 2019)

---

## CHT intake data from 397 clients

- Follow-up/Discharge data collected from 388 clients

## Data Collected:

- Demographics
- Health Risk
- Social Determinants of Health
- Behavioral Health Risks
- 19-item patient outcome survey covering Health Literacy, Health Information & Knowledge, Confidence, Support, Adherence, Quality of Life, & Wellbeing.

# CHT Client Demographics

Age	<b>M = 54 years (sd = 17)</b>
Non-English Speaking	21%
White, Non-Hispanic	60%
Hispanic/Latino	26%
Black/African American, Non-Hispanic	8%
Other	6%

# All SDOH Categories Showed Significant Changes

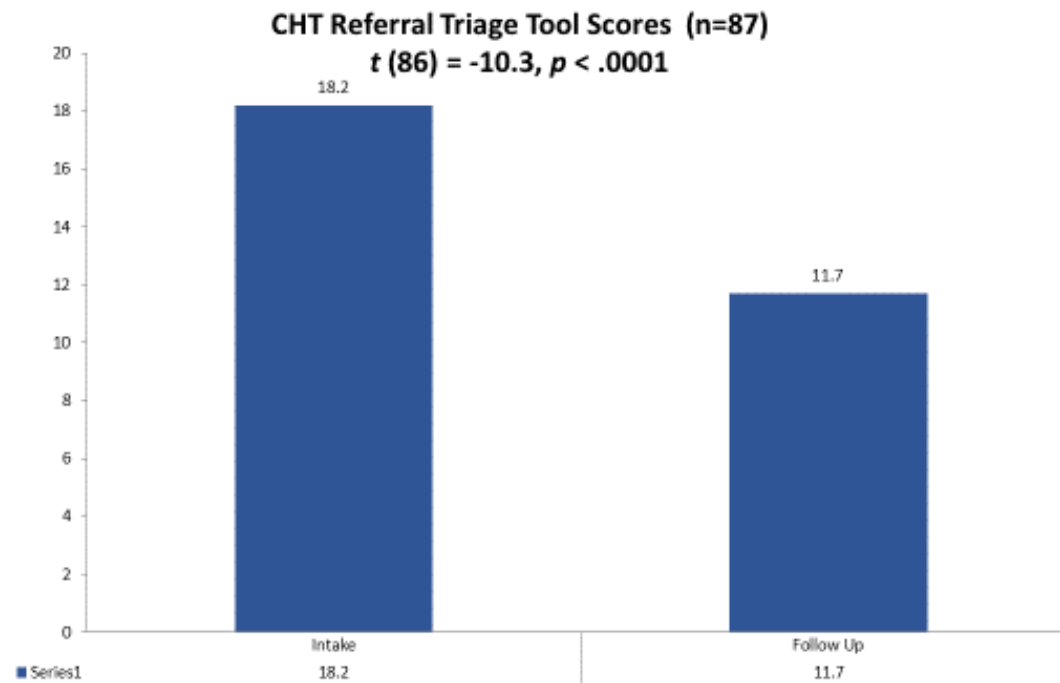
From Intake to Follow-Up (n=108-162)

	<b>% reporting issue at intake</b>	<b>% no longer reporting issue at follow-up</b>
Housing	<b>41.4%</b>	56.7%
Finance/ Utilities	<b>39.0%</b>	66.7%
Food Insecurity	<b>32.9%</b>	63.5%
Transportation	<b>31.0%</b>	44.9%
Caregiver Support	<b>22.2%</b>	50.0%
Interpersonal Violence	<b>19.3%</b>	71.4%

# Pre-Post Changes in Health Risk: 36% decrease

---

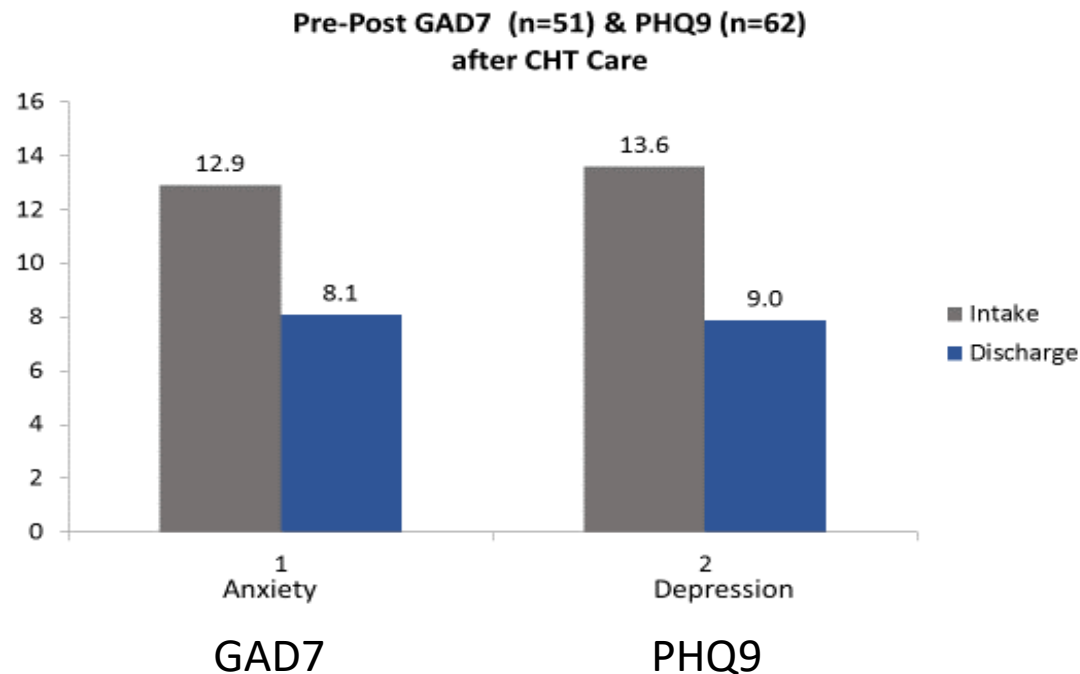
## FollowUp CHT Changes - Health Risk



36% decrease in RTT score, intake to discharge

# Pre-Post Changes in Behavioral Health: Over 30% decrease

## FollowUp Changes Anxiety & Depression

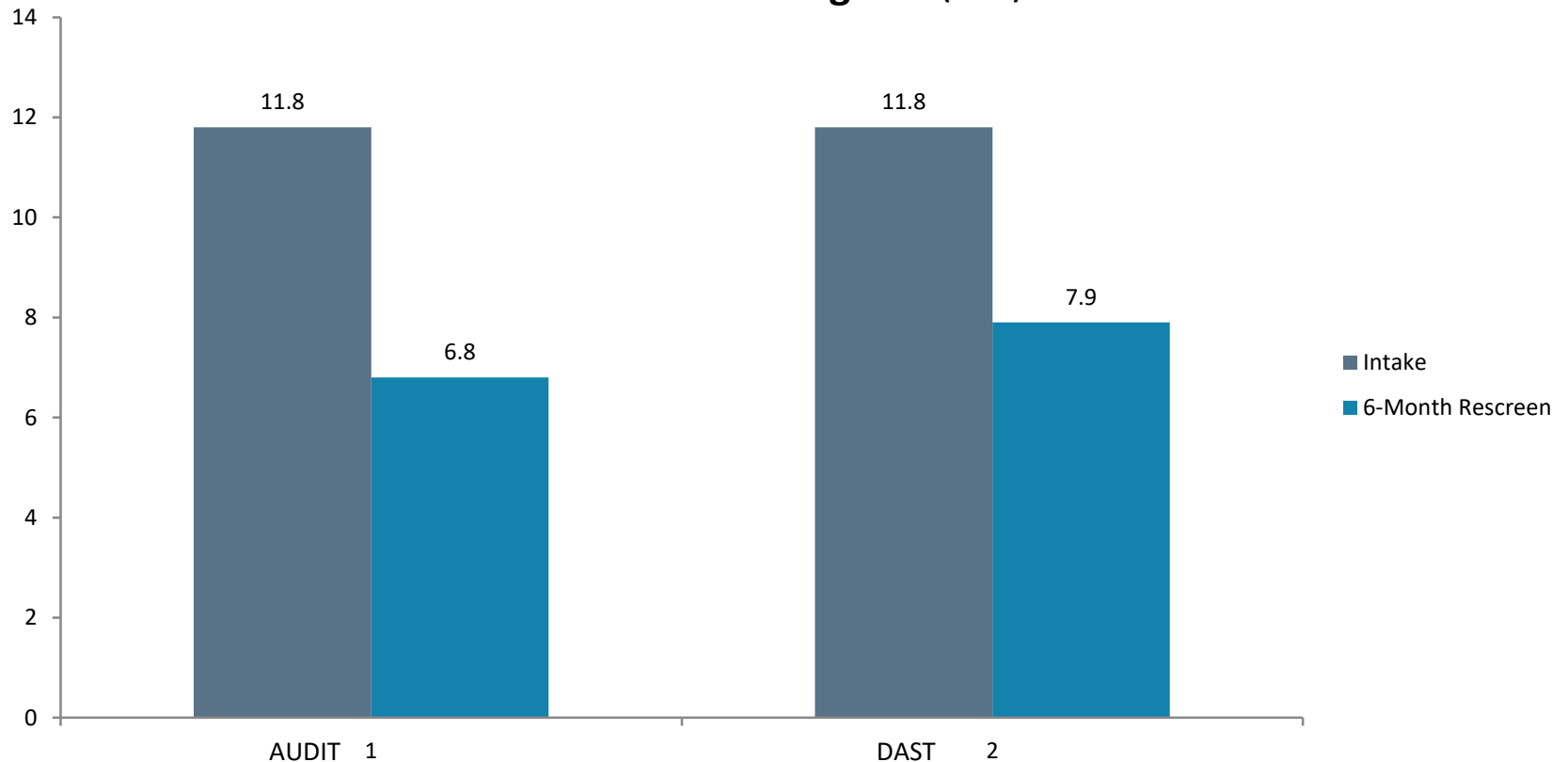


37% decrease in GAD7 score, intake to discharge, \* $p < .0001$

34% decrease in PHQ9 score, intake to discharge, \* $p < .0001$

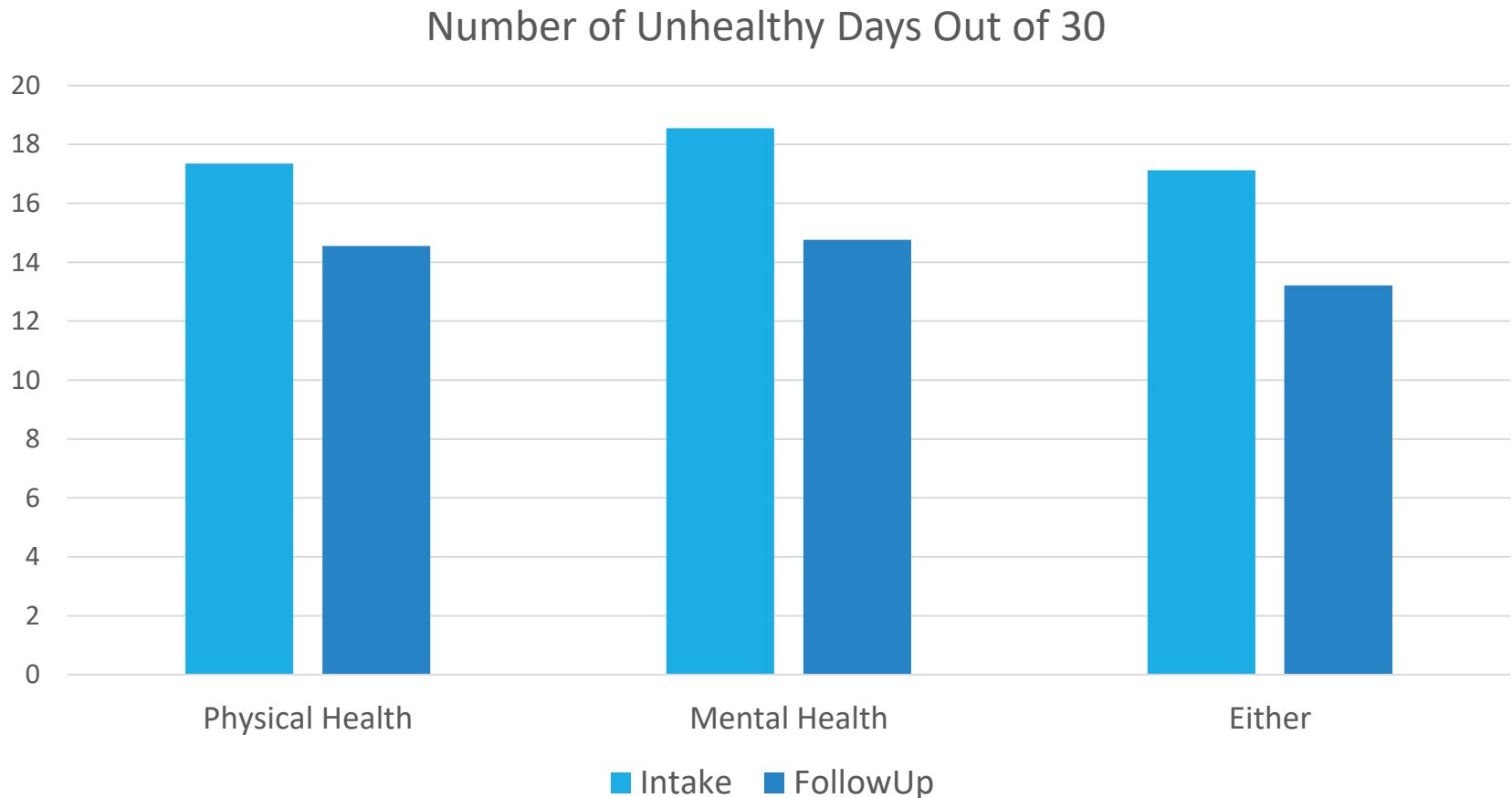
# Pre-Post Changes in Alcohol + Drug Use: Over 30% decrease

**Pre-Post Past 30 Day  
Alcohol & Drug Use (n=51)**



# Quality of Life: Number of Unhealthy Days Changes from Intake to Follow-Up

( $p < .05$ )





# Current CHTs

---



**Team serving Washington County; serving multiple practices in the region; expanding to Kent County 10/1/19**



1 1 team serving Pawtucket/Central Falls; serving BVCHC and other practices in the region



Using funding for 1 team to support 2 teams - W. Warwick and Woonsocket; primarily serving their own patients



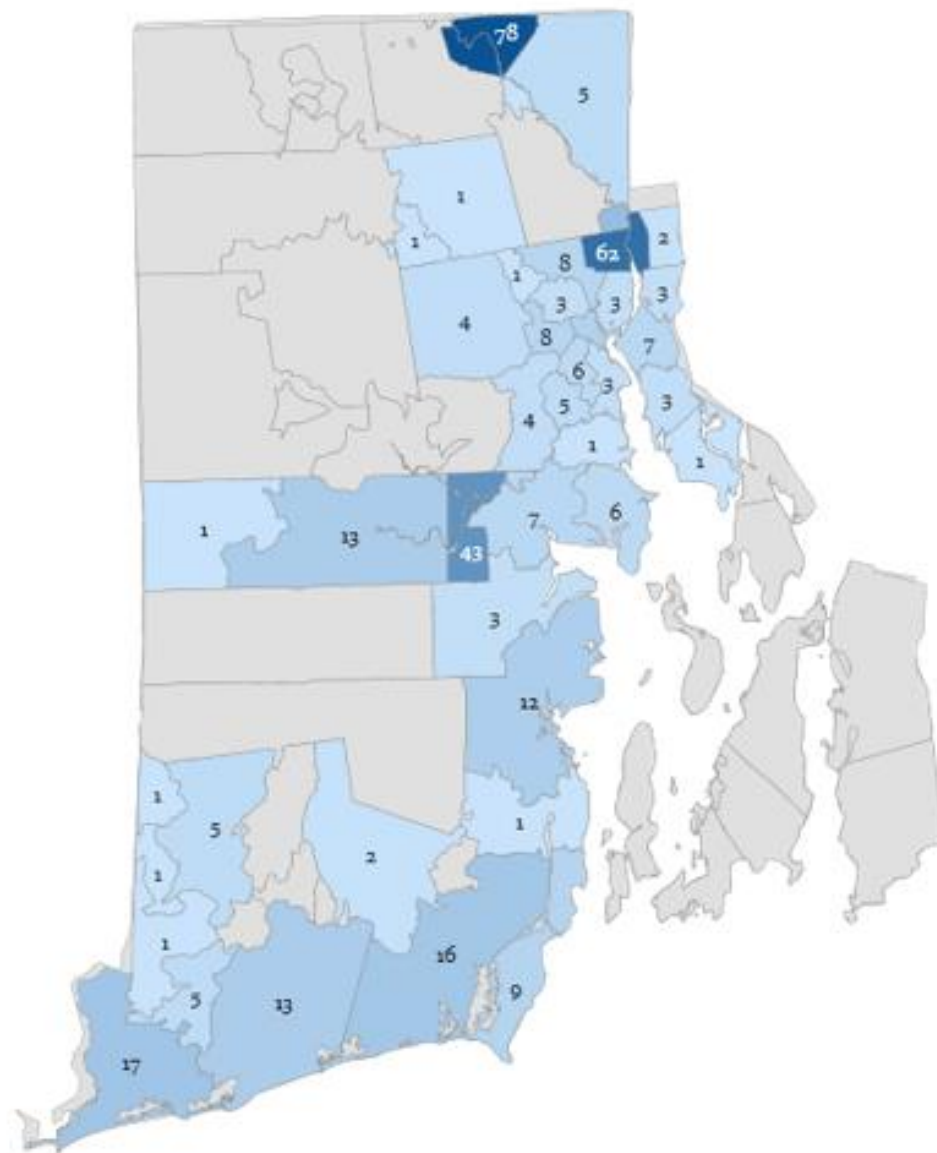
Expanded to two teams to serve Greater Providence region; serving multiple practices



1 team serving primarily internal clients in Newport and a small number in East Providence

RI CHT Reach by Zipcode

Frequency



# Current: CHT Relationships and Reach

---

- **30 practices** across the state have referring relationships with Community Health Teams
- **326 providers** across all partnering practices have referring relationships with Community Health Teams
- **Approximately 1500 adult patients** are served by CTC-RI Community Health Teams each quarter

# Leveraging Cedar

---

Cedar Family Centers provide intensive care coordination for families with children, ages birth – 21, who have special healthcare needs.

- Locating clinical services (medical and behavioral)
- Referrals to community and social supports
- Health education and prevention
- Screenings for physical and mental health
- Assistance with changes between levels of service
- Supporting families

# Eligibility for Cedar Support

---

- **Who is Eligible for Intensive Care Coordination?**
- Families of children birth - 21 with 2 or more chronic conditions or have 1 chronic condition and are at risk of developing a second
- Children having a severe mental illness or severe emotional disturbance
- Children must be Medicaid-eligible

# Cedar Triage Tool



## Cedar Online Referral Form

Child's First Name:	MI:	Last Name:
DOB: Click or tap here to enter text.		Current Age:
Gender:		
Address:		
City:	State:	Zip:
Mother's Name:		Father's Name:
Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell		Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell
Email Address:		Email Address:
Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Language:		Language:
Primary Health Insurance:		Member ID#:
Secondary Health Insurance:		Member ID#:
*Is parent/guardian aware of and in full agreement with this referral? <input type="checkbox"/> Yes		Enrolled in Current Care? <input type="checkbox"/> Child <input type="checkbox"/> Mother <input type="checkbox"/> Father
Date of referral:	Referral Source:	Phone:
Primary Care Physician:		Phone:
Social Security #:		Medical ID# (Found on Medical Identification card): Click or tap here to enter text.

**Chronic Conditions requiring Intensive Care Coordination:** (Please check all that apply)

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Autism, Asperger's, ASD	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Tourette Syndrome
<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Bone, joint, or muscle problems		<input type="checkbox"/> Other (please specify):	



## Cedar Online Referral Form

Child/Family Risk Factors:	Current Need	Current Services	Past Services	Current Barriers
Current hospitalization/inpatient admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2+ ED visits related to chronic condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to follow through (appts/med regimen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School issues (low performance, absenteeism, behavior)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to socially interact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent/Caregiver MH concern or cognitive delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use <input type="checkbox"/> Parent <input type="checkbox"/> Caregiver <input type="checkbox"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food uncertainty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (Please provide any additional information that you would like us to know)

Click or tap here to enter text.

Fax Document to 1-401-270-7049

OR

Save document, and attach in an email to: [RIPINCedarFamilyCenter@ripin.org](mailto:RIPINCedarFamilyCenter@ripin.org)

OR

Print out the form and mail to us at:

Rhode Island Parent Information Network

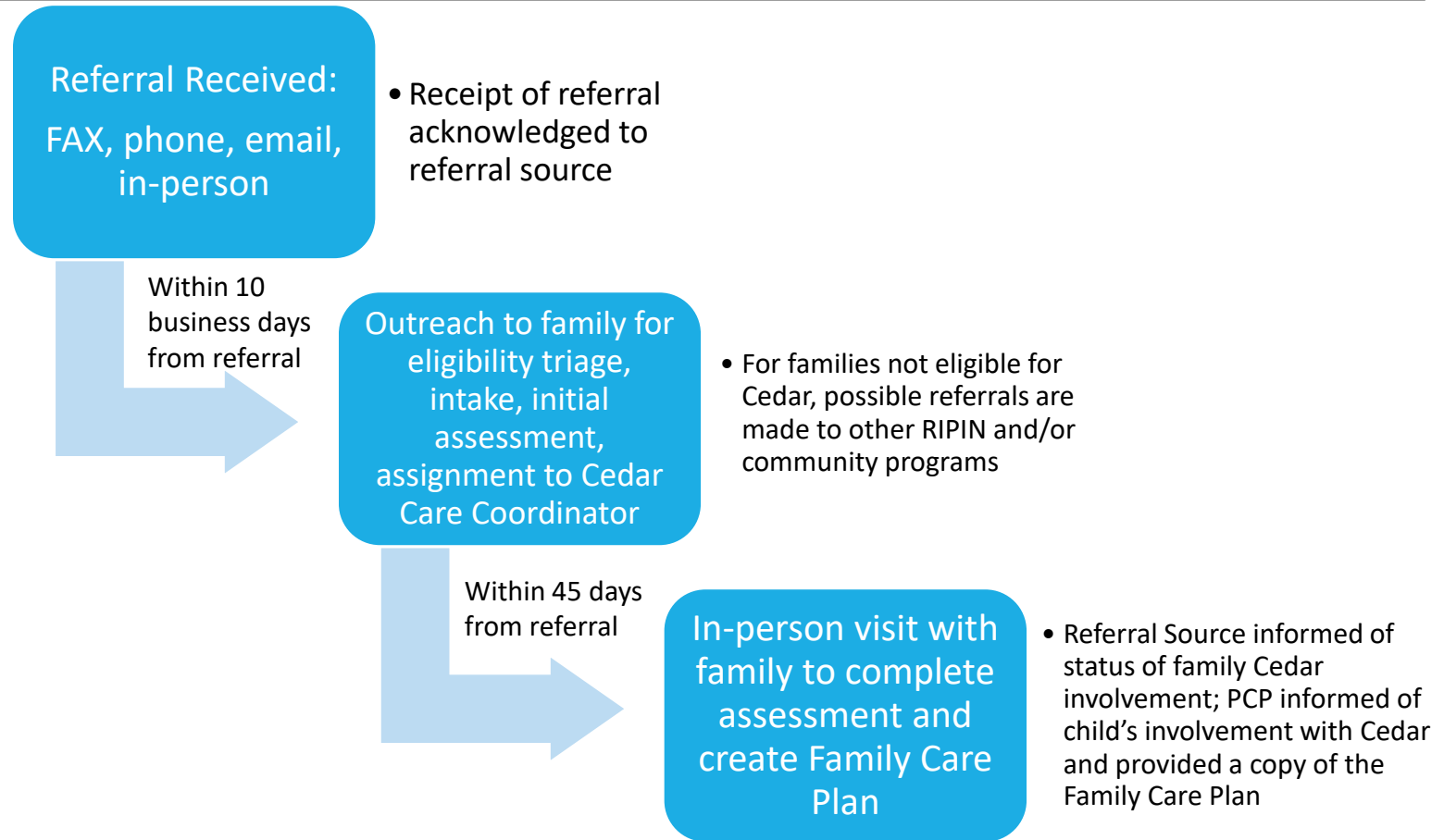
ATTN: Cedar Family Center

1210 Pontiac Avenue

Cranston, RI 02920

# RIPIN Cedar Referral Process

---



# RIPIN Cedar Family Center

---

**Care Coordination Services provided by a team of Community Health Workers who are culturally and linguistically representative of the families served**

- Referrals to home-based therapeutic services
- Connections to Developmental Screening
- Support for transition from EI
- Special Education information and support
- Access to health insurance, SSI, Child Care
- Connections to specialty providers, DME
- Social determinants of health
- Transition to adult services

## **Quick Facts (2018)**

*Average Open Panel: 150-250*

*Care Plans Completed: 232*

*Direct Client Interactions: 7,432*

*Documented Collateral Tasks: 4,949*

*In-Person Interactions: 550*

*Formal Education Meetings: 96*



# Access to Cedar Support

---

Currently Cedar Family Centers receive referrals from many sources

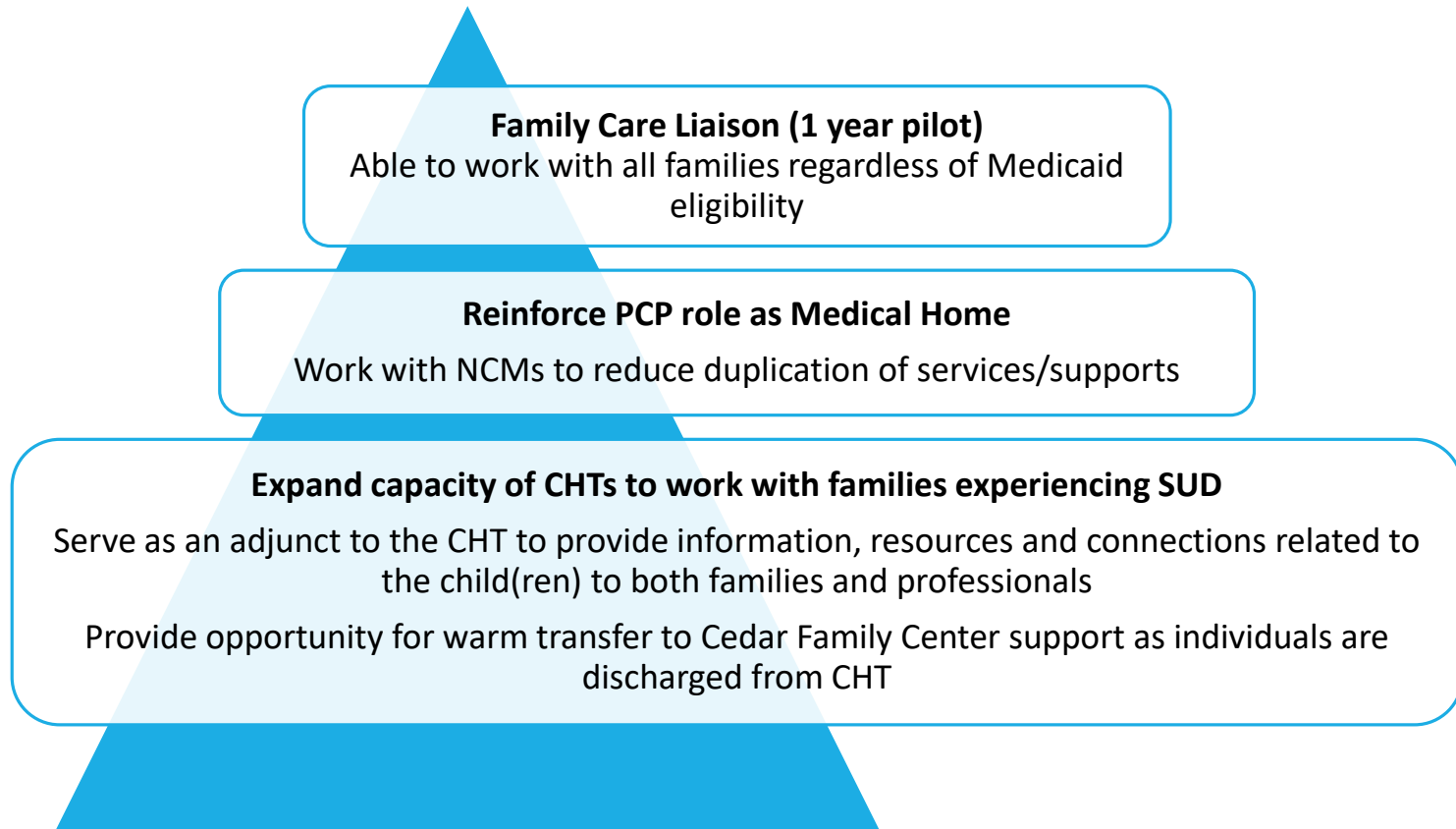
- Primary Care Physicians
- Specialty Providers
- Schools
- Community Agencies
- Families
- Nurse Case Managers

**Basically, anyone involved in child's life may make a referral for Cedar Support.**

**When in doubt....REFER!**

# Expanding CTC - RIPIN Partnership

---



# Feedback and further topics

---

Next Friday meetings :

- December 13, 2019,
- March 13, 2020,
- June 12, 2020

**PLEASE complete evaluation with proposed topics**

# Transition to Tabletop Exercise

---

