Quarterly Breakfast of Champions

February 08, 2019, 7:30am-9:00am
The Rhode Island Shriners Imperial Room, 1 Rhodes Place, Cranston, RI 02905

1. Welcome and Agenda Review
   with Table Discussing and Report Out

   Pano Yeracaris, MD, MPH
   Chief Clinical Strategist
   CTC-RI
   7:30-7:35am

2. Making Sense of the Madness: Focused discussions on social determinant of health screening and primary care specialist relationships. Which activities are best done through systems of care and which need to be done at the practice level?

   Andrew Saal MD MPH
   Chief Medical Officer
   Providence Community Health
   Andrea Galgay, MBA
   Director, ACO Development
   RIPCPC
   7:35-8:30am

3. Efforts to Improve Technology and Data Flow to Impact Care: Seeking feedback on roadblocks and which actions we can take together to meet common goals.

   Kim Paull, MPH
   Director
   RI EOHHS Data and Analytics
   8:30-9:00am

Evaluation/Feedback
Making Sense of the Madness ...while maintaining your sanity

Care Transformation Collaborative of R.I.

QUARTERLY BREAKFAST OF CHAMPIONS
FRIDAY, FEBRUARY 8, 2019

Andrea Galgay, MBA, Rhode Island Primary Care Physicians Corporation
Andrew Saal, MD MPH, Providence Community Health Centers
Pano Yeracaris, MD MPH, Care Transformation Collaborative - RI
The Challenge of Transformation
Transformation Strategies

**Care Team Redesign**
- Nurse Care Management
- Community Health Workers
- Integrated Behavioral Health

**Interagency Relationships**
- Specialist Compacts
- Continuity of Care Documents
- Transitions of Care
  - **Referrals Management**

**Improved Data**
- EHR-derived data
- Panel-level data
- HIE / CurrentCare
- All-Payer Claims Database

**Population Management**
- Historical – Top 5% Total Cost
- Predictive – Who Might Need Help?
  - **Health Risk Assessments**
Population Management

Getting the right resources to the right patient – before they get into trouble

But how can you predict who is more likely to have trouble?
What if someone had a simple tool that could accurately predict a patient’s risk *before* they decompensated?
<table>
<thead>
<tr>
<th>7. What is your housing situation today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have housing (staying with other people)</td>
</tr>
<tr>
<td>I do not have housing (staying with other people)</td>
</tr>
<tr>
<td>A hotel, in a shelter, living outside in street, on a beach, in a car, or...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Are you worried about this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Do you or any family members you live with have any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Other (please write):</td>
</tr>
</tbody>
</table>

The Social Determinants of Health are More Accurate than the Best Computer Algorithms.
HRA as a Population Health Strategy

If you knew who was more likely to have bad outcomes, then you could steer additional resources to them to mitigate the problem.

The Social Determinants of Health are potentially modifiable risk factors!
### Medicaid Comprehensive AE Common Measure Slate

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF #</th>
<th>Measure Steward</th>
<th>Measure Domain</th>
<th>Measure Source</th>
<th>Measure Description</th>
<th>Age Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast Cancer Screening</td>
<td>2372</td>
<td>HEDIS®</td>
<td>Preventive Care</td>
<td>Admin</td>
<td>The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer</td>
<td>Adult</td>
</tr>
<tr>
<td>2. Weight Assessment &amp; Counseling for</td>
<td>0024</td>
<td>HEDIS®</td>
<td>Preventive Care</td>
<td>Hybrid</td>
<td>The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/Gyn and who had evidence of the</td>
<td>Pediatric</td>
</tr>
<tr>
<td>10. Social Determinants of Health (SDOH) Screen</td>
<td>N/A</td>
<td>N/A</td>
<td>Social Determinants</td>
<td>Practice-reported</td>
<td>% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*</td>
<td>Adult and Pediatric</td>
</tr>
<tr>
<td>11. Self-Assessment/Rating of Health Status</td>
<td>N/A</td>
<td>N/A</td>
<td>Health Status</td>
<td>Practice-reported</td>
<td>Measure to be defined and submitted to EOHHS for approval (e.g., Institute for Healthcare Improvement)</td>
<td>Adult and Pediatric</td>
</tr>
</tbody>
</table>
COLLABORATION WITH SPECIALISTS AND REFERRAL MANAGEMENT
Reasons for Collaboration

- Enhanced management of patient population
- Standardization of care
- Aligned incentives
- ACO/Group ‘preferred’ networks
- MACRA
- Product design
Stakeholders

- PCPs
- Specialists
- Insurers
- Hospitals

Patient
Common Issues

Access and Communication – Specialist AND PCP
One time consult versus ‘annuity’
Managing patient expectations
Fear of offending peers
Red tape
1) How is your practice screening and capturing that information?

2) What problems have you had with the screening process? What types of problems are patients facing?

3) How are you responding to patient needs that have been identified?
Referrals Management

1) What drives your referral network / patterns?

2) Who decides which specialist gets the referral? (e.g. front desk based on next available appt, other)?

3) Are there clear expectations with specialists about the clinical question being asked and how to coordinate care (expected number of visits, etc.)?