CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Integrated Comprehensive Primary Care: Model Expansion and Payment

Care Transformation Collaborative of R.I.

WARREN ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY
HEALTH SYSTEMS SCIENCE II
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Co-convened by the Office of the Health Insurance Commissioner and EOHHS, **CTC-RI** is a non-profit, multi-payer collaborative focused on health system transformation

Mission:

The Care Transformation Collaborative of Rhode Island's (CTC-RI) mission is to lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve health equity, quality of care, the patient experience, affordability of care and the health of the populations we serve.

CTC-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care.

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ADVANCING INTEGRATED HEALTHCARE

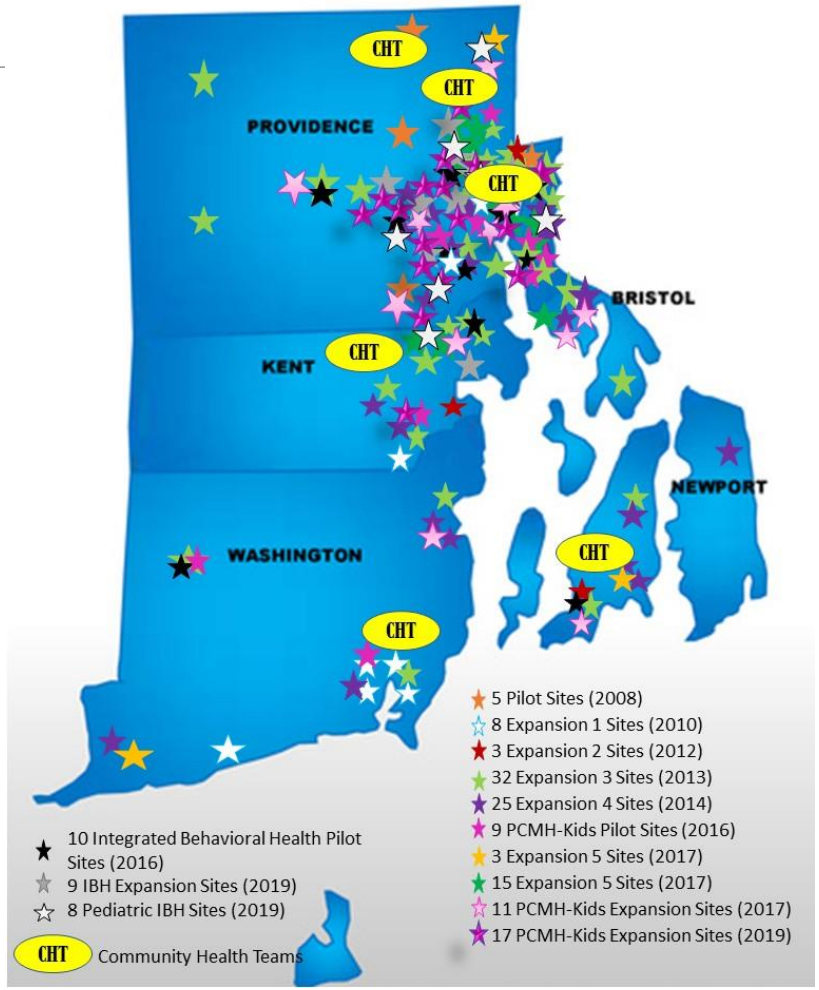
The Rhode Island Affordability Standards

- Legislation enacted 2006, regulations promulgated 2008-2010
  - Office of Health Insurance Commissioner (OHIC)
  - 1% yearly increase primary care spend (commercial insurers)
  - Support statewide multi-payer PCMH transformation
- Revised 2014 and 2020 – primary care spend increased from 6.3% to 10.7%
  - Add focus on community health teams, now also IBH
- Sustainability payments for care mgt infrastructure

Expanding Primary Care Impact

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

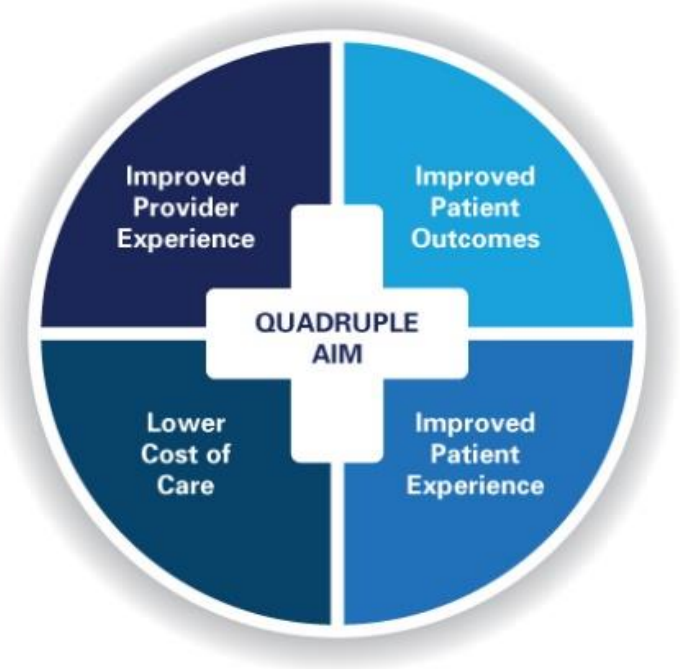
- **131 primary practices, including internal medicine, family medicine, and pediatric practices.**
- **Over 800 providers across our adult and pediatric practices.**
- **31 primary care practices are part of Integrated Behavioral Health initiative**
- **Approximately 750,000 Rhode Islanders receive their care in a patient-centered medical home.**
- **Investment from every health insurance plan in Rhode Island, including private and public plans.**
- **All Federally Qualified Health Centers in Rhode Island participate in our Collaborative**



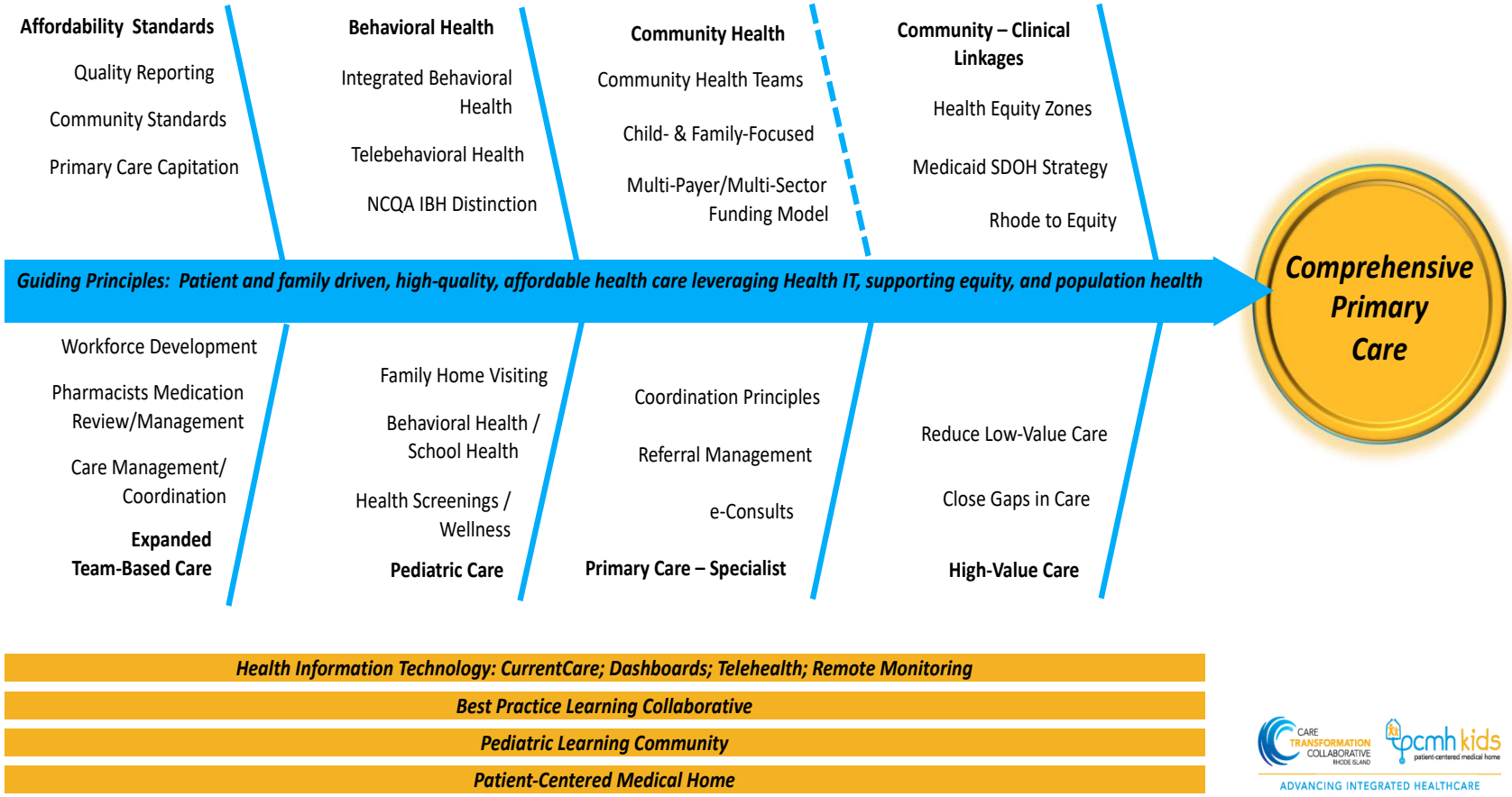
Major Initiatives

Our multi-payer table is uniquely situated to bring together key stakeholders who will select, test and evaluate innovative clinical strategies to build the capacity of the care teams to meet the needs of children, adults and families living in our communities.

- Patient Centered Medical Home
  - Adult and Pediatric
  - Comprehensive PC Capitation
- Integrated Behavioral Health
- Community Health Teams



Roadmap to Comprehensive Primary Care



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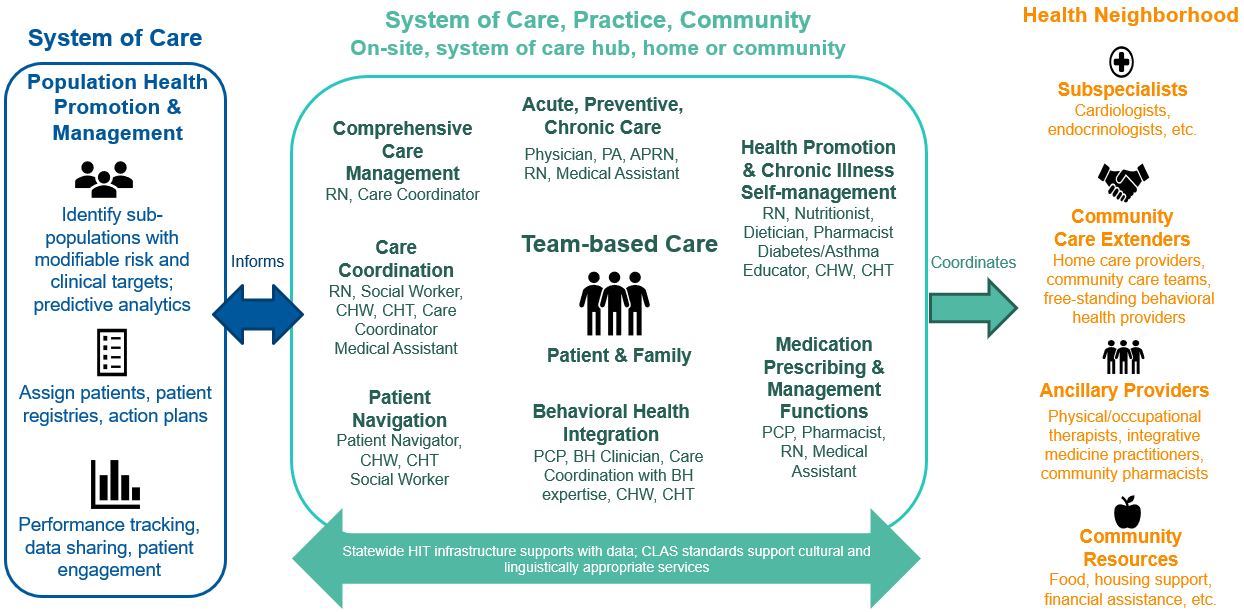
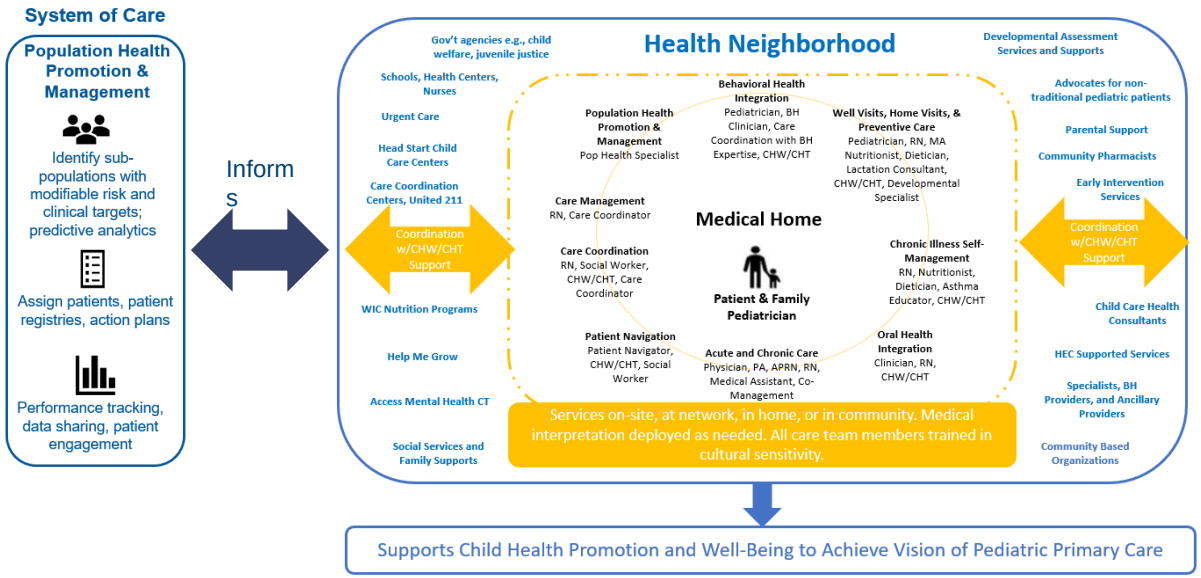
EXPANDED CARE TEAMS
Who is on the team?



- Optional members of the care team
- This graphic is based on work in other states and adjusted slightly to reflect work in RI
- Different practices serve different patients with different care team needs

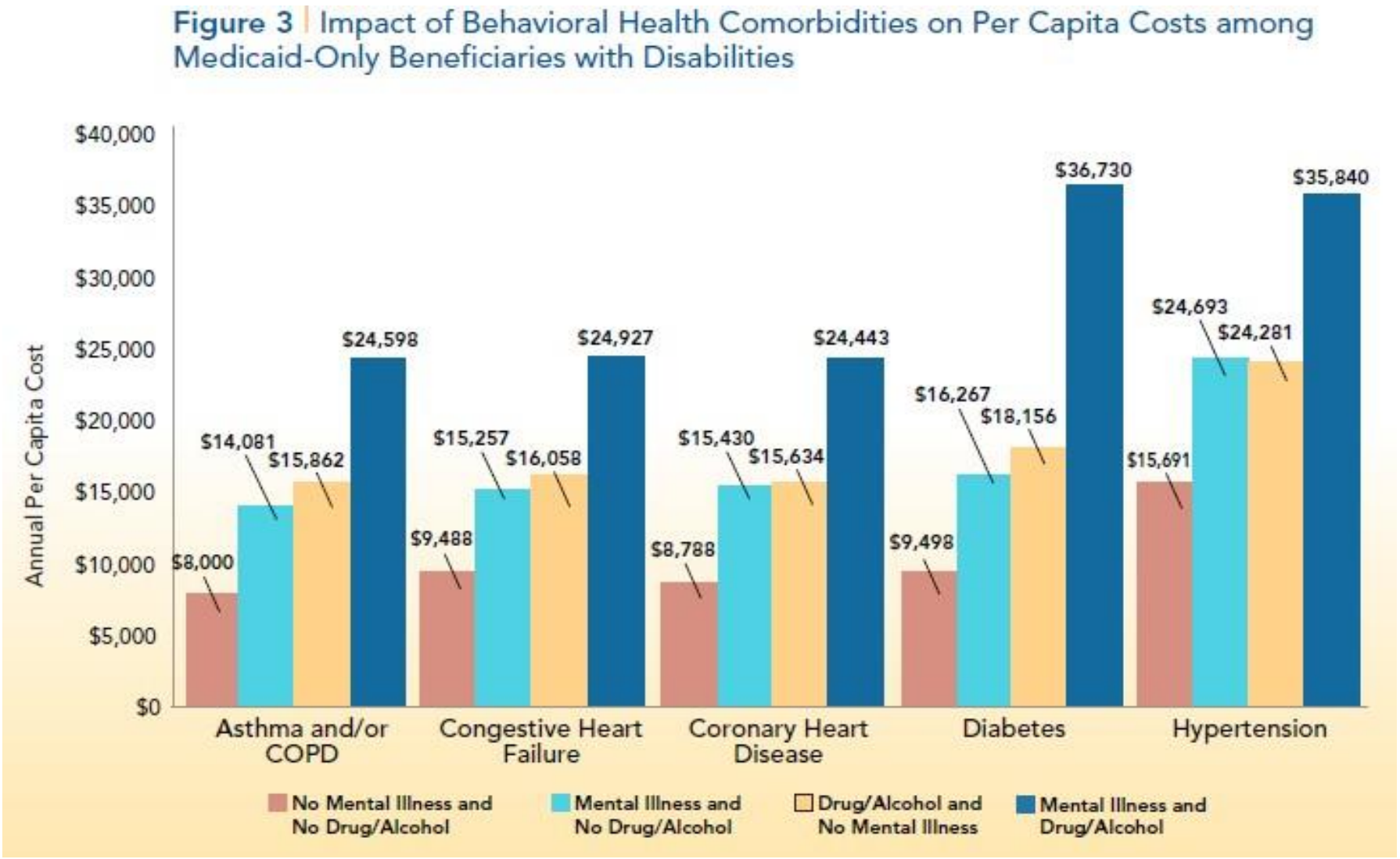
PEDIATRIC EXPANDED CARE TEAMS
Who is on the team?



- Optional members of the care team
- This graphic is based on work in other states and adjusted slightly to reflect work in RI
- Different practices may require different care team compositions
- Statewide HIT infrastructure supports improved quality and efficiency

Comorbidities and Cost

(Boyd et al 2010, courtesy of Cadence Consulting)



Payment Reform To Sustain Comprehensive Primary Care

- Determine required core clinical services and move towards primary care capitation in standardized, systematic, aligned statewide manner. Meyers et al estimate for mixed adult practice including integrated behavioral health (IBH) $45 PMPM
- Need to develop a PMPM framework for innovation and access to “Community Health” resources (social needs).
- Payments could include support for the statewide CHT network as well as risk adjusted payments for additional practice based resources.
- PMPM for these added resources ARE definable

Beyond PCMH, Payment and Delivery System Reform

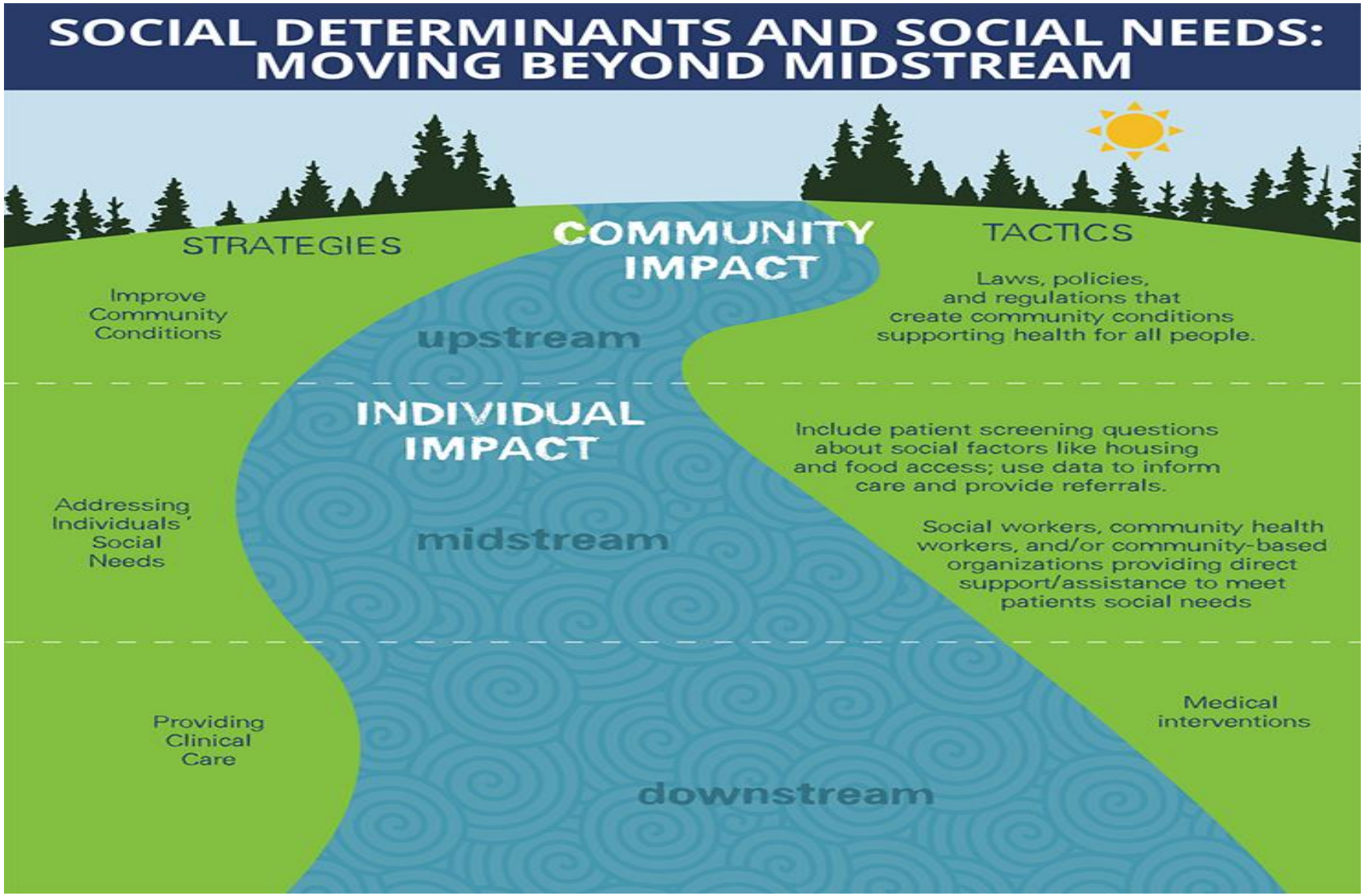
- A strong primary care foundation with PCMH-like features necessary, not sufficient, and is most effective within a transformed, better coordinated health system.
- New "Value-Based" payment systems generally reflect quality, patient experience, total cost of care but until now have been limited in going beyond fee for service as the basis of transactions
- Move towards "Accountable Care" (plus/minus "Organizations") success requires collaboration between hospitals, primary care, and specialist physicians. Hospital and physician led.
- Remember, we have a $3.5 trillion system which is "perfectly designed…."

Social Determinants and Social Needs

(*Castrucci and Auerbach* Health Affairs Blog Jan 16, 2019)

- World Health Organization Commission on Social Determinants of Health (2008) defined these determinants as the "conditions in which people are born, grow, live, work, and age" and "the fundamental drivers of these conditions." A community-wide focus "Place-based"
- Social Needs are at the level of the individual and family – important to their health and how they relate to the health care system.
- Need to concentrate on both – different strategies and different (potential) funding sources.

Source: Created by Authors; Castrucci and Auerbach Health Affairs Blog January 16, 2019



Scope and Staffing: Community Health Teams

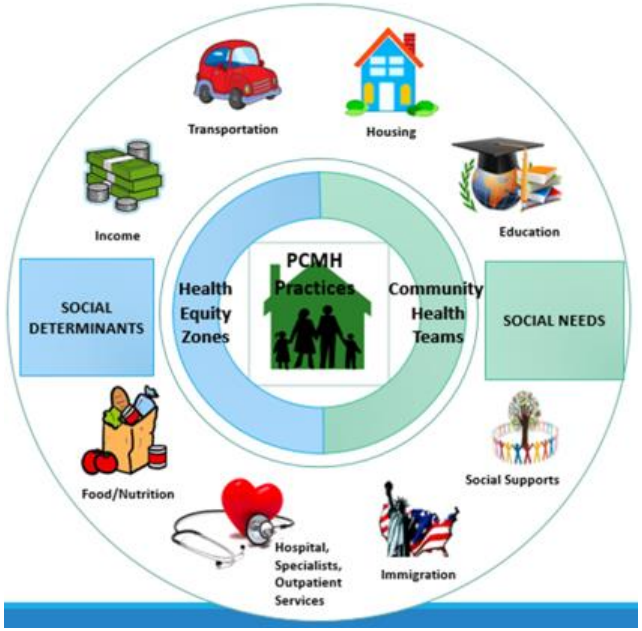
Patients Served - Approximately 3,000 patients annually (300-500 per team)

Core Staffing - Community Health Workers & BH Clinicians

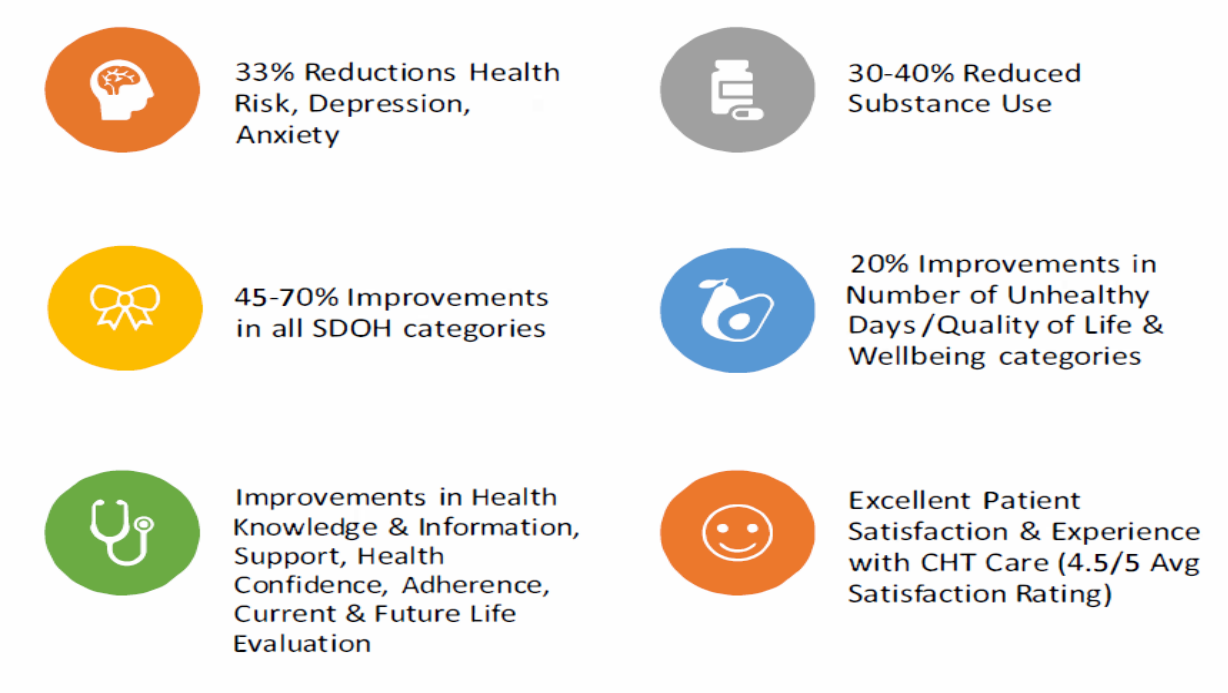
- CHW/Peer Recovery Coaches (SOR)

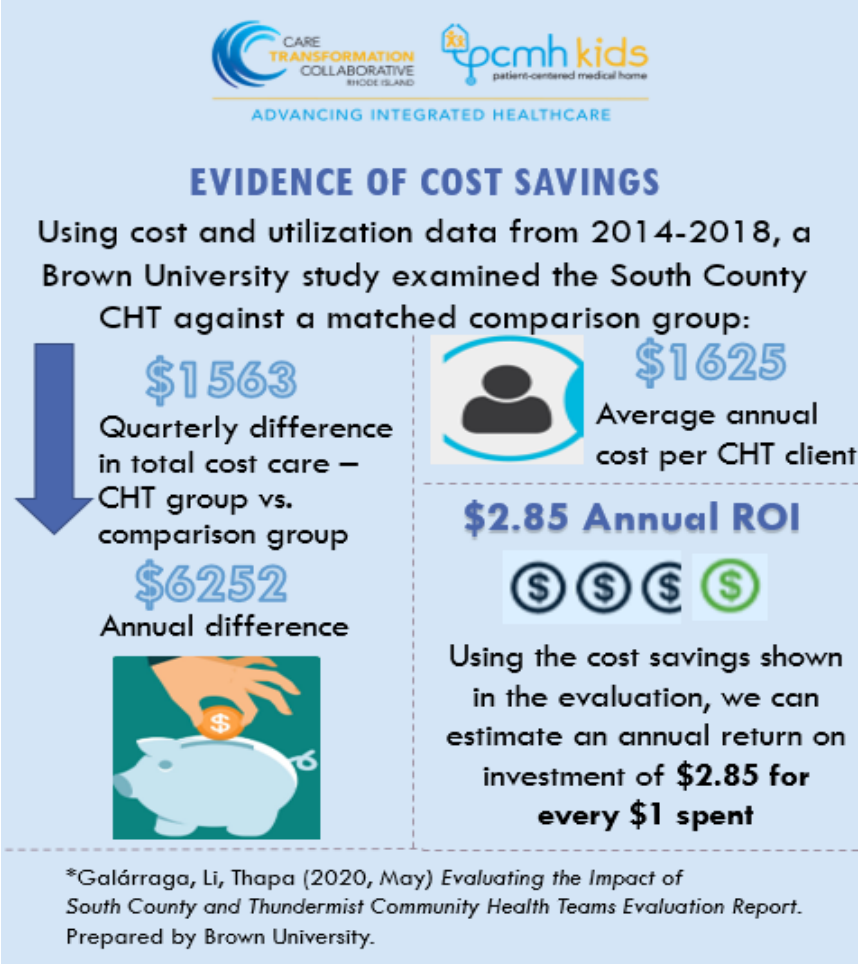
Partner Agencies – Family Service of Rhode Island, South County Health, Thundermist, EBCAP, and Blackstone Valley CHC

This program is <u>payer-blind -</u> No specific type of insurance is required to participate



SUMMARY: Clinically & Statistically Significant Client Changes after 4.7 months of CHT Care





Annual savings over comparison group: **$6252**

Minus the annual cost of CHT services: **$1625 =**

Annual savings of per client **$4627**

Questions

Contact information

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