



#### ADVANCING INTEGRATED HEALTHCARE

# Integrated Comprehensive Primary Care: Model Expansion and Payment Care Transformation Collaborative of R.I.

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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.



## The Rhode Island Affordability Standards

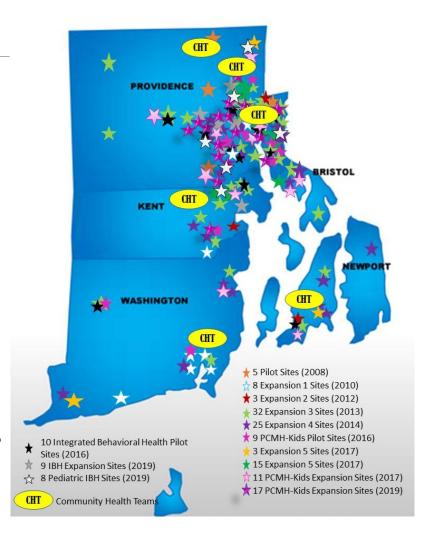
- Legislation enacted 2006, regulations promulgated 2008-2010
  - Office of Health Insurance Commissioner (OHIC)
  - 1% yearly increase primary care spend (commercial insurers)
  - Support statewide multi-payer PCMH transformation
- Revised 2014 and 2020 primary care spend increased from 6.3% to 10.7%
  - 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:

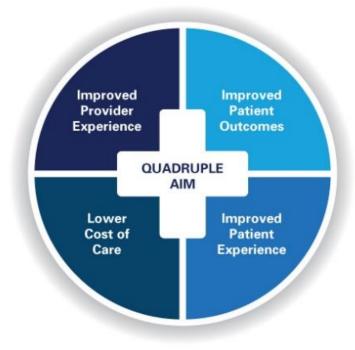
- 131 primary practices, including internal medicine, family medicine, and pediatric practices.
- Over 800 providers across our adult and pediatric practices.
- 31 primary care practices are part of Integrated Behavioral Health initiative
- Approximately 750,000 Rhode Islanders receive their care in 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

**Affordability Standards Behavioral Health** Community - Clinical **Community Health** Linkages **Quality Reporting** Integrated Behavioral Community Health Teams Health **Health Equity Zones Community Standards** Child- & Family-Focused Telebehavioral Health **Primary Care Capitation** Medicaid SDOH Strategy Multi-Payer/Multi-Sector NCQA IBH Distinction Funding Model Rhode to Equity Guiding Principles: Patient and family driven, high-quality, affordable health care leveraging Health IT, supporting equity, and population health Workforce Development Family Home Visiting Pharmacists Medication **Coordination Principles** 

Comprehensive **Primary** Care

Review/Management Care Management/ Coordination Expanded **Team-Based Care** 

Behavioral Health /

School Health

Health Screenings / Wellness

**Pediatric Care** 

Referral Management

e-Consults

Primary Care - Specialist

Reduce Low-Value Care

Close Gaps in Care

**High-Value Care** 

Health Information Technology: CurrentCare; Dashboards; Telehealth; Remote Monitoring

**Best Practice Learning Collaborative** 

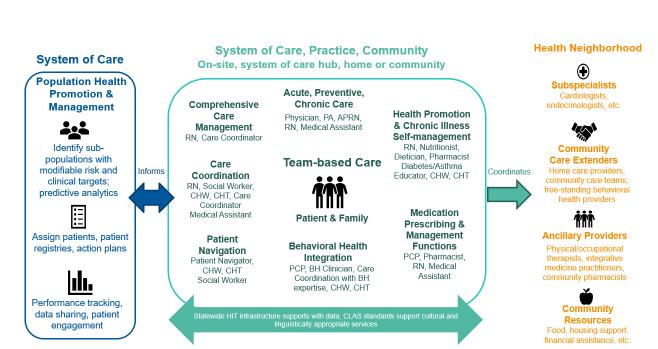
**Pediatric Learning Community** 

Patient-Centered Medical Home



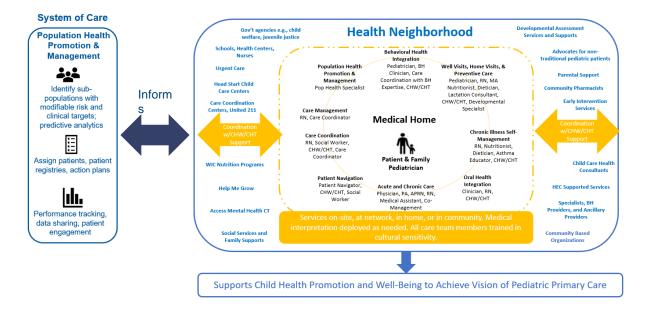


### EXPANDED CARE TEAMS Who is on the team?



- 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?

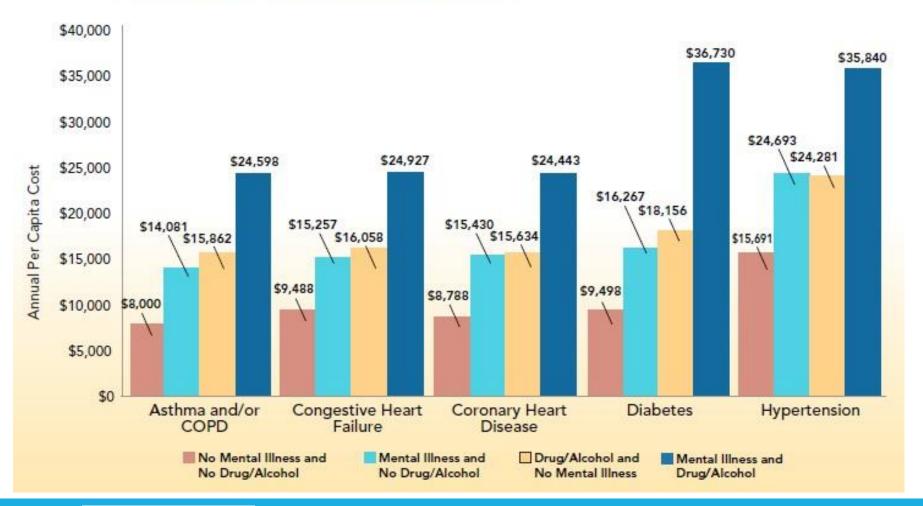


- Optional members of the care team
- This graphic is based on work in other states and adjusted slightly to reflect work in RI
- Different practices may require different care team compositions
- Statewide HIT infrastructure supports improved quality and efficiency

### **Comorbidities and Cost**

(Boyd et al 2010, courtesy of Cadence Consulting)

Figure 3 Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities



# 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.

#### **SOCIAL DETERMINANTS AND SOCIAL NEEDS:** MOVING BEYOND MIDSTREAM COMMUNITY TACTICS STRATEGIES IMPACT Laws, policies, Improve and regulations that Community create community conditions Conditions upstream supporting health for all people. INDIVIDUAL Include patient screening questions IMPACT about social factors like housing and food access; use data to inform care and provide referrals. Addressing Individuals Social workers, community health midstream Social workers, and/or community-based Needs organizations providing direct support/assistance to meet patients social needs Medical Providing interventions Clinical Care downstream



### 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



33% Reductions Health Risk, Depression, Anxiety



30-40% Reduced Substance Use



45-70% Improvements in all SDOH categories



20% Improvements in Number of Unhealthy Days/Quality of Life & Wellbeing categories



Improvements in Health Knowledge & Information, Support, Health Confidence, Adherence, Current & Future Life Evaluation



Excellent Patient Satisfaction & Experience with CHT Care (4.5/5 Avg Satisfaction Rating)





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#### EVIDENCE OF COST SAVINGS

Using cost and utilization data from 2014-2018, a Brown University study examined the South County CHT against a matched comparison group:

**\$1563** 

Quarterly difference in total cost care -CHT group vs. comparison group

Annual difference





Average annual cost per CHT client

\$2.85 Annual ROI







Using the cost savings shown in the evaluation, we can estimate an annual return on investment of \$2.85 for every \$1 spent

\*Galárraga, Li, Thapa (2020, May) Evaluating the Impact of South County and Thundermist Community Health Teams Evaluation Report. Prepared by Brown University.

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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