



## Quarterly Breakfast of Champions

February 08, 2019, 7:30am-9:00am

The Rhode Island Shriners Imperial Room, 1 Rhodes Place, Cranston, RI 02905

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| 1. <b>Welcome and Agenda Review</b><br><b>with Table Discussing and Report Out</b>  | <i>Pano Yeracaris, MD, MPH</i><br>Chief Clinical Strategist<br>CTC-RI   | <i>7:30-7:35a</i>  |
| 2. <b>Making Sense of the Madness:</b> 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? | <i>Andrew Saal MD MPH</i><br>Chief Medical Officer<br>Providence Community Health<br><i>Andrea Galgay, MBA</i><br>Director, ACO Development<br>RIPCPC | <i>7:35-8:30a</i>  |
| 3. <b>Efforts to Improve Technology and Data Flow to Impact Care:</b><br>Seeking feedback on roadblocks and which actions we can take together to meet common goals.  | <i>Kim Paull, MPH</i><br>Director<br>RI EOHHS Data and Analytics  | <i>8:30- 9:00a</i> |

**Evaluation/Feedback**



# Making Sense of the Madness ...while maintaining your sanity

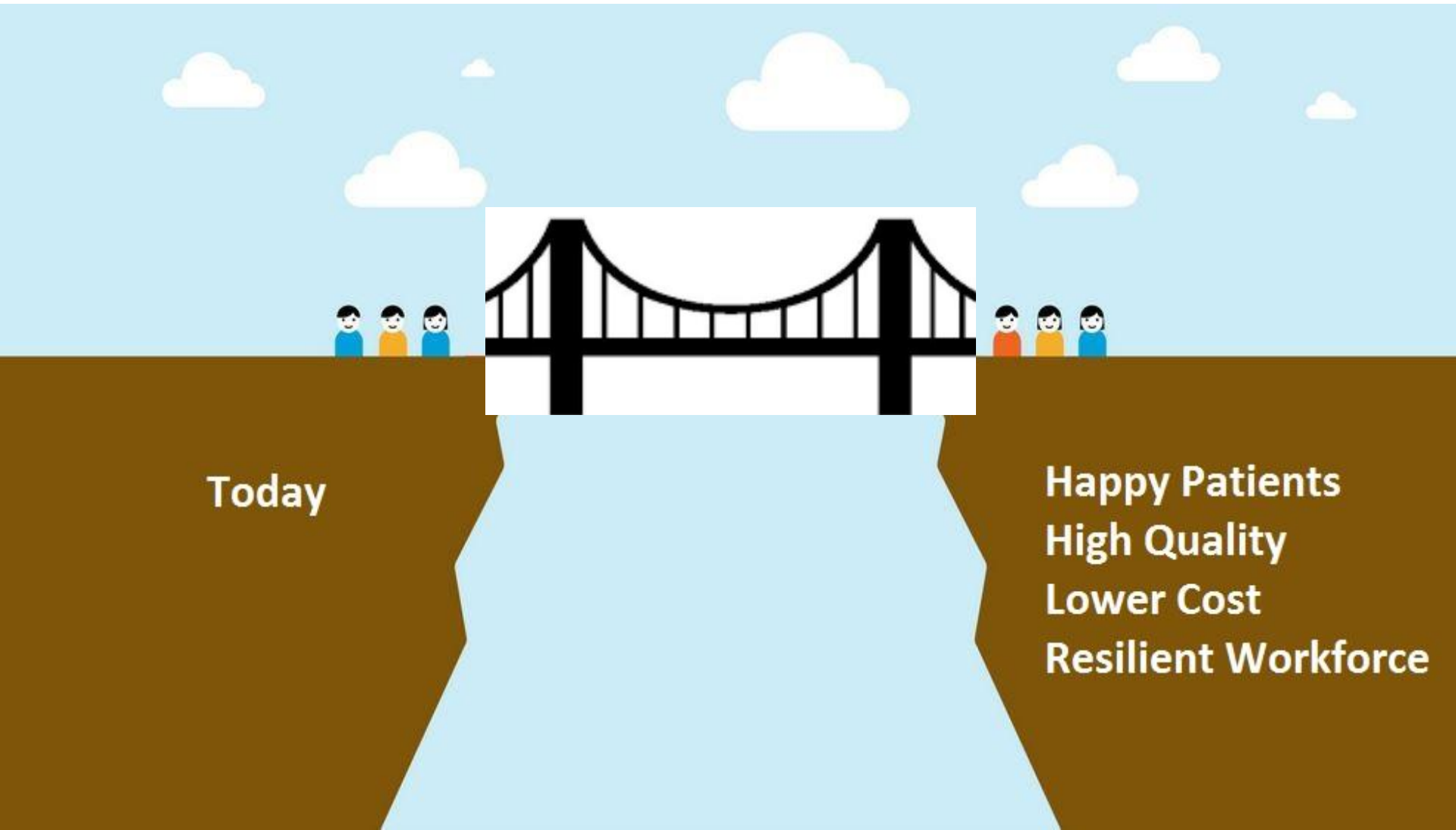
## Care Transformation Collaborative of R.I.

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**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



Today

Happy Patients  
High Quality  
Lower Cost  
Resilient Workforce

# Transformation Strategies

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## Care Team Redesign

Nurse Care Management  
Community Health Workers  
Integrated Behavioral Health

## Improved Data

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

## Interagency Relationships

Specialist Compacts  
Continuity of Care Documents  
Transitions of Care

***Referrals Management***

## Population Management

Historical – Top 5% Total Cost  
Predictive – Who Might Need Help?

***Health Risk Assessments***

# Population Management

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**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?

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# Health Risk Assessments

Which common conditions predict poor health outcomes?

7. What is your housing situation today?

<input type="checkbox"/>	I have housing
<input type="checkbox"/>	I do not have housing (staying with others, in a hotel, in a shelter, living outside on a street, on a beach, in a car, or in a tent)
<input type="checkbox"/>	I choose not to answer this question

8. Are you worried about not being able to get any of the following when it is needed? Check all that apply.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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Are you or any family members you live with able to get any of the following when it is needed? Check all that apply.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Phone
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Clothing
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Child Care
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Other (please write):
<input type="checkbox"/>	I choose not to answer this question				

**The Social Determinants of Health are More Accurate than the Best Computer Algorithms**

## HRA as a Population Health Strategy

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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!**



# SDOH – Everybody Wants to Know

## Medicaid Comprehensive AE Common Measure Slate

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort
1. Breast Cancer Screening	2372	HEDIS®	Preventive Care	Admin	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	Adult
2. Weight Assessment & Counseling for	0024	HEDIS®	Preventive Care	Hybrid	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	Pediatric

10. Social Determinants of Health (SDOH) Screening	N/A	N/A	Social Determinants	Practice-reported	% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*	Adult and Pediatric
11. Self-Assessment/Rating of Health Status	N/A	N/A	Health Status	Practice-reported	Measure to be defined and submitted to EOHHS for approval (e.g., Institute for Healthcare Improvement)	Adult and Pediatric

EOHHS Medicaid AE Core Quality Slate

# **COLLABORATION WITH SPECIALISTS AND REFERRAL MANAGEMENT**

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# Reasons for Collaboration

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Enhanced management of patient population

Standardization of care

Aligned incentives

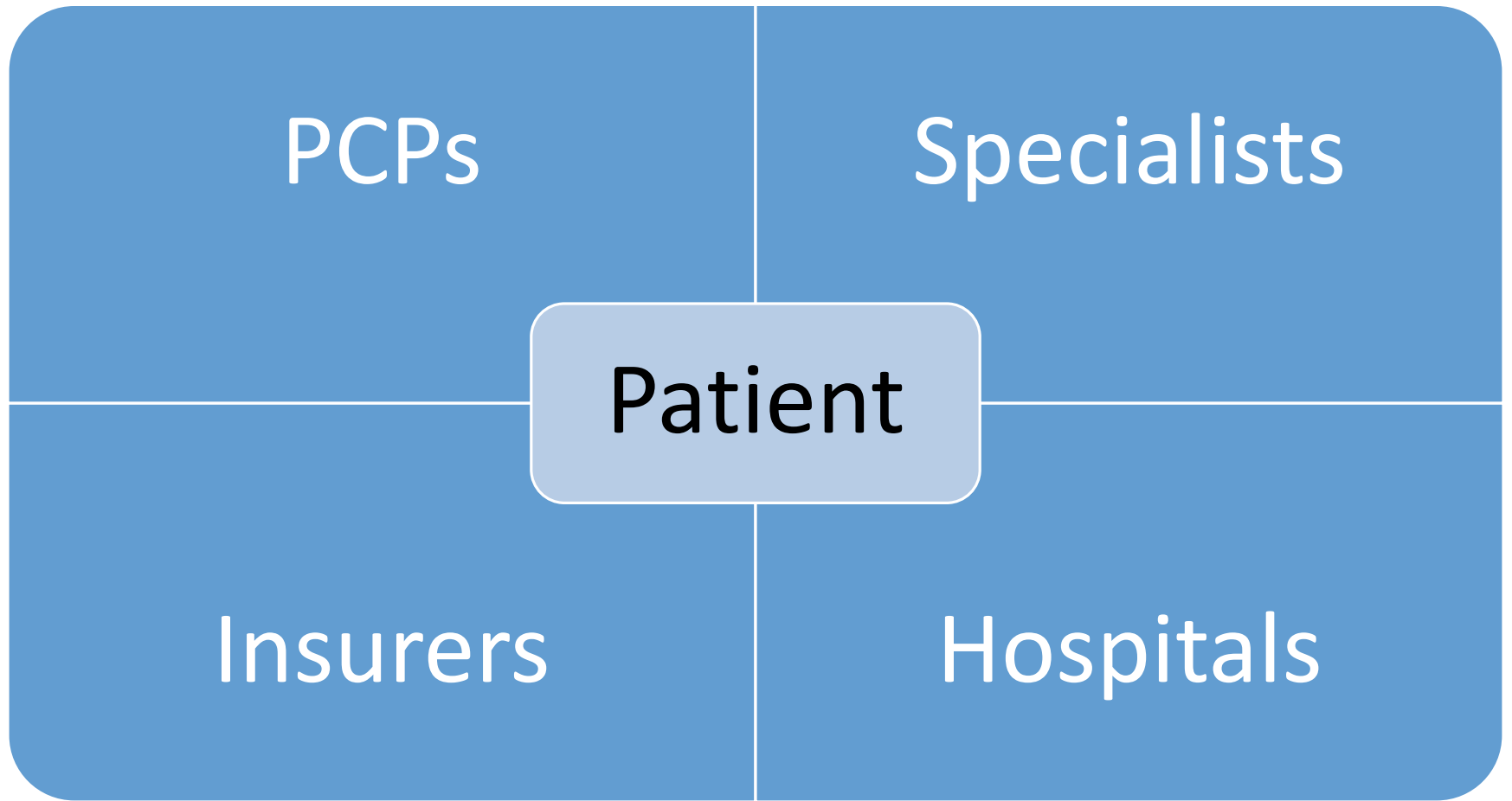
ACO/Group 'preferred' networks

MACRA

Product design

# Stakeholders

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# Common Issues

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Access and Communication – Specialist AND PCP

One time consult versus ‘annuity’

Managing patient expectations

Fear of offending peers

Red tape



## Social Determinants of Health

- 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.)?