CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Clinical Strategy Committee Meeting

March 21, 2025

Care Transformation Collaborative of RI

Agenda

Topic	Duration
Welcome & Announcements ***Moderator:*** *Pano Yeracaris, MD, MPH, Chief Clinical Strategist, CTC-RI*	**7:30 – 7:35 AM** (5 Min)
Navigating Uncertainty Together*:** ***Supporting Providers & Patients with Immigration and SOGIE Concerns *Rebecca Kislak, JD, Law & Policy Consultant, Legal Key*	**7:35 – 8:15 AM** (40 Min)
Our Journey to Global CAP *Robert Millette, CEO, CharterCare Provider Group RI & SVP, Prospect Medical*	**8:15 – 8:55 AM** (40 Min)

Announcements

CTC-RI is excited to announce its annual conference on **November 19, 2025, at the Crowne Plaza in Warwick, RI.**

The 2025 conference is themed **"Advancing Primary Care: Innovating for a Sustainable Future".**

Some topic areas include, but are not limited to:

- Primary Care & Workforce Development
- Behavioral Health (IBH)
- Population Health
- Family-Child Health
- Aging & Older Adult Care
- Innovation in Healthcare
- Other topics such as: patient voice, policy, and technology

See Detailed Submission Guidelines & Details

SUBMIT HERE by April 11

Announcements

ADVANCING INTEGRATED HEALTHCARE

Call for Applications

Implementing Improvements in Collection and Use of Patient Demographic Data in Primary Care Quality Improvement Initiative

- Offering up to **10 primary care practice teams** (adult medicine, family medicine, and pediatric) the opportunity to apply for funding of **$10,000 per practice** to participate in a **9-month Demographic Data Quality Improvement Initiative**.
- This project is made possible through the generous support from UnitedHealthcare and does not include federal funding.
- **Deadline to submit: April 11th**: Read More

Upcoming Programs

ADVANCING INTEGRATED HEALTHCARE

Improving Child Health in RI - Quarterly Meeting

Thurs, April 03, 7:30 – 8:30AM

- Sarah Kelly-Palmer, LICSW, Chief of Behavioral Health, Family Service of Rhode Island, will review how RI Certified Community Behavioral Health Clinics (CCBHC) can help in pediatric care.
- The group will have additional discussion regarding integrating CHW into pediatric care: with focus on pros, cons, and CHW billing considerations.

Upcoming Programs

ADVANCING INTEGRATED HEALTHCARE

Team Based Care - April 15, 8-9AM

Resilience in Uncertain Times: How healthcare teams can apply psychological safety and mindfulness from an evidence base

- Nelly Burdette, PsyD, Chief Clinical Officer, CTC-RI
- Patricia Holland, M.S., C.R.C., Assistant Director for Mindfulness in Public Health and Medicine, Mindfulness Center at Brown University

Clinical Strategy Committee – April 19, 7:30-9AM

MomsPRN & COPD/Asthma Management

- Jim Beasley, MPA, MomsPRN Program Manager
- Dr. Zobeida Diaz, Division Director, Center for Women's Behavioral Health, Women and Infants Hospital
- Matt Brazier, PharmD, Director of Pharmacy, Prospect CharterCARE RI

CTC-RI Conflict of Interest Statement

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

Claim CME Credits Here

The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 04/16/2024 to 04/16/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Objectives

- Learn about current and potential changes to federal law relating to immigration and gender
- Discuss if or how these changes might change clinical healthcare practice
- Apply best practices in data collection and documentation while considering patient privacy and concerns
- Learn about primary care and other strategies and programs in a successful System of Care performance for a global risk Medicare Advantage contract

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Navigating Uncertainty Together

Rebecca Kislak, JD, Law & Policy Consultant, Legal Key

*****To create a safe space for discussion, Zoom meeting recording and AI functions will be paused for this presentation.*****

Rebecca Kislak, JD (she/her)

Rebecca M. Kislak is a Law and Policy Consultant whose career is rooted in collaborative law and policy. Rebecca was a founding attorney of the Medical-Legal Partnership at Community Legal Aid in Worcester, MA, and director of the initial Rhode Island Medical-Legal Partnership program. She also served as Policy Director and Counsel at the Rhode Island Health Center Association. Rebecca teaches health policy as an adjunct professor at Rhode Island College and the Brown University School of Public Health and represents her Providence district as a State Representative in the Rhode Island General Assembly. A graduate of Georgetown University Law Center and Brown University, she is licensed to practice law in RI, MA, and PA.

Navigating Uncertainty Together

Presented to CTC-RI on zoom by
Rebecca Kislak, Esq.
Law and Policy Consultant
March 21, 2025

LEGAL KEY
PARTNERSHIP FOR
HEALTH AND JUSTICE

Mission Statement

Legal Key Partnership equips communities of care with legal education and problem-solving insight that fosters prevention, health equity and human-centered system change.

Through training, consultation/telementoring and technical assistance, we help teams and organizations more effectively connect people to the resources and legal protections they seek. This work is embodied in our team-facing legal partnering framework and in our *Unlocking Access* capacity-building suite.

Learning Objectives

Learn about current and potential changes to federal law relating to immigration and gender

Discuss if or how these changes might change clinical healthcare practice

Apply best practices in data collection and documentation while considering patient privacy and concerns

CME-CEU Conflict of Interest Statement

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

Rebecca Kislak holds stock/interest in various health care companies, but this relationship is not considered a conflict of interest for the content of this presentation.

Legal disclaimer

I am a lawyer but I am not *your* lawyer. I am not the lawyer for your healthcare practice.

Today we will talk about the current status of federal law, and data collection, and how they intersect with your healthcare practice. We will talk about patient fears, and how you can support your patients.

If you have any questions about how you might reconsider the design of your practice, or your healthcare records, please talk to your practice manager, medical director and general counsel.

Take Care of Yourself

Our trainings provide information that not only affect the members we work with, but also affect our community, our loved ones, and even ourselves.

Please take care of yourself.

LEGAL KEY
PARTNERSHIP FOR HEALTH AND JUSTICE

What is an executive order?

Executive Orders: A written instruction issued by the US President that is generally **directed to a government agency.**

Some EOs immediately implemented, but many EO call on government agencies to implement.

Just because an EO was signed doesn't mean that it's the new rule.

Executive orders can be:

- Challenged in court
- Revoked/Reformed by Congress
- Rescinded by a president

How do agencies implement executive orders?

- Implementation memoranda:
  - Purchasing authority
  - Content on websites
  - External communications
- Rule making authority
- Grants

Challenges to EOs

Mostly through court cases

EO:

Trump issues order to ban transgender troops from serving openly in the military

UPDATED JANUARY 28, 2025 · 6:14 PM ET

Court order (Mar. 17):

POLITICS

Federal judge blocks Trump effort to ban transgender troops from military service

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Tracking Current Information

Executive Orders

Tracking executive action and responses: Democracy Response Center

Tracking litigation: Just Security

Tracking Immigration Policy: Immigration Policy Tracker

Some Recent Executive Orders

Defending women from gender ideology extremism and restoring biological truth to the federal government (Jan. 20, 2025)

Ending procurement and forced use of paper straws (Feb. 10, 2025)

Ending Taxpayer Subsidization of Open Borders (Feb. 19, 2025)

Invocation of the Alien Enemies Act Regarding the Invasion of The United States by Tren De Aragua (March 15, 2025)

Paper Straw Example: Limits to Executive Orders

NEWS > WA GOVERNMENT

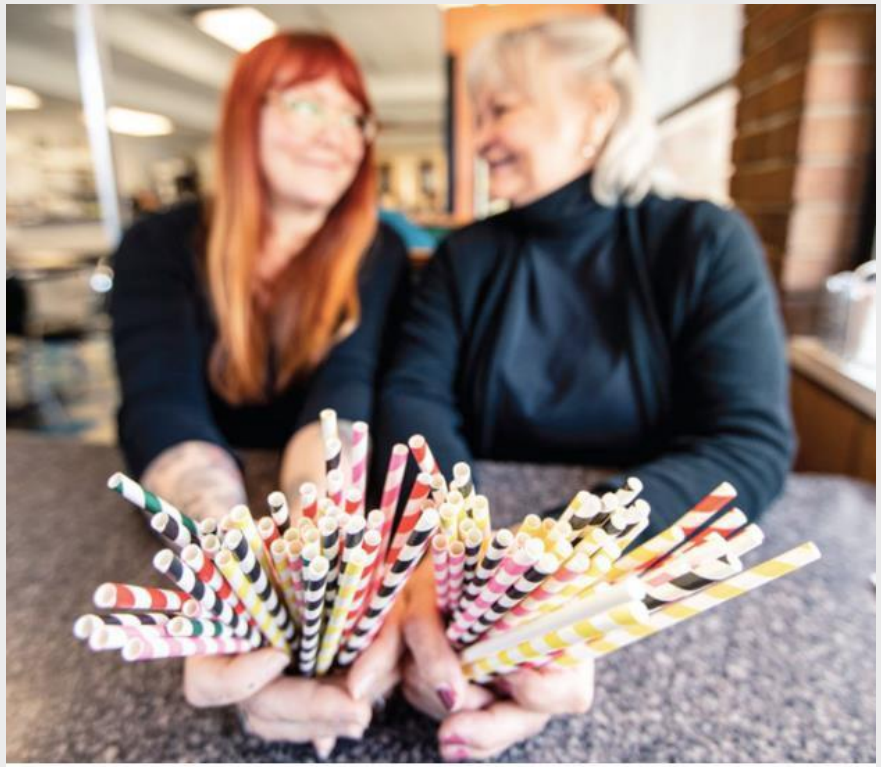
Trump signed executive order against paper straws. Does that mean they'll be banned in WA?

Feb. 12, 2025 | Updated Wed., Feb. 12, 2025 at 8:59 p.m.

ENVIRONMENT

Trump's order on paper straws worries local manufacturer

By **JACOB SCHERMERHORN** | March 10, 2025



Karrie Laughton, left, with her mother

Some Recent Immigration Executive Actions

ALERT: On Feb. 1, 2025, Secretary of Homeland Security Kristi Noem decided to terminate Temporary Protected Status (TPS) under the 2023 designation for Venezuela.

TPS and related benefits associated with the 2023 designation will end on April 7, 2025.

Reuters

Judge Wants U.S. to Explain Timing of Deportation Flights Amid His Order Barring Them

Tom Homan, the Trump administration's so-called border czar, suggested he would continue deportation flights no matter what. "I don't care what the judges think," he said.

Some Executive Branch Actions based on Gender EO

Regulations.gov
Your Voice in Federal Decision Making

SUPPORT

‹ View Docket

NOTICE

Share

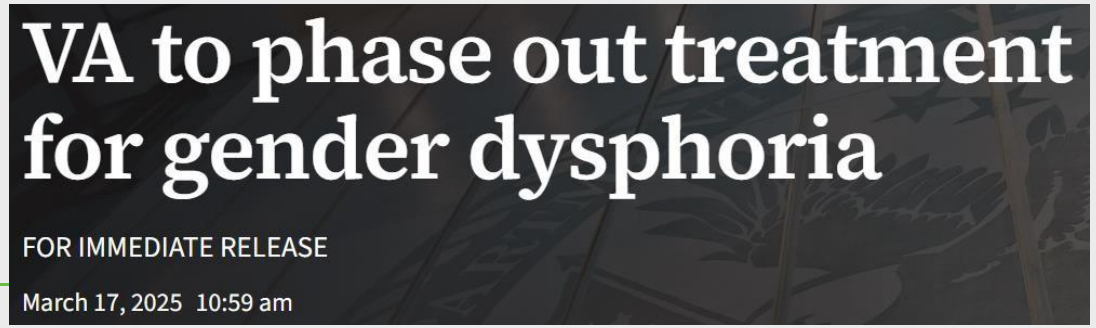
Agency Information Collection Activities; Proposals, Submissions, and Approvals: U.S. Passport Renewal Application for Eligible Individuals

Posted by the **U.S. Department of State** on Feb 18, 2025

Comment

Comment Period Ends: **Mar 20, 2025 at 11:59 PM EDT**

"To comply with E.O. 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," the Department updated the form to replace the term "gender" with "sex.""



Patient Care Tips

BUILD TRUST

- Be patient and trust families as experts in their own lives
- Only document what is necessary
- Use interpreters

GIVE CONTEXT

- Tell people why it's important for you to know
- Tell who will receive the information (and who won't)
- Tell that it's ok not to share and care won't be withheld

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Changes to Immigration Enforcement have Prompted Widespread Safety Concerns

- Some families may consider carrying certain documents
- Consider Family Preparedness Planning
- Knowing rights
- Knowing the reliable information sources
- Using online immigration tools

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Health care practice design tips.

Care teams can consider these steps with their organization to protect immigrant families

- Develop a written response policy and preparedness plan in advance.
- Designate an authorized person to review warrants and subpoenas.
- Train staff how to respond to ICE requests.
- Designate spaces as public and non-public accordingly.
- Document all interactions with immigration enforcement.
- Connect with immigration response networks in your area.
- Educate and reassure families and individuals of their rights and confidentiality laws.

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Change to former Sensitive Locations Policy

Prior policy for ICE was to avoid "sensitive locations"

- Schools
- Hospitals
- Houses of worship
- Shelters
- Places where people gather for ceremonies etc.

RESCINDED

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Change to former Sensitive Locations Policy

Public space v. private space

- Be sure to define and know the difference
- Train all staff; reinforce for front desk staff

Key resources:

- RI AG – RIDE joint guidance for schools re: law enforcement
- National Immigration Law Center Protected Areas Fact Sheet

Change to former Sensitive Locations Policy

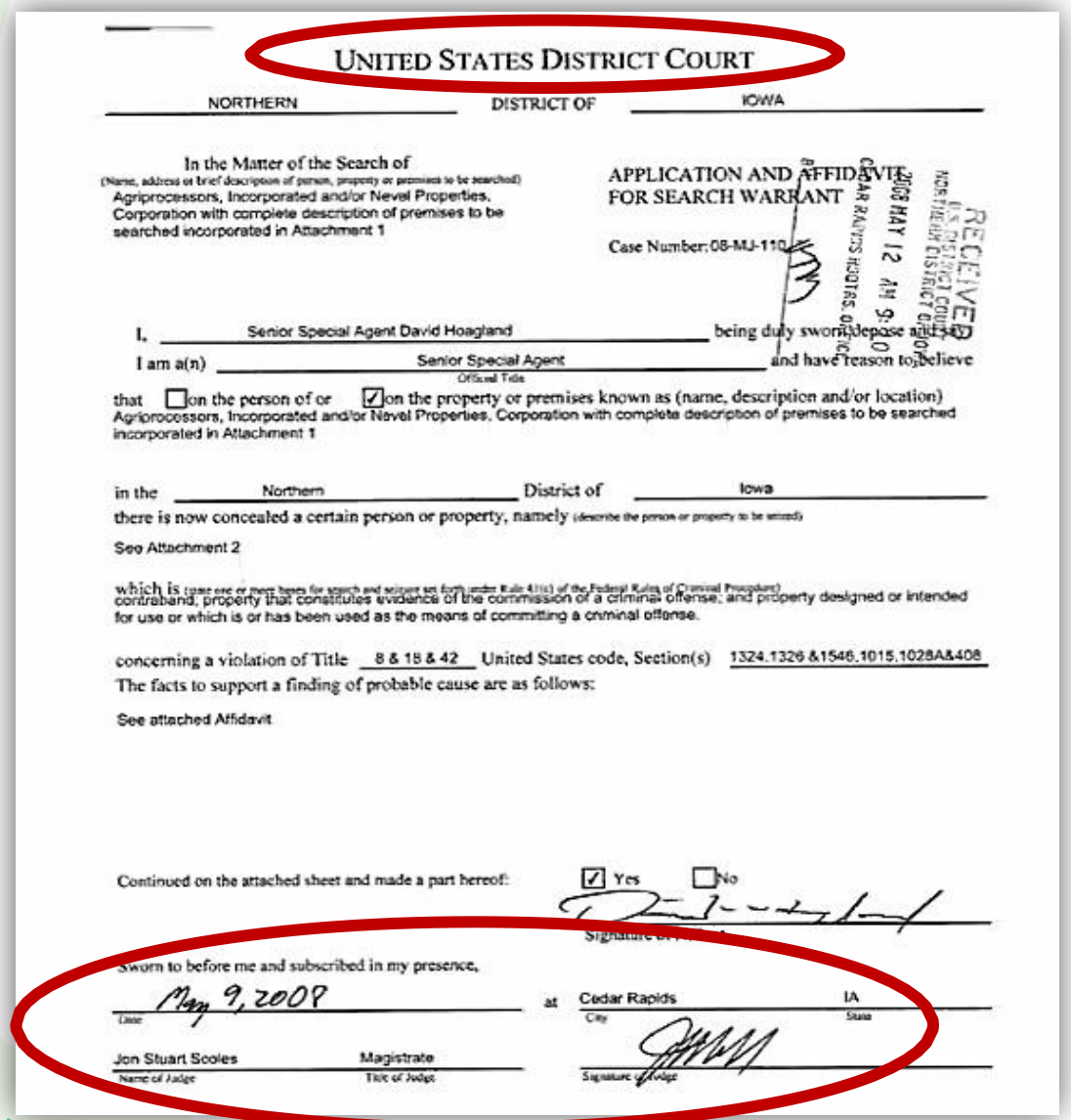
ICE now has a policy they can go to:

- Schools — Are locked
- Hospitals — Designated private patient areas
- Houses of worship — Not Quakers, Sikh Temple Sacramento, GA Cooperative Baptist Fellowship
- Shelters
- Places where people gather for ceremonies etc.

- Must still have a **criminal judicial warrant issued by a federal judge** to enter these facilities to make arrests (unless staff consent to search).

- "Generally avoid" enforcement in/near courthouses wholly dedicated to non-criminal proceedings (Ex. Family court, small claims court)

Criminal judicial warrant signed by a federal Judge



UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF IOWA

In the Matter of the Search of
(Name, address or brief description of person, property or premises to be searched)
Agriprocessors, Incorporated and/or Nevel Properties, Corporation with complete description of premises to be searched incorporated in Attachment 1

APPLICATION AND AFFIDAVIT FOR SEARCH WARRANT

Case Number: 08-MJ-110

I, Senior Special Agent David Hoagland being duly sworn depose and say

I am a(n) Senior Special Agent and have reason to believe
Official Title

that ☐ on the person of or ☑ on the property or premises known as (name, description and/or location)
Agriprocessors, Incorporated and/or Nevel Properties, Corporation with complete description of premises to be searched incorporated in Attachment 1

in the Northern District of Iowa

there is now concealed a certain person or property, namely (describe the person or property to be seized)

See Attachment 2

which is (state one or more bases for search and seizure set forth under Rule 41(c) of the Federal Rules of Criminal Procedure)
contraband, property that constitutes evidence of the commission of a criminal offense, and property designed or intended for use or which is or has been used as the means of committing a criminal offense.

concerning a violation of Title 8 & 18 & 42 United States code, Section(s) 1324,1326 &1546,1015,1028A&408

The facts to support a finding of probable cause are as follows:

See attached Affidavit

Continued on the attached sheet and made a part hereof: ☑ Yes ☐ No

Signature of Affiant

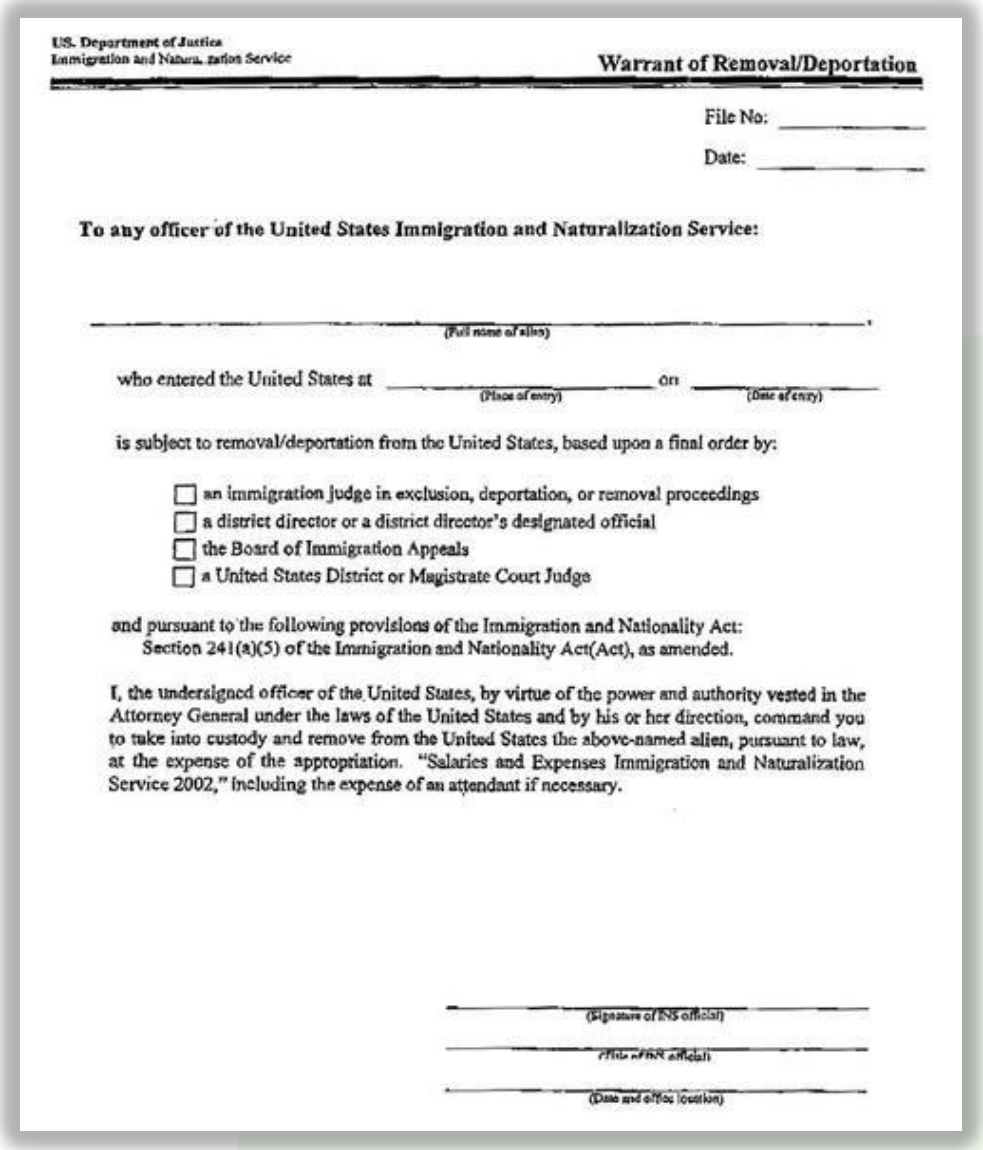
Sworn to before me and subscribed in my presence,

May 9, 2008 at Cedar Rapids IA
Date City State

Jon Stuart Scoles Magistrate
Name of Judge Title of Judge

Signature of Judge

ICE Administrative Document is NOT a judicial warrant



U.S. Department of Justice
Immigration and Naturalization Service

Warrant of Removal/Deportation

File No: _____

Date: _____

To any officer of the United States Immigration and Naturalization Service:

_____
(Full name of alien)

who entered the United States at _____ on _____
(Place of entry) (Date of entry)

is subject to removal/deportation from the United States, based upon a final order by:

☐ an immigration judge in exclusion, deportation, or removal proceedings
☐ a district director or a district director's designated official
☐ the Board of Immigration Appeals
☐ a United States District or Magistrate Court Judge

and pursuant to the following provisions of the Immigration and Nationality Act:
Section 241(a)(5) of the Immigration and Nationality Act(Act), as amended.

I, the undersigned officer of the United States, by virtue of the power and authority vested in the Attorney General under the laws of the United States and by his or her direction, command you to take into custody and remove from the United States the above-named alien, pursuant to law, at the expense of the appropriation. "Salaries and Expenses Immigration and Naturalization Service 2002," including the expense of an attendant if necessary.

_____
(Signature of INS official)

_____
(Title of INS official)

_____
(Date and office location)

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New Enforcement Policy: Expanded Expedited Removal

Expedited removal allows the US government to quickly deport people they believe to be undocumented in ICE custody, without seeing an immigration judge.

- **Current policy as of 1/24/2025**: applies to people ***anywhere*** in the US.

- To avoid expedited removal, people must affirmatively show:
  - They have been in the US **longer than 2 years**
  - Have lawful status
  - Have a claim to protection, like asylum.

NATIONAL IMMIGRATION LAW CENTER

Key Resource: National Immigration Law Center's Know Your Rights "Expedited Removal"

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Carrying documents/copies could stop expedited removal (but not regular deportation proceedings)

Documents that show they have lawful status in the US

- Pending application for asylum or other immigration court case/appeal
- Unexpired TPS
- Unexpired work permits
- Photos of lawful status

Documents that show lawful entry into the US

- I-94 arrival cards
- Passport stamps

Documents that show residence in the US longer than 2 years

- Signed leases
- Shelter records
- Mail from postmarked address in the US
- School enrollment records
- Medical provider letters

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Red Cards:

https://www.ilrc.org/red-cards-tarjetas-rojas

Care teams can share Family Preparedness Plans

- **Rhode Island:** Immigrant Coalition of RI's Family Preparedness Plan
- **Massachusetts:** BMC's Family Preparedness Plan (ESP) and Facilitator Guide

Patient Care Tips

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GIVE CONTEXT

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What is SOGIE data and why is it important?

Sexual Orientation, Gender Identity, and Expression

Important to collect data to reflect the world so that we can understand who is seeking care and what their needs are

Federal HHS issued guidance on SOGIE data collection in 2024

Stemmed from 2022 EO: Advancing Equality for Lesbian, Gay, Bisexual, Queer, and Intersex (LGBTQI+) Individuals

Many EHRs have collected SOGEI information longer

Data collection and documentation

- Reminder: No laws about data collection and documentation have changed for most people.
  - Exception: Federally employed healthcare providers (e.g. military and VA)
  - Exception to the exception: where courts have stopped restrictions.
- Records protected by HIPAA.
- Patients, particularly immigrants and Trans and GNC patients are concerned about their medical records.
- Patients might be concerned that information that had been protected in the past might not be.
  - Example: IRS considering whether disclose undocumented immigrant tax filers

Data collection and documentation

Consider:

- Do you need the information?
- How do you record it? Where?
- Is your AI notetaker secure? Does patient consent?
- Where do you share data? Were opt-out notices adequately informative and respectful?
- How do you share your data – aggregate or identifiable records

Patient Care Tips

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Take Care of Yourself

Our trainings provide information that not only affect the members we work with, but also affect our community, our loved ones, and even ourselves.

Please take care of yourself.

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Some places for up-to-date information

Immigration rights:

DIGITAL DIGEST

PROTECTING IMMIGRANT FAMILIES

IMMIGRANT COALITION OF RHODE ISLAND

MIRA Massachusetts Immigrant & Refugee Advocacy Coalition

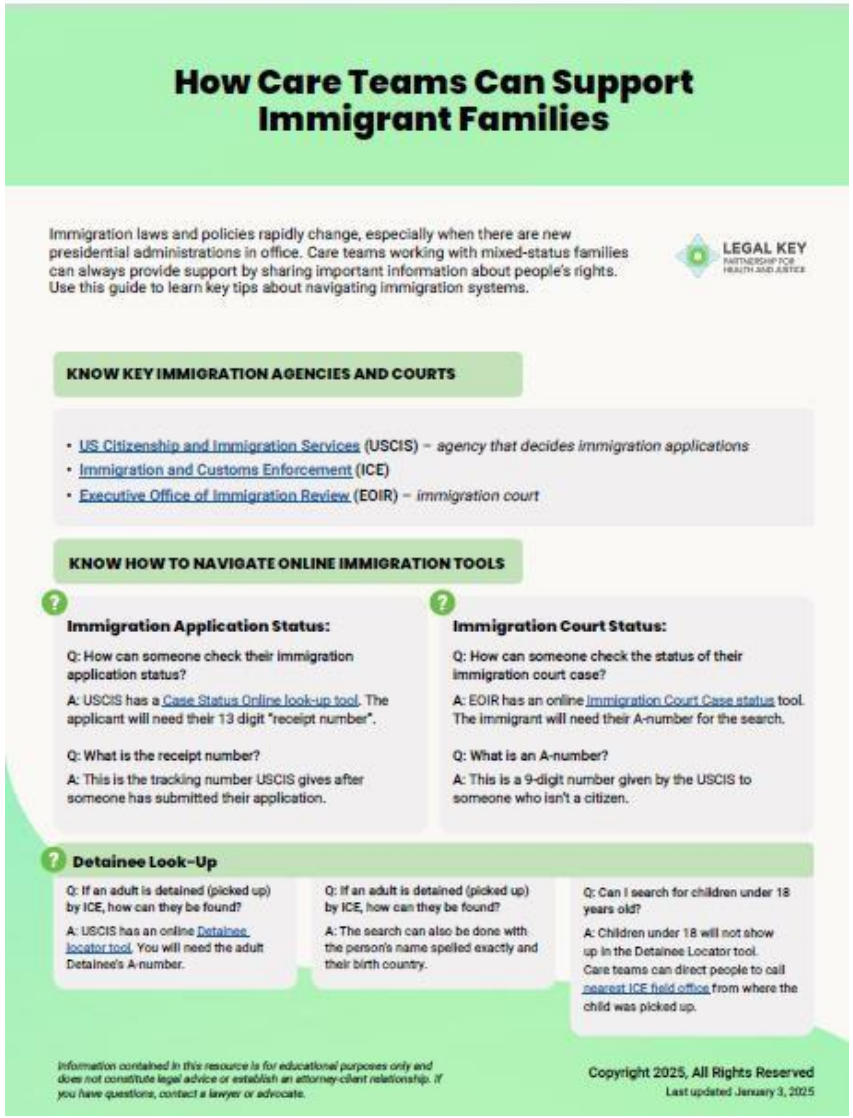
LGBTQ+ rights:

GLAD LAW
GLBTQ Legal Advocates & Defenders

A4TE ADVOCATES FOR TRANS EQUALITY

THE TREVOR PROJECT

Fact Sheets on the Hub!



How Care Teams Can Support Immigrant Families

Immigration laws and policies rapidly change, especially when there are new presidential administrations in office. Care teams working with mixed-status families can always provide support by sharing important information about people's rights. Use this guide to learn key tips about navigating immigration systems.

LEGAL KEY PARTNERSHIP FOR HEALTH AND JUSTICE

KNOW KEY IMMIGRATION AGENCIES AND COURTS

- US Citizenship and Immigration Services (USCIS) – *agency that decides immigration applications*
- Immigration and Customs Enforcement (ICE)
- Executive Office of Immigration Review (EOIR) – *immigration court*

KNOW HOW TO NAVIGATE ONLINE IMMIGRATION TOOLS

Immigration Application Status:

Q: How can someone check their immigration application status?

A: USCIS has a Case Status Online look-up tool. The applicant will need their 13 digit "receipt number".

Q: What is the receipt number?

A: This is the tracking number USCIS gives after someone has submitted their application.

Immigration Court Status:

Q: How can someone check the status of their immigration court case?

A: EOIR has an online Immigration Court Case status tool. The immigrant will need their A-number for the search.

Q: What is an A-number?

A: This is a 9-digit number given by the USCIS to someone who isn't a citizen.

Detainee Look-Up

Q: If an adult is detained (picked up) by ICE, how can they be found?

A: USCIS has an online Detainee locator tool. You will need the adult Detainee's A-number.

Q: If an adult is detained (picked up) by ICE, how can they be found?

A: The search can also be done with the person's name spelled exactly and their birth country.

Q: Can I search for children under 18 years old?

A: Children under 18 will not show up in the Detainee Locator tool. Care teams can direct people to call nearest ICE field office from where the child was picked up.

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Last updated January 3, 2025

SUPPORT MIXED STATUS FAMILIES

Offer emergency planning for the care of the children. This includes:

- Having passports for the adults and children
- Give a copy of the parent's A-number to family and emergency contacts
- Identifying a caregiver for the child
- Creating a family reunification plan
- Listing the child's personal, health, and educational needs and service provider information

Key Planning Resources

- Massachusetts: BMC's Family Preparedness Plan (ESP) and Facilitator Guide
- Rhode Island: Immigrant Coalition of RI's Family Preparedness Plan
- Passport application for minors: US Dept. of State
- Benefits and immigration: Protecting Immigrant Families Coalition guides on public charge

HELP PEOPLE BE PREPARED FOR ICE INTERACTIONS

- Know their rights in case ICE comes to their home.
- Print and Use "Red Cards" with Rights information
- Memorize phone numbers of family members and/or legal resources.
- Identify one person with US citizenship or immigration

FOR MORE INFORMATION, VISIT THE DIGITAL DIGEST

DIGITAL DIGEST

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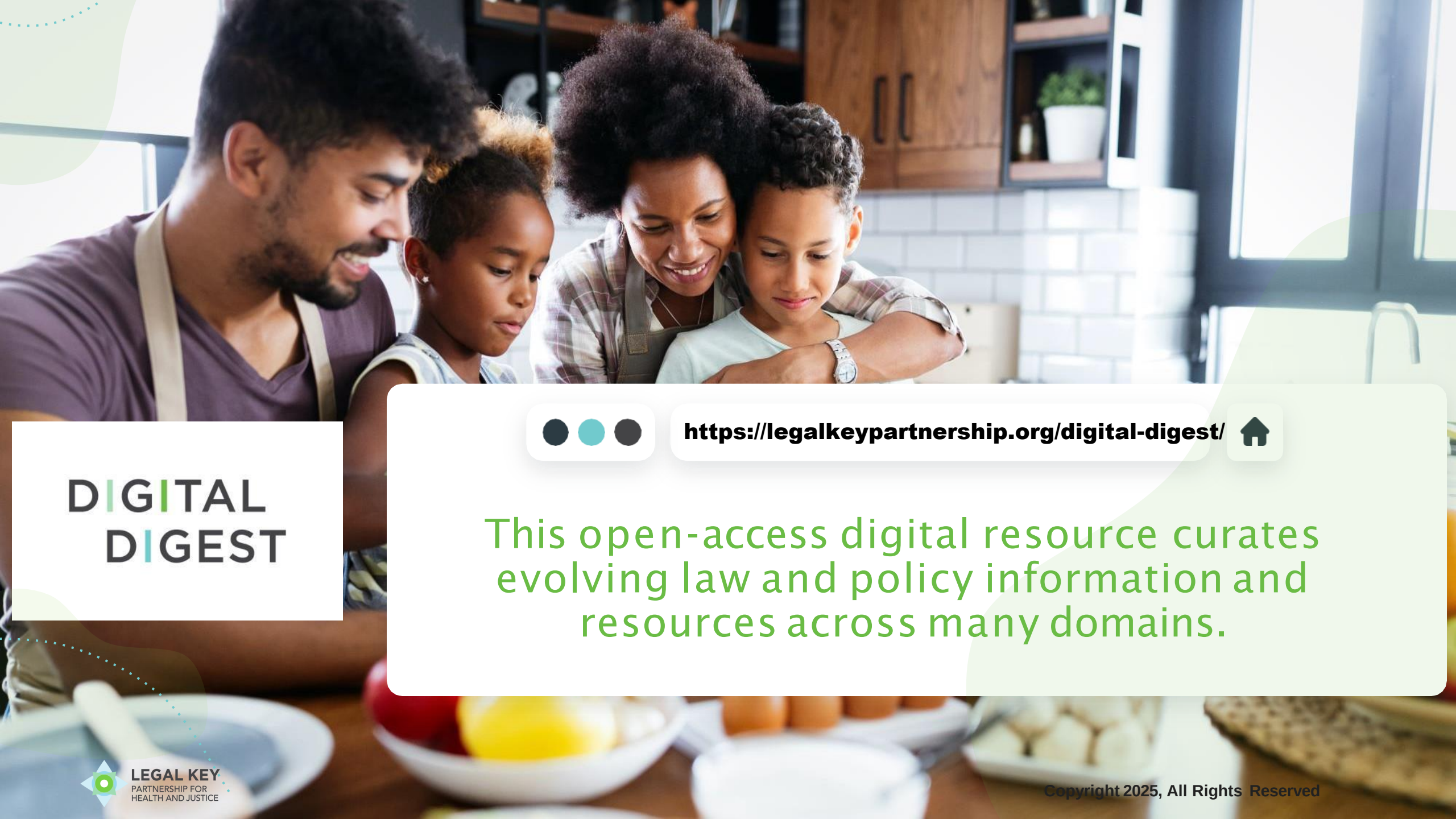

DIGITAL DIGEST

https://legalkeypartnership.org/digital-digest/

This open-access digital resource curates evolving law and policy information and resources across many domains.

LEGAL KEY
PARTNERSHIP FOR HEALTH AND JUSTICE

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Integra
RI-based CHW

Sarah Yan
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Brockton NHC
East Boston Social Center
Lynn CHC
Family Supports (Children's Trust)
MetroHousing | Boston

Not a partner?
Email Jeff Gilbert at
jgilbert@legalkeypartnership.org

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HEALTH AND JUSTICE

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ANY QUESTIONS?

Our Journey to Global CAP
March 21, 2025

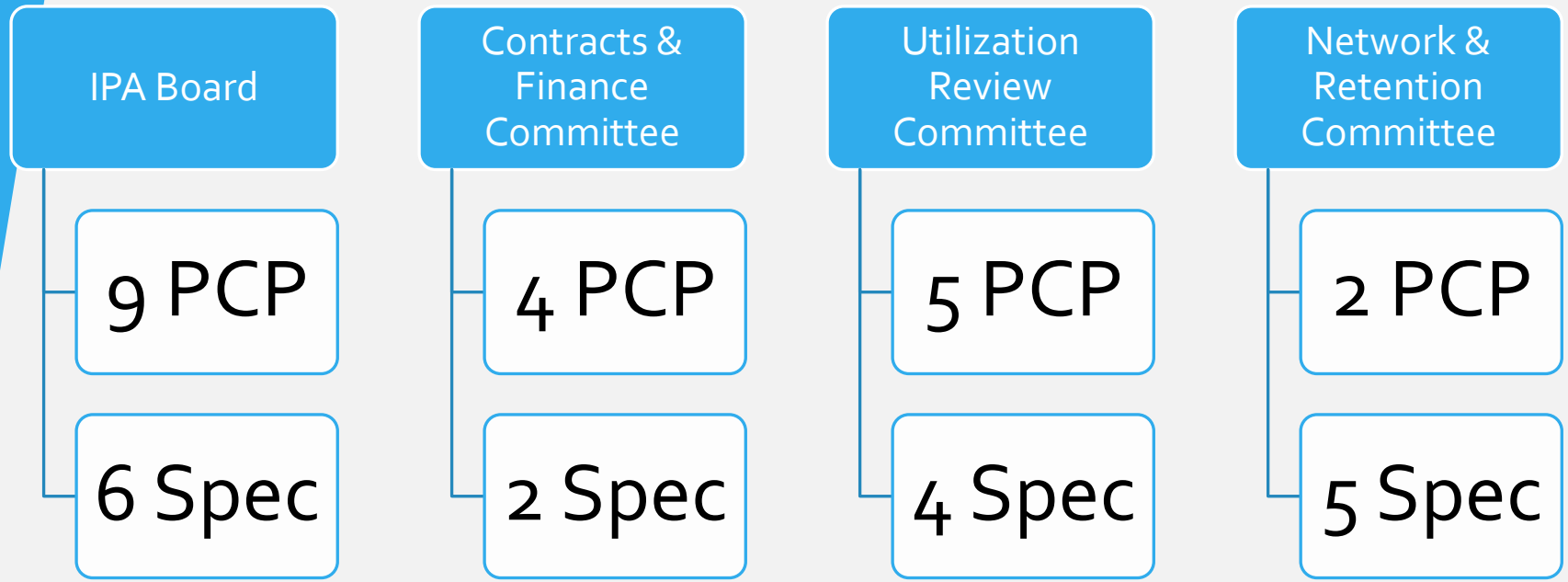
Agenda

- Introduction to CPGRI – What are we fixing?
- Our Journey – Stake in the Ground – How Global CAP Works
- Network Strategy & Tactics
- Clinical, UM, and Coding Work
- Results – Wins and Losses
- What's next?

Our Network – Who Are We?

- Independent Providers – PCPs & Specialists
- Provider Groups (Multi-Location Provider Groups)
- CharterCARE Medical Associates (PCPs & Specialists employed by CharterCARE Hospitals)
- 111 PCP's – 85 Independent
- 270 select Specialists

IPA Governance & Engagement



We engage both our Primary Care and Specialist partners in all governing aspects of our IPA:

- Strengthens and Builds support for our Network
- Innovation
- Higher Quality
- Cost Efficiency
- Increased Engagement

What are we fixing?

"If you pay for volume, you will get volume"

CPGRI has a goal to transform a network of PCPs and Specialists into a cohesive, integrated group, not compensated through fee for service, but through quality and outcomes, with a focus on removing unnecessary care from the continuum. We want to manage populations, and support PCPs and Specialists with care outside the 4 walls of offices and acute care centers.

Stake in Ground - "Our goal is to prevent patients from crossing the threshold of ED"

"In 2019 in *JAMA*, Shrank et al estimated that between $760 and $935 billion dollars (25% US health care spending) are consumed by waste.[2] It should be noted that these numbers are comparable to total annual US federal government spending on defense and dwarf combined primary and secondary education expenditures . The authors defined waste based upon Institute of Medicine criteria, which include overtreatment or low value care, failure of care coordination, failure of care delivery, fraud and abuse, and administrative complexity."

How does anyone get paid in healthcare?

To move away from fee for service toward alternate payment methods we must first understand how we get paid.

What is MLR?

Medical Loss Ratio: Different between revenue received and expenses paid out.

Many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing.

The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. **The Affordable Care Act requires insurance companies to spend at least 85% of premium dollars on medical care**. If an issuer fails to meet the applicable MLR standard in any given year, as of 2012, the issuer is required to provide a rebate to its customers or the government. This includes Medicare, Medicaid, and Commercial insurance.

Every measurement we have is through the MLR lens.

What is Global Capitation for CPGRI?

- Delegation of everything we can get our hands on – UM, CM, Network
- It is a clean, easy view of how we are performing. i.e. There are not complex trends, formulas, inflation factors, Blah, blah, blah
- The payor gets a certain amount of revenue and passes down a % to us
- We set PCP Capitation to incent taking care of "populations" not focus on Volume
- MA is the easiest, as there is a revenue "lever" and an expense "lever". Accurate disease burden coding is imperative for us to have the right resources around the sickest patients
- CPGRI underwrites all risk for its network
- Global CAP is a reality with Commercial & Medicaid – we need to get there

Why Global Capitation?

- Control Total Dollars – no complicated formulas
- Move to "population management", focused on PCP transformation to team-based approach, reduce PCP burn out through non-volume-based reimbursement
- Access – Helps to increase panel sizes without volume, with increased PCP reimbursement
- Improve member experience, packed with needed resources
- Alignment between PCPs and Specialist – incentivize the behaviors you want
- Fix the struggle with empowering PCPs with the actionable data and information necessary to inform clinical interventions and optimize referral patterns to efficient specialists

Simple Explanation

- Payor gets $1,200 PMPM in revenue
- Payor Passes down $1,100 to IPA
- Away we go…..100% risk that we will spend less than $1,100 PMPM

How to Perform

- Align the work **everyone** does with quality and financial incentives
- Incentivize the behaviors you want – Our PCPs get $ for the current performance year in that year
- Participation of all providers and office staff
- Adjust programs where needed and make good decision on Buy vs. Build vs. Partner
- "Build the capabilities you need"

Save 6 Admissions a Year

~Average Revenue per patient = $1,100 PMPM = $13,200 annually (this doesn't cover 1 acute care stay. Not one.

~ If you have 100 MA Patients = $1.32M in Revenue to pay all their bills

~ If you have a 100% MLR you have 1.32M in Revenue and 1.32M in Expense

~ 6 admissions = $96,000

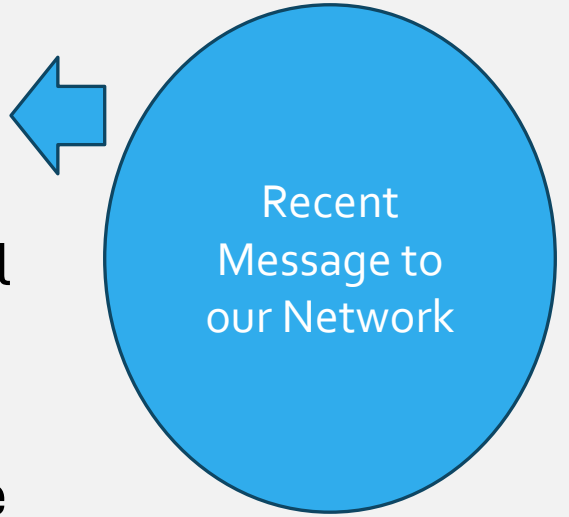
~ Expenses now are 1.22M = 92% MLR

Example PCP Scorecard

PCPName	Average Membership	RAF	Final Revenue PMPM	Total Professional Claim PMPM	IP Acute Admits PTMPY	IP Acute Days PTMPY	IP Acute PMPM	ER Visits PTMPY	SNF Admits PTMPY	SNF Days PTMPY	SNF PMPM	Total Institutional Claim PMPM	Blue Card PMPM	Total Health Care Cost	Gross Margin	MLR
[redacted]	63	1.08	$962.03	$167.34	169.95	849.46	$171.50	126.63	63.70	679.53	$21.24	$371.55	$2.95	$682.17	$279.86	70.91%
	172	1.15	$1,004.82	$183.28	159.26	791.29	$181.35	173.21	39.63	327.16	$16.27	$373.37	$32.75	$729.69	$275.13	72.62%
	48	0.99	$913.81	$260.46	29.26	87.79	$28.61	168.50	0.00	0.00	$0.00	$287.78	$3.69	$667.14	$246.67	73.01%
	21	1.20	$1,082.47	$252.02	131.76	521.86	$113.28	644.66	189.20	3,532.55	$163.82	$399.28	$0.94	$791.99	$290.48	73.17%
	58	1.27	$1,079.26	$203.71	213.71	1,320.47	$282.80	441.03	115.70	1,925.95	$62.37	$444.10	$2.70	$797.05	$282.20	73.85%
	192	1.01	$932.64	$195.52	158.29	929.05	$218.78	175.47	35.02	610.93	$20.52	$372.49	$9.01	$707.31	$225.33	75.84%
	30	1.15	$1,052.88	$201.98	45.44	136.32	$26.40	225.74	45.30	951.36	$29.51	$260.98	$198.06	$811.21	$241.67	77.05%
	204	0.97	$900.94	$226.89	147.00	546.36	$199.21	164.21	26.32	427.68	$13.57	$305.86	$19.86	$701.66	$199.28	77.88%

What can I do, as a Physician or Advanced Provider?

- Refer to the specialties tied to PCP Shared Savings - Orthopedics, GI, Dermatology, and Cardiology. We are actively engaged with these specialties in our network to reduce costs. We are focusing on utilizing outpatient facilities and avoiding costly hospital procedures, as well as developing pharmacy prescribing protocols to reduce unnecessary costs.
- Answer your phone – Stop your patients from going to the ED, using your access and our clinical programs.
- Address your high-risk and high-cost patients and engage them in our care management programs. Higher engagement saves money.



Network

Our Network Goals

Transform

- Transform PCP Practice Methods

Develop

- Develop new PCP Revenue Streams

Reduce

- Reduce Healthcare Costs

Raise

- Raise Patient Quality

Promote

- Promote Coordinated & Integrated Care

Improve

- Improve Patient Outcomes

Achieve

- Achieve Operational Efficiencies

Accelerate

- Accelerate Innovation

Tactics to Achieve Network Goals

We don't decide who is in our network by who "owns" who or who has a "relationship" with who. It's about performance.

- Use data to determine who is providing:
  1. Highest Quality
  2. Appropriate Cost
  3. Who has volume of our patients
- Contract with groups on specific metrics and reward them for performance
  1. i.e. migrate surgical cases to ASC
  2. surgical case/,1000
  3. use of preferred drug list
  4. present best practices at POD. Engage with us!

Evaluating High Quality & Cost Efficiency

Utilizing BCBSRI Claims data we can evaluate areas of Opportunity to engage with our Specialists in both Quality and Cost Efficiency

- **Education** on quality outcomes and cost variation at **Place of Service** for various ambulatory procedures.
- **Education** on quality outcomes and cost variation on similar **drugs**.
- **Education** on **Clinical Services** offered to potentially avoid future ED/Admissions

Patient care ALWAYS comes first!!

Specialty Engagement –2024 POD Presentations

Humberto Leal Bailey, MD – CCMA Neurology	• Diabetic Neuropathy Overview
Thaer Abdelfattah, MD | CCMA Gastroenterology	• Colon Cancer Screening (Guidelines)
Joanna Abi Chebl, - Geriatric Fellow - RWMC	• Fall Risk Prevention
Larissa Kruger Gomes, MD | Nephrology Associates	• Evaluation & Treatment of Resistance Hypertension
Joseph Mazza, MD | Cardiovascular Institute of New England	• CHF - Getting to Goal Guidelines
Kelley Sanzen, PharmD | Consultant Pharmacy Practice Facilitator	• Continuous Glucose Monitor
Michael C. Mariorenzi, MD | University Orthopedics	• Probability or Prejudice: Risk factors associated with total hip & total knee replacement

Longitudinal Care Model & UM – Build, Buy, Partner

Clinical Programs: Care Coordination Resulting in Better Patient Care

- Clinical programs rolled out in a silo, with PCPs who are unaware, are never successful due to breakdown in communication
- 80% of all CPGRI's clinical programs are in house (developed and operated by CPGRI clinical team, with open communication back to PCP)
- The other 20% of clinical programs are seamlessly co-managed by CPGRI clinical leaders and vendor
- CPGRI clinical programs are integrated with our embedded Nurse Care Managers and Pharmacists at our Primary Care sites
- Our referral base is our CPGRI clinical staff along with our CPGRI PCPs
- Communication flows between all clinical teams and PCPs
- Patient experience is high (NPS 90) as clinicians and PCPs are working towards same goal: better outcomes
- Average age of patient under care management= 78, the perfect audience for education around realities of health care system and clinical program alternatives that CPGRI has to ***empower our patients to remain independent- at home***

Clinical Programs:
Day to Day Care Management

Transitions of Care

- Medication review
- Plan of Care review
- Red flag education
- Follow up with PCP within 7 days
- Followed for 30 days; refer to care management programs as needed

Pharmacy Support

- Comprehensive medication review
- Medication education
- Device education
- Polypharmacy, deprescribing and symptom management

Telephonic Care Management

- High Intensity Care Management (HICM) for patients who require ongoing care management telephonically for CHF/COPD/DM

In home Care Management

- Care@Home (CAH) provider led team for frequent readmissions, end stage illness and those who need in home visits, 24/7 coverage
- Advanced Illness for patients with serious illness to review Advance Care Planning
- Remote Patient Monitoring for BP/O_2/weight

Disease Management

- Conversio COPD program, for COPD/asthma patients; includes free COPD meds and virtual pulmonary rehab
- Heart Health program for heart failure patients to gain immediate access for treatment at cardiology office

Social Work

- Social work and coaching for patients who have social needs or require transition to higher level of care

*Optum runs similar CARE MANAGEMENT programs and claims 4:1 ROI for engaged patients

Care@Home Clinical Outcomes

CAH Program Utilization 2024	% Reduction
Inpatient Admits per thousand reduction	75%
ED visits per thousand reduction	39%
UC per thousand reduction	85%
SNF admits per thousand reduction	0%
SNF LOS reduction	32%

- **Positive reduction in all metrics except for SNF admits** which were 48 ADK vs goal of 39 ADK
- CAH enrolled patients had SNF LOS of 7 days **(50% lower SNF LOS)**

CAH Metrics 2024	Total
# of home visits	4,264
After hours calls	264
After hours home visit	240
# of ED visits prevented	231

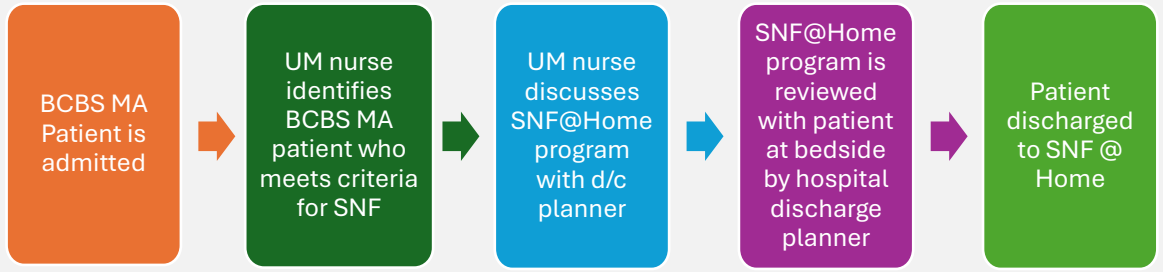
- **Over 4,000 home visits** for symptom management/treatment in home setting **covering 500+ patients**
- **231 ED visits prevented**

CAH Interventions 2024	Total
Close Monitoring	60
Labs/tests orders	24
Medication order	166
Sent to UC	10
Sent to ED	20

- **166 interventions related to medication changes**

Clinical Opportunities

‘SNF@Home’ Program



Mission: to disrupt the traditional cycle of hospital discharges to SNFs for our patients. Clinical studies show that SNF admissions significantly decreases patient’s lifespan as a direct result of deconditioning, staffing shortages in SNF and poor care coordination resulting in multiple SNF to hospital readmissions. We seek to bring our patients home to recover quicker, safer and with smoother care coordination compared to a traditional disjointed SNF stay for rehabilitation.

Goal: Reduce SNF admissions which will improve patient outcomes, reduce cost of care

Program: Offered as an alternative to traditional SNF admissions, SNF@Home Program starts with outreach from CPGRI UM team, services from Care@Home and external vendors from HighbarPT@Home or from Homecare Advantage (VNA).

Criteria: Patient meets criteria for SNF admit **BUT** does not require 24 hour care, no extensive wound care and has some family/friend support at home

Pharmacy in the Office

Pharmacy services in medical offices include:

- Medication counseling and disease state education
- Review of standard of care guidelines for chronic disease management
- Assessment and solution for adherence issues
- Education on proper administration and technique for new medications or devices
- Assistance to patients/families regarding polypharmacy
- Medication cost mitigation and drug formulary review

Patients can be seen by the pharmacist before, after, or in-between office visits. We encourage offices to schedule patients to meet exclusively with the pharmacist.

The pharmacy team collaborates with other teams within our SOC (e.g. care management, Care@Home) to comprehensively assist our patients while improving quality measures.

*The pharmacists do not complete medication prior authorizations, but can train the clinical staff upon request

Patients who may benefit from having a pharmacist consultation include those with:

- Chronic conditions
- Uncontrolled high-risk diseases
- High volume of medications
- Cost concerns/limitations
- Medication adherence issues

Your patients and office staff may hear from the pharmacy team for:

- Adherence management
- Medication list requests
- Cost-effective alternatives
- Office outreaches for reluctant or hard-to-reach patients
- Contractual pharmacy opportunities

Pharmacy in the Home

Target C@H patients:

- High-risk medications: Currently taking medications with a narrow therapeutic index (e.g., warfarin, digoxin, lithium), high potential for drug interactions (e.g., polypharmacy), or requiring close monitoring
- Fall risk (with known or unknown medication causes)
- Multiple chronic conditions: Diagnosed with 3 or more chronic conditions (e.g., heart failure, diabetes, COPD)
- Medication non-adherence: Demonstrated difficulty adhering to medication regimen (e.g., missed doses, reports of confusion, financial barriers)
- Adverse drug events: Experiencing or at risk of experiencing adverse drug events (e.g., side effects, medication errors)
- Need for medication reconciliation: Discrepancies identified in medication lists across different healthcare settings, or patients with numerous outdated, expired, or unneeded prescription medications at home.

Pharmacist role:

- Comprehensive medication review
- Medication reconciliation
- Assessment of medication adherence
- Patient education and counseling
- Identification and management of drug-related problems
- Collaboration with the care team to optimize medication therapy
- Monitoring for medication effectiveness and safety
- Disposal of expired or unnecessary medications

Outcome:

- Improved medication adherence
- Reduced medication errors
- Prevention of adverse drug events
- Decreased hospitalizations and emergency department visits
- Enhanced patient satisfaction and quality of life

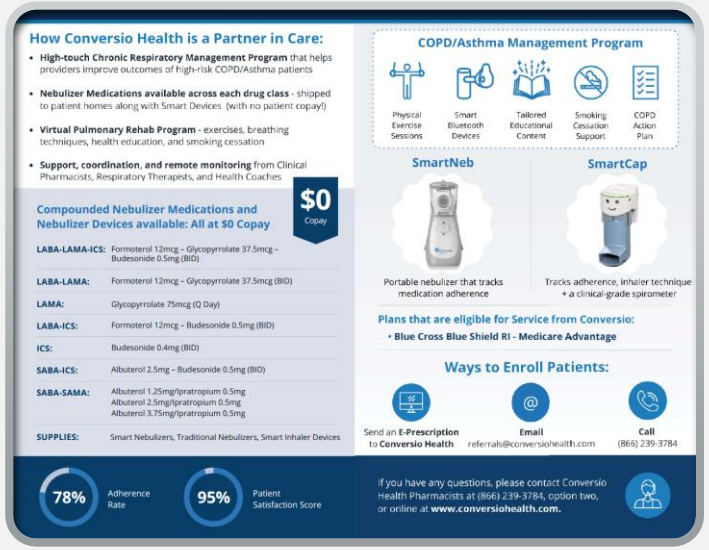
Partnerships

- Conversio is a COPD/Asthma support program helping thousands of patients with chronic respiratory conditions across the country
- Eligible patients receive a custom-made, compounded medication to use with a nebulizer machine
  - Convenient and easy
  - CharterCARE absorbs cost of the program, making it free for the patient
    - Removes financial barriers to medication adherence and increases patient satisfaction
  - Clinical care team provides personalized support and remote monitoring
- Focus on improving COPD outcomes for BCBSMA patients

Conversio HEALTH

Coversio Innovation

- Handheld smart nebulizers
  - Portable with the ability to track medication adherence, inhaler technique, and spirometry data
- Compounded nebulizer medications in all drug classes
  - May not be a 1:1 change from conventional inhaler to compounded medication, but therapeutic options are available in every iteration of "traditional" drug classes
- Virtual pulmonary rehabilitation program
  - Support from pharmacists, respiratory therapists, and health coaches
  - Proactive clinical interventions upon increases in exacerbation risk



Conversio HEALTH

Performance

Gross savings to date = $592 PMPM

Pharmacy: *$188 PMPM (77% reduction)*

Medical: *$404 PMPM (33% reduction)*

Net Savings (after Conversio fees): $417 PMPM

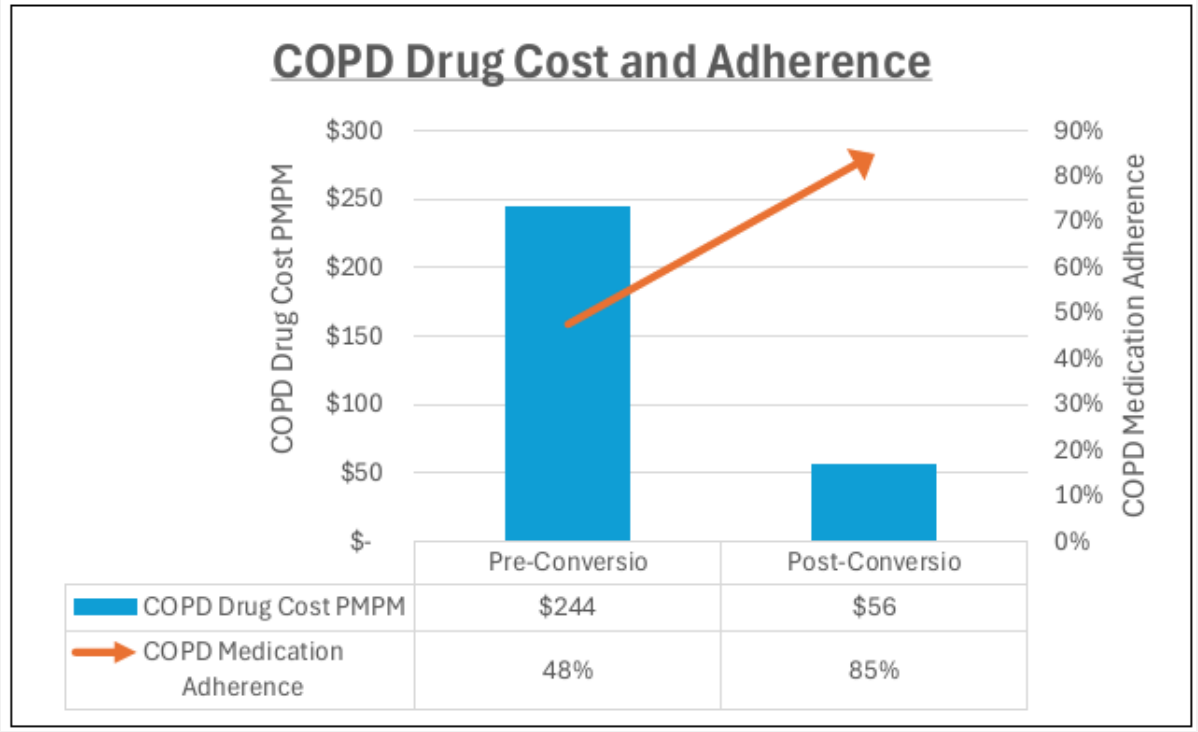
Net Annualized Savings (after Conversio cost): $966 K

(assuming no additional enrollment)

- **Based on 193 active members**

Post-Conversio COPD Medication Adherence: 85%

COPD drug cost decreased by: *77%*



Patient Satisfaction: 90.4% Patient Satisfaction Rate (based on 221 completed surveys)

Program Challenges

Program Challenges

- Pharmacy workload: Increased demands on pharmacy team
  - Embedded pharmacists in MD offices facilitated growth for offices, but at the cost of time available to other patients
- Out-of-state company (California-based)
  - Challenges with communication and coordination
  - Medication delivery: Ensuring timely and accurate delivery to patients
- Technical difficulties noted with:
  - Device, needing new parts, patient literacy
  - Patients not using all the tech options (like syncing with smart phone)
- Cost-sharing:
  - Without financial investment from the patient, in some cases, waste noted
- Targeting errors:
  - Patient not on maintenance inhalers; the diagnosis code ended up on the chart in error
  - Patient has mild disease, does not need maintenance
- Conversio pharmacy not contracted with Prime Therapeutics
  - Unable to run zero dollar claims to capture medication fills

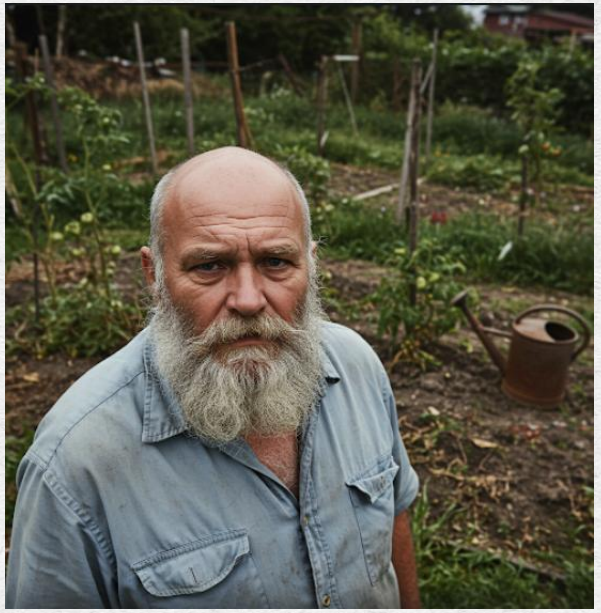
Patient Success Story

John, a long-time COPD patient with a recent hospitalization currently on COPD medications

- **COVID-19 Legacy: After a severe case of COVID-19 in late 2023, John was hospitalized for 4 days and missed 3 months of work. He faced ongoing lung and heart issues, as well as some memory problems. His weight increased to 325 pounds, making everyday activities a struggle.**

- **Inspire Program Offered Hope: To regain his health, John enrolled in Conversio Health's Inspire Program. The program personalized his nebulizer treatment and provided weekly support from a respiratory therapist, health coach, and pharmacist, who guided him on exercise and nutrition.**

- **John's Remarkable Progress: Through the program, John lost an impressive 54 pounds, improving his mobility and overall health. He can now enjoy activities like walking to the park. With continued monthly support, John maintains his progress and enjoys a better quality of life.**



"The Program is easy to follow, and with the health coaches from Conversio Health, they make it a cinch to be successful. I continue to work the program and continue to lose weight and exercise daily."

Provider Success Story

- Mr. C, a patient with COPD, was trapped in a cycle of frequent ED visits and poor medication adherence.
  - His condition was poorly controlled, impacting his quality of life
  - I referred him to Conversio Health, and their personalized program made a significant difference. They provided tailored medications, education, and support. Which led to improved symptom control, zero ED visits, and increased medication adherence.

"Conversio Health is a valuable partner in helping patients like Mr. C achieve better respiratory health."

- While enrolling into Conversio, the embedded pharmacist met with patient for demonstration/education

Outcome

Patient enrolled in program - motivated by no cost option

Provider happy to have this resource and the teamwork to share responsibility for the patient

Clinical Programs

CPGRI CLINICAL PROGRAMS

Program	Description	Criteria	Payor
Transitions of Care (TOC)	30 day NCM led telephonic program; outreach to patients within 48 hrs of discharge for med rec, 7 day f/u TOC PCP appt and red flag pt education	Discharge to home from hospital/SNF	BCBSRI Medicare Advantage (DSNP, BlueChip), MSSP (ACO), UHC MCD, NHP MCD
High Intensity Care Management (HICM)	90-120 day NCM led telephonic high touch program for high risk patients including outreach by care coordinators, SWs & CHWs	Dx CHF/COPD/DM with 3 or more ED/inpatient visits in last 3 months	BCBSRI Medicare Advantage (DSNP, BlueChip), BCBSRI Comm, MSSP (ACO), UHC, NHP, Tufts
Care @ Home (CAH)	Longitudinal in home Provider led program for high risk patients, monthly visits by NP/PA/RN/SW + TOC visits by CAH Provider, 24/7 on call	Dx CHF/COPD/DM/end stage illness, multiple admits, LACE score ≥10, CCI >8	BCBSRI Medicare Advantage (DSNP, BlueChip), MSSP (ACO)
Advanced Illness (AI)	90-120 day CAH RN led in home program, reviewing Advance Directives and activating hospice benefit earlier as needed	Dx serious illness, ≥21 years	All payors
Remote Patient Monitoring (RPM)	Remote monitoring for BP, weight, pulse ox	Dx COPD/CHF/DM, patient able to participate with monitoring	BCBSRI Medicare Advantage (DSNP, BlueChip), MSSP (ACO)
Coleman Transitions Coaching (CTC)	30 day program, non-clinical coach completes home or telephonic visit for med rec, 7 day f/u TOC PCP appt, red flag education	Discharge to home from hospital/SNF, excludes dx better met by RN	BCBSRI Medicare Advantage (DSNP, BlueChip), BCBSRI Commercial, MSSP (ACO)
Social Work (SW)	In home or telephonic visits by SW to solve for SDOH needs	Unmet social needs	All payors
Conversio COPD Program	Nebulized medications and portable inhaler provided at zero cost to patient, virtual pulmonary rehab, adherence outreach by Pharmacist, coach and RT	Dx COPD or asthma	BCBSRI Medicare Advantage (DSNP, BlueChip)
CINE Heart Health Program	90-120 day CINE Provider led telephonic HF program with ongoing calls from health coach; access for urgent cardiology appt	Dx CVD	BCBSRI Medicare Advantage (DSNP, BlueChip)

Referral Fax: 401.429.6378 | Referral Line: 844.762.9231 Option 3

Utilization Management

When most people think about Utilization Management (UM) – if they think about it all – they see it as a distant, mysterious process that determines what will or will not be covered by their health insurance. And for many, this accurately captures the impact UM has on them.

A Different Approach to Utilization Management

But when conducted as an *integrated* part of comprehensive care management – UM is much more. Our experience demonstrates how it can be a powerful tool to ensure patients receive the right care at the right time in the right place. This is a fundamentally different way to think about the role of UM.

CPGRI is the only system of health care *providers* in Rhode Island delegated for UM, a process most commonly performed by a patient's health insurer. Under a delegation agreement, an insurer allows UM to be conducted by a contracted partner, in accordance with strict guidance and oversight.

Utilization Management

Following NCQA guidelines, the mission of the UM Program is to ensure that medically appropriate services are provided to all members that assures the provision of high quality, cost effective, medically appropriate healthcare services in compliance with the patient benefit coverage and in accordance with regulatory and accreditation requirements.

•**BCBSRI Medicare Advantage** - Delegated UM with focus on evaluating the medical necessity, appropriate level of care and need for continued stay on the following:

- **Acute Inpatient Admissions**
- **Skilled Nursing Facility**
- **Acute Inpatient Rehabilitation**
- **High-Cost Radiology**
- **Select Procedures and DME**

- **Support IPA Initiatives:**
  - Build and refer to high value partners – Specialist, SNF, HH, Hospice and Palliative Care

Utilization Management

Utilization Management, The Partner to Care Management

Our UM decisions are built on a foundation of coordinated care that encompasses PCPs, specialists, nurse care managers, pharmacists, social workers, clinical programs, as well as staff who monitor and improve quality across our network. This collaborative approach supports patients with high-quality, individualized services delivered where patients want them most – in the community and at home.

- ***Patients Benefit***

This is also what's best for patients. When a patient discharges to home, they avoid the risk of infection that can come with a prolonged hospitalization or a SNF stay.

Patients do better with the support of family and friends, in a familiar setting – not an impersonal, clinical building, surrounded by people they do not know. Patients learn better how to stay healthy when they are learning where they live.

Working with our providers, by listening to patients and their families, and by drawing on our experience closely watching the journey our patients make through the care continuum, we have built a broad array of programs and services that inform our UM decisions:

- Care management that ensures a smooth transition from the hospital and assists with longer-term needs.
- A *Care@Home* team delivering in-person home visits by providers, nurses, and social workers to prevent disease exacerbations and improve symptom management.
- Remote patient monitoring so we can spot the warning signs of trouble *before* a patient requires an admission or readmission.
- In-person assistance so patients properly use, and get the full benefit of, COPD/Asthma inhalers.
- Physical therapy at home to help patients regain strength *where they live*.

And more.

Coding & Quality

CPGRI's Coding and Risk Adjustment Team

What does the Coding and Risk Adjustment team focus on?

- Post Visit chart review to ensure accuracy of claims billed
- HCC focused training based on Retrospective chart reviews
- Impactful coding education in large group settings
- Individualized provider chart reviews for assistance in understanding RAF impact
- Group setting HCC/ICD10 coding education
- Suspect Condition Identification in EMR systems

What is Risk Adjustment?

- Risk adjustment is a methodology utilized to ensure that insurers and providers receive appropriate revenue for the healthcare costs of the population under their care. Risk adjustment plays a critical role in ensuring insurer premiums and benefit designs do not discriminate against individuals with significant health needs and preserving a competitive private market for health insurance

Your patients and office staff may hear from the Coding and Risk Adjustment team for:

- **Access to billing charges for retrospective chart reviews**
- Patient outreach activities
- Training needs

The CPGRI Coding and Risk Adjustment team works in collaboration with provider teams, administration teams, vendor partners, and payer partners to improve proper ICD10 coding and ensure patients' chronic conditions are managed

CPGRI's Approach

Providers in our network are surrounded by a strong coding team

Each provider who has been identified as needing additional educational support is paired with our coding team for an in-depth chart review process.

- Initial review with the team showcases opportunities for continued education
- Team meets one on one with provider for feedback session
- Second chart review occurs 60 days after feedback session with additional opportunities for the provider to learn through POD meetings with clinical disease burden focus

Using our BCBSRI partnership, the coding education team at BCBSRI also reviews charts for an outside view of potential opportunities

Partnership with educational tool DoctusTech allows providers to follow a self-paced learning approach on their own time

- DoctusTech is a mobile application designed to help providers learn coding documentation skills outside of clinic settings on their own time through weekly challenges and leaderboard competitions

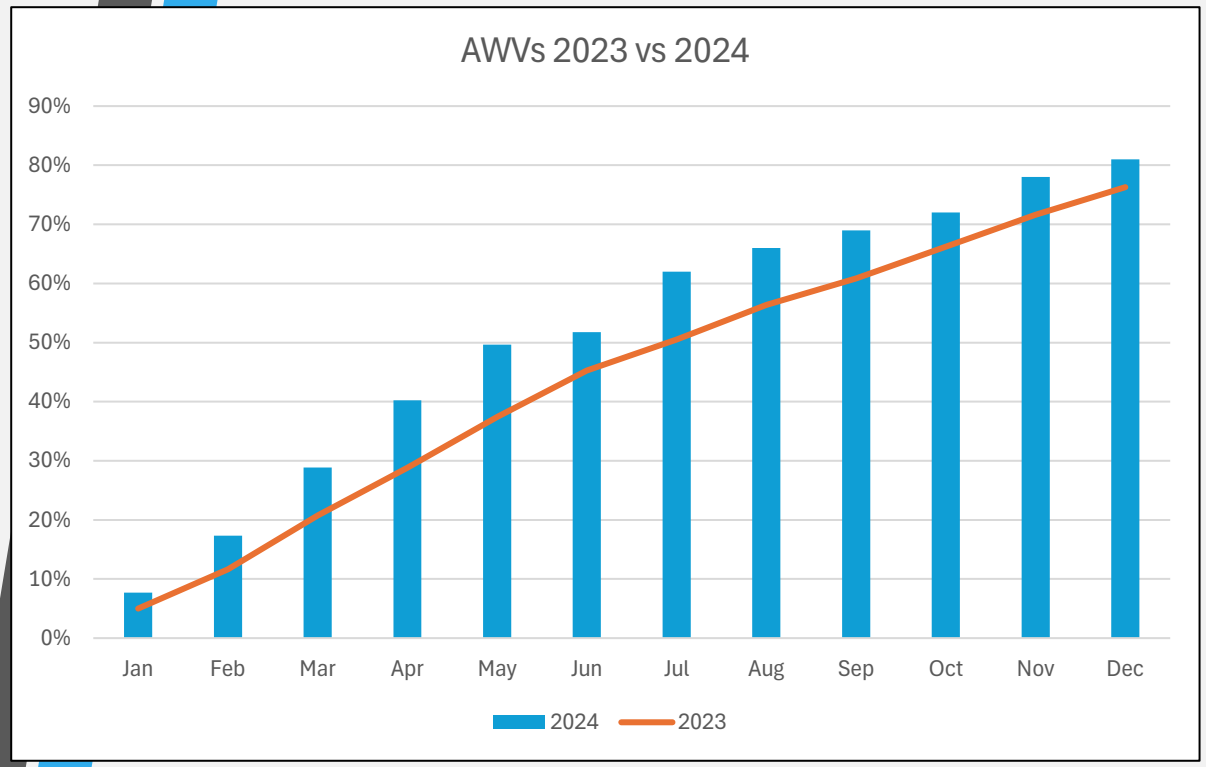
Group Educational Sessions

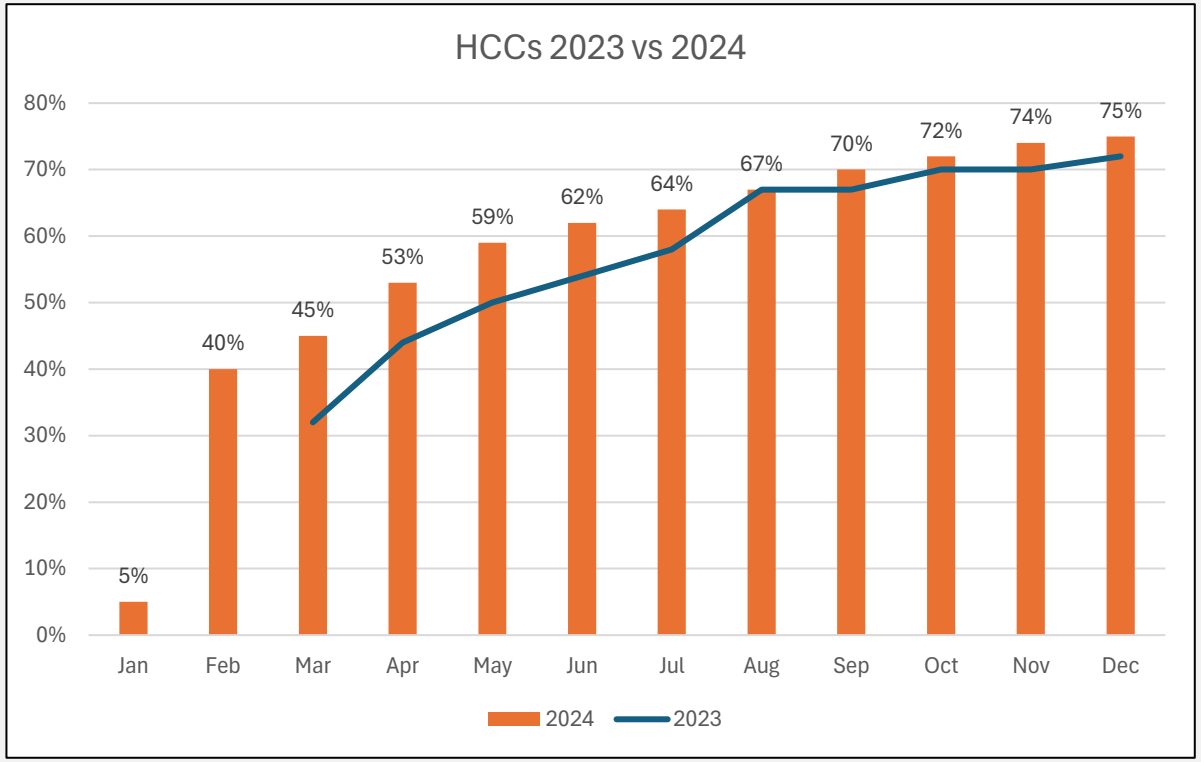
- Each month at CPGRI the coding team is given time in the meeting to discuss coding educational opportunities aligned with the clinical disease topic of the month

Rewarding providers for their work engaging with patients

- Incentive plans designed to reward providers for scheduling AWVs, performance goals with quality performance measures, and addressing chronic conditions

AWV and HCC Recapture Results





CPGRI's Quality Improvement Team

The CPGRI Quality team offers the following services to provider offices:

- Dedicated Quality Care Coordinator Support
  - Chart reviewing and mining for Quality Gaps in Care
  - Payer point of contact for clinical quality gaps
  - HEDIS/STAR documentation review
  - Process improvement projects
  - Quality best practice sharing
- Patient outreach to schedule appointments to address chronic conditions and quality gaps in care
- HEDIS/STAR chart audits and data submissions for quality programs under contract
- Tactical improvements projects for HEDIS/STAR goals
- Standardized central reporting to highlight patient care opportunities

The CPGRI quality team works in collaboration with provider teams, administration teams, vendor partners, and payer partners to ensure patients' chronic conditions are managed and office work is reflected in improved Quality HEDIS/STAR ratings

Leigh Nyahe, Dir. of Physician Quality and Risk adjustment
Email: leigh.nyahe@prospectmedical.com
Phone: 401-479-0417

Our Approach

The approach of the CPGRI Quality Care Coordinators (QCCs) team is designed to be an extension of the office staff to the payer plans with the goal of ensuring success in the pay for performance programs.

Success is achievable with the right resources

- Each office is given a dedicated resource to help guide them through understanding quality measure sets, determine eligible populations, expanding clinical care to patients who have selected the provider as their PCP, and providing best practice recommendations to closing quality care gaps.
- QCC team works together to develop and deliver best practice recommendations in our unique system of care
    - Practices can run their business the way they choose with the support of the CPGRI Quality team to still achieve success in pay for performance quality programs

Group Educational meetings for office staff

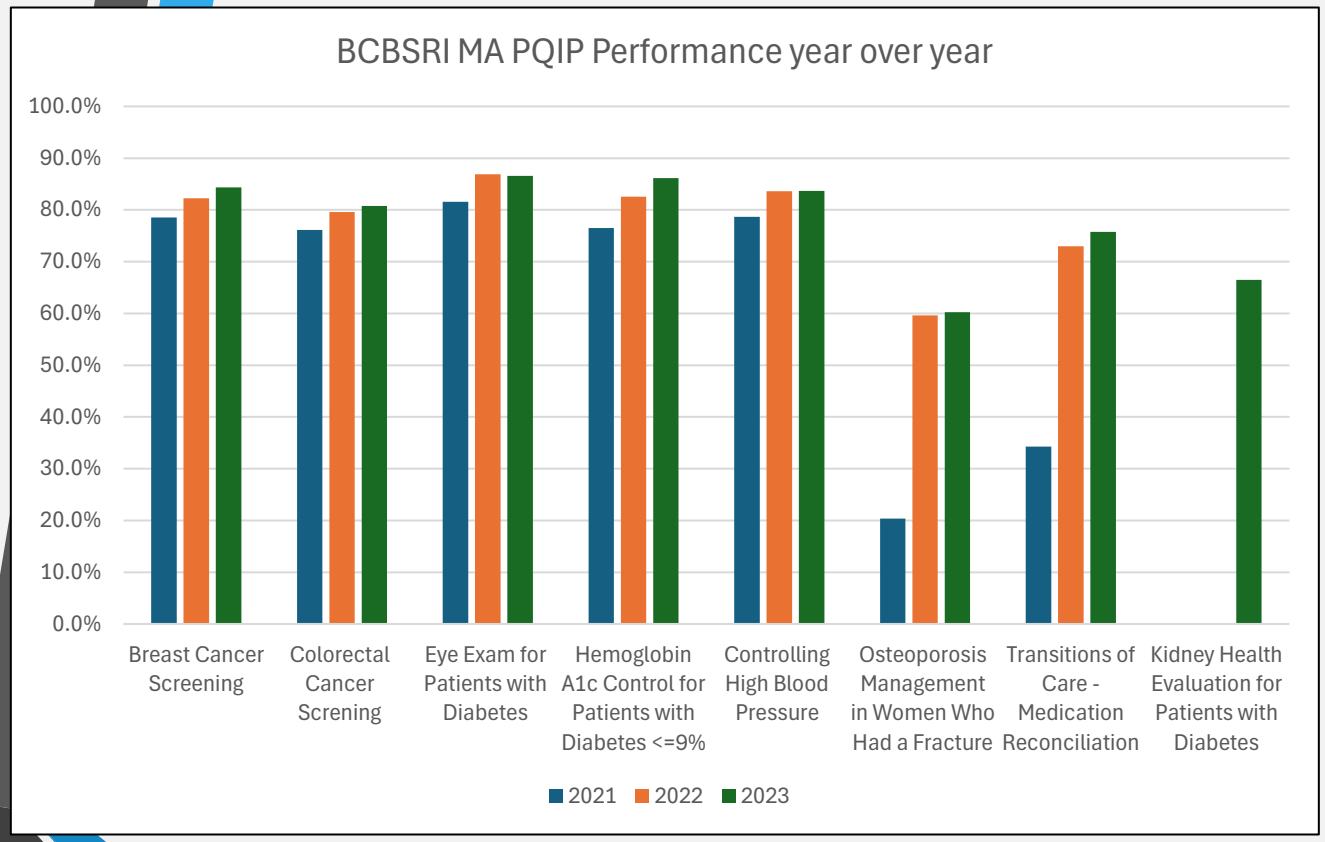
- Monthly office manager staff meetings are opportunities for all offices to receive the same training and updates regarding quality programs

Rewarding providers for their dedication

- The correct incentive plan drives performance in quality measure achievement

Leigh Nyahe, Dir. of Physician Quality and Risk adjustment
Email: leigh.nyahe@prospectmedical.com
Phone: 401-479-0417

CPGRI's Proven Results



- Proper management of quality data has led to year over year measure success growth
- A focus on knowing each of our patients and ensuring THEY know the PROVIDER is key to success
  - If the patient does not know the provider, they are missing out on appropriate care
  - Providers are better informed of the patients' chronic conditions and clinical needs
- Strong relationships with our payer partners leads to overall greater success for both organizations.

Our Overall Results

- Quality as defined by STAR, has risen every year in Global CAP.
- Coding accuracy, through the use of tools and more education of providers on how it impacts the resources for their patients, has increased 3 years in a row.
- PCP support of a longitudinal model has never been higher, but we always ask – are these the right programs?
- $$ - Dollars are flowing different to our PCPs and Specialist, away from FFS
- Still not impacting the patient in the periphery, enough…

Opportunities for the Future

- Rising Risk for all populations – we are not getting to patients 'enough' before they have an episode
- Move to global capitation for all payor partners
- True Practice Transformation – access, outcomes, reduce burnout
- Better define quality
- Done correct, acute care centers can change how they invest their capital in the future, to perform in these models.

Questions??

CME Credits & Evaluation

Reminder to please complete the evaluation to claim CME credits!

Claim CME Credits Here

The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 04/16/2024 to 04/16/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

THANK YOU

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