Governance Models for Multi-payer Primary Care Initiative

Care Transformation Collaborative of R.I.

MMF LEARNING COLLABORATIVE

JANUARY 31ST , 2017

Governance Model for Statewide Multi-payer Primary Care Initiative

2006 multi payer-provider stakeholders group convened by State; 2 year planning grant funded the development of a pilot project.

2008 Pilot program launched (5 practice sites)

- Steering Committee and 6 Committees to do the work
- Project charter and work plans were developed (see charter documents)

2010 Pilot program expanded with MAPCP (8 practice sites)

- Executive Committee Formed

2012 Pilot program expanded to increase MAPCP covered live (3 practice sites)

- Steering committee; Executive Committee; 5 committee (D&E; PTS; PR. Physician Champions; NCMs)

2013 Statewide Program Expansion (32 practice sites)

2015 Pediatric pilot project (9 practices); Adult expansion (25 practice sites)

- Incorporated as 501c3; bylaws; Board of Directors (19 large multi-stakeholder representation)

2016 CPC+ - Statewide (31 practices sites)

CSI Steering Committee

Staff Liaison: Deidre Gifford, Chris Koller, Lynn Pezzullo

Members: P. Arnold, E. Balasco, T. Bledsoe (chair), T. Boucher, D. Bourassa, R. Bromley, C. Campanile, D. Delmonico, H. Dulude, M. Evans, N. Galinko, D. Goldman, M. Jacobs, M. Johnston, J. Lopes, G. Manocchia, W. Marshall, G. Martin, E. Mauro, M. Moss, A. Puerini, S. Rodriguez, K. Schwab, D. Spano, K. Sperber

Charge: The CSI Steering Committee oversees the implementation of the CSI project. It accomplishes this through the use of work plans, six standing work groups, and ad hoc work groups. The Committee will also direct to and receive administrative and contractual issues from project staff as needed. The Committee will make resource, policy and prioritization decisions as appropriate. Consistent with the collaborative nature of the work, the Steering Committee works by consensus where at all possible.

Agenda Development:

Co-chairs; Driven by work group reports

Membership:

Per invitation of Committee; All project stakeholders should be represented

Expectations of Members:

Engaged participation in meetings and work in between; Commitment to the success of the project; Participate on a minimum of one work group

Meeting Frequency:

Bi-monthly

Work Groups:

- Training and Implementation: Nurse Care Manager / Practice Reporting
- Physician Leadership
- Data and Evaluation
- Marketing and Communications
- Purchasing and Employer Outreach
- Sustainability and Spread

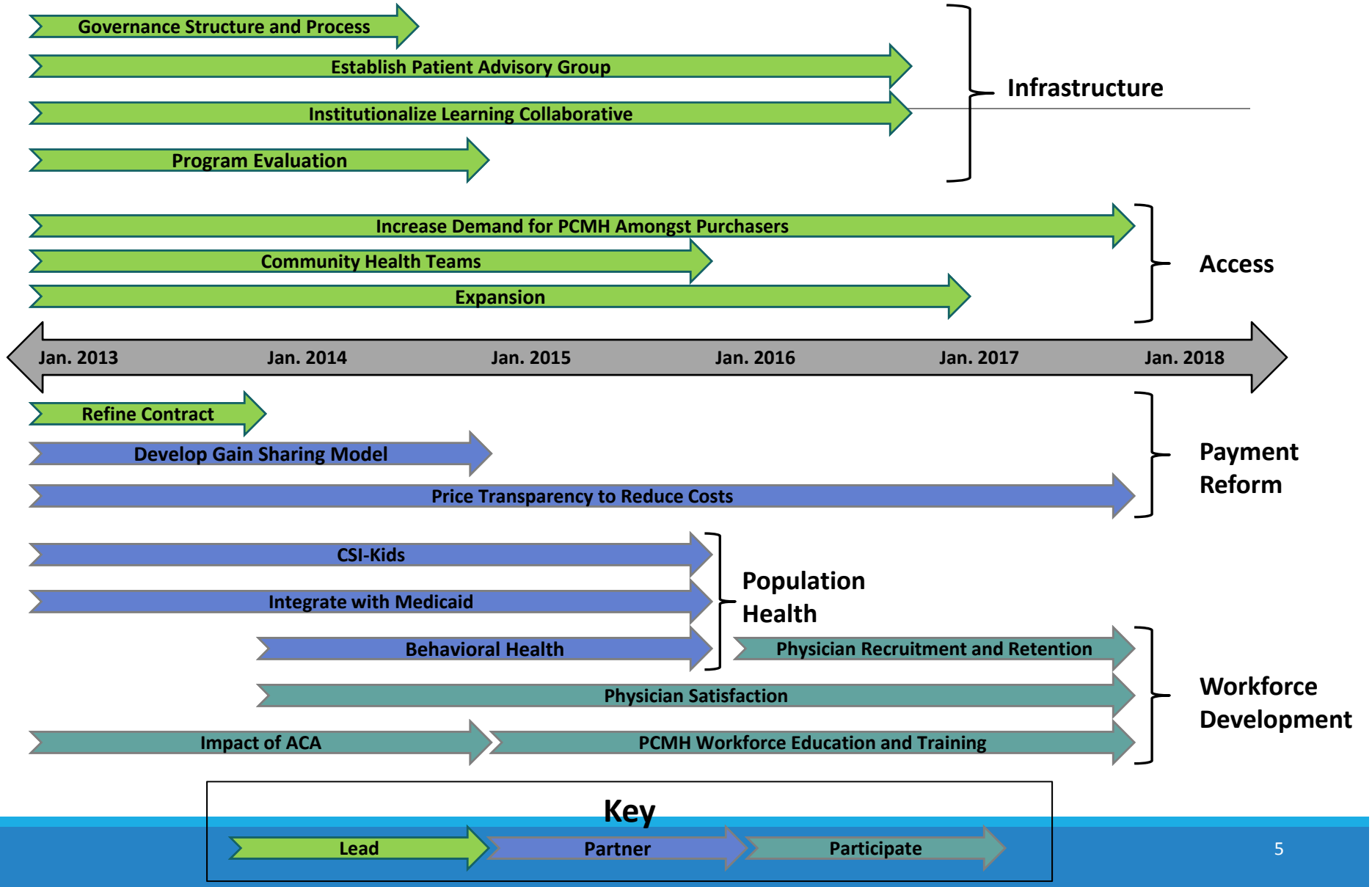
Chronic Care Sustainability Initiative (CSI-RI)
Strategy Map 2013 -2018

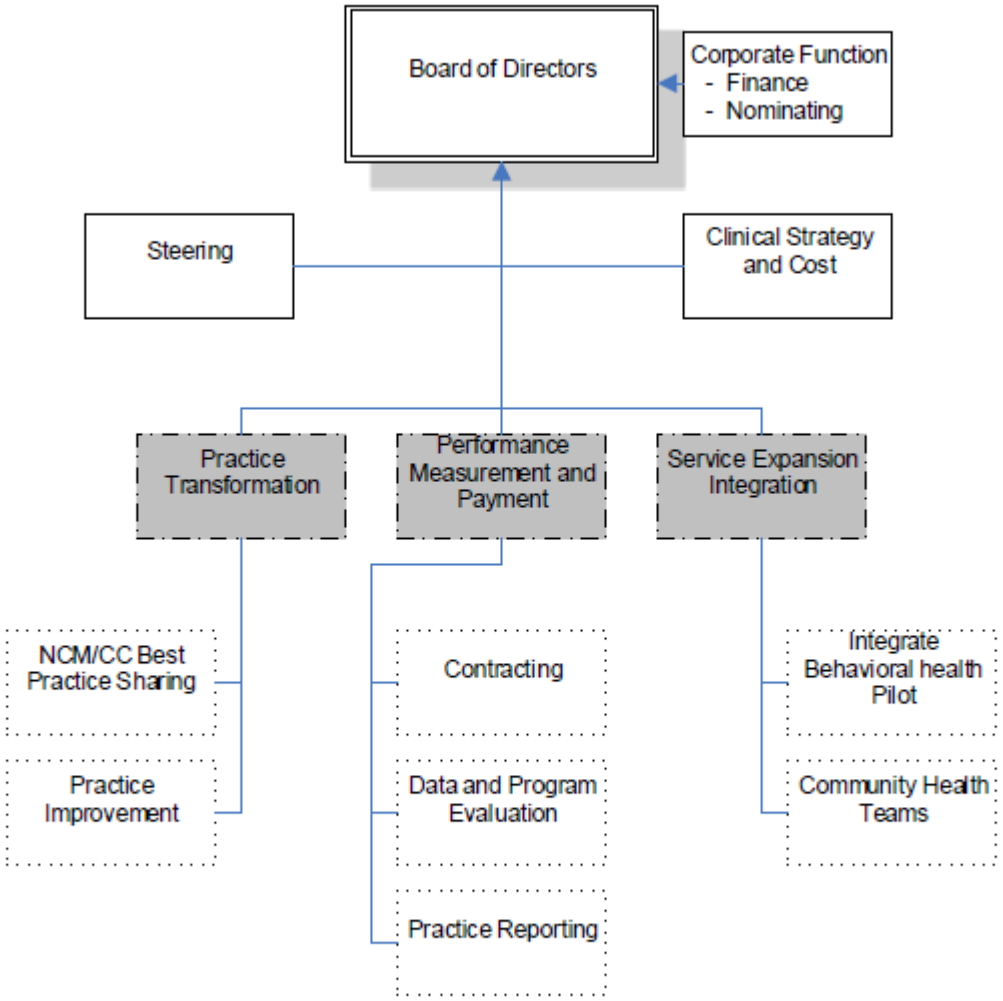
Vision Rhode Islanders enjoy excellent health and quality of life. They are engaged in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care.

Mission To lead the transformation of primary care in Rhode Island. CSI-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for, and sustain high quality comprehensive accountable primary care.

Goals			
Increase capacity and access to PCMH	**Improve quality and patient experience**	**Reduce the cost of care**	**Improve population health**
Strategies			
❖ Increase access to PCMH practices ❖ Improve provider satisfaction ❖ Increase recruitment and retention of primary care physicians ❖ Institutionalize participation in the learning collaborative-provide incentives and reimburse provider time for supporting other practices	❖ Establish a Patient Advisory Group ❖ Continue to measure and improve practice performance on quality metrics • Diabetes • Hypertension • Tobacco Cessation • Adult BMI	❖ Implement developmental contracts and new payment methodologies (e.g. shared savings) ❖ Continue to refine the claims data extract project to include Medicare and Medicaid ❖ Consider the impact of new practices on aggregate measures	❖ Expand to include children and behavioral health ❖ Reduce disparities between Medicaid and non-Medicaid users
Measures			
❖ Increase the percentage of patients in CSI PCMHs from 10% of the population to 20% in 2013	❖ Improve in CAHPS survey: access 53%; communication 82%; and office staff 79% ❖ Practices achieve 4 out of 7 quality measures in 2013	❖ Reduce all cause inpatient admissions by 5% ❖ Reduce all emergency department visits by 7.5%	❖ Children and disparities measures TBD

CSI–RI Implementation Timeline




Board of Directors
Corporate Function
- Finance
- Nominating
Steering
Clinical Strategy and Cost
Practice Transformation
Performance Measurement and Payment
Service Expansion Integration
NCM/CC Best Practice Sharing
Practice Improvement
Contracting
Data and Program Evaluation
Practice Reporting
Integrate Behavioral health Pilot
Community Health Teams

Evolution of Governance Structure

Steering committee initially made decisions and Executive committee small sub group to do the work

Over time Executive Committee morphed into decision making body and Steering committee became more of an advisory committee

Executive Committee then became the Board of Directors

Board of Directors review of strategic priorities which drive managements work plan and budget