

Provider Advisory Group  
October 27, 2015

Attendees: Dr. Nicole Alexander-Scott, Secretary Elizabeth Roberts, Steve Detoy, Newell Warde, Sam Marullo, Mary Dwyer, Peter Hollman, Alan Post, Unidentified Medical Resident, Dieter Pohl, Lauren Lapolla, Lynn Hob. Karen Dalton, Sarah Fessler, Phil Salko, Betsy Farnum, Psychiatrist (*name not captured*), Gary Bubly, Steve Brown, Pablo Rodriguez, Claire Nadeau

**I. Welcome**

Secretary Roberts gave a brief overview of the overall goals of the Working Group for Healthcare Innovation to provide background and context to our new attendees this evening. Presentation slides available online, and upon request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

**II. Population Health Goals for the State – Director of Health Nicole Alexander-Scott, MD, MPH**  
The Director gave a presentation on RI's Public Health Priorities, Strategies, and Population Goals. Slides will be available online, and upon request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

Questions:

Alan Post: Are these your strategies, or the feds?

Dr. Alexander-Scott: Self-created on behalf of RI thus specific to what we are addressing here, as a state, to discuss and reflect on and to shoot after. We all have a variety of goals that exist and this helps for us to have goals to target together.

Steve Detoy: The substance abuse issue and the opioid task force recommendations are coming out, from my standpoint and perhaps that of the Medical Society, we think they are spot on in reducing addiction issue we have, yet silent on the Good Samaritan law or lack thereof in the state. That will be part of our comment, and a heads up for that. It is an opportunity, one that we can use to reduce addiction and provides an opportunity to save lives.

Dr. Alexander-Scott: Absolutely, and that is well-received. Thank you for the head's up. Went to the Attorney General's office today to speak further about that.

Pablo Rodriguez: The governor, as part of the charge, wants by 80% of payments are tied to quality by 2018. These targets are for 2020, how will these be joined or tied to what the Governor is asking the Working Group for Healthcare Innovation to do?

Dr. Alexander-Scott: I am showing the 2020 metrics so that you can see the standard that already exists. We are meeting with the governor next week and I am hoping to share each year target prior to this. Separate from that, as we shoot for these health outcomes and goals with specific metrics, the changing from volume to value is an additional process as we make that transition. The goals and these outcome measures are so that we have a specific direction to move in, as you know the process for implementing the change from volume to value is where the rubber meets the road and that is where your input is welcomed.

Secretary Roberts: We have other work going on, particularly in the SIM, where we work on

aligning measures, and one of the things we are looking at and looking at aligning measures how do we connect it into this conversation. Dr. Alexander-Scott brought in this document into that discussion, and how do we align around health and community.

Dr. Alexander-Scott: That is why I did more than present the strategies and goals, but also give you today the metric ideas, so that we have a reimbursable framework to push toward outcome.

Dieter Pohl: Is the value-based concept, is that a copy of Medicaid? Or do we have specific RI metrics for that value?

Secretary Roberts: Every major payer for care in our environment have set out these same goals, Medicaid, BCBS, NHP, and likely United. One thing we are looking at is that we don't control Medicare, but others are locally controlled and can we come to some shared measures. These are bigger; how broad they are in different areas and can you tie them to broader population health measures, or a narrow description of success in your practice. A lot of this is a work in progress, and many of you are in value-based payment contracts already. We have lots of people coming in, to talk about what their using now to see where we have common language, and then Dr. Alexander-Scott has brought in how we may tie it to where we want to go. It is a work in progress, but an interesting question especially at the specialty and sub-specialty level.

Dieter Pohl: Right, that is it – a lot of the numbers we have now does not make sense for specialty; do we create our own, do we have that leverage with insurers?

Secretary Roberts: Our leverage is that 60% of the people in RI are insured by BCBS, NHP or Medicaid FFS. A high percentage and thus leverage.

Steve Deto: To the extent that they are fully insured products.

Secretary Roberts: Fair enough, Peter Andruskiewicz [of BSBSRI] & I were discussing, they tend to use the same management structures w their self-insured.

Peter Hollman: Is there an age cutoff on the A1C?

Dr. Alexander-Scott: The national standard by 2020 didn't include specifics, but I can delve back into it.

Secretary Roberts: Dr. Brown do you have RI data on this [re: dental]? We have national, but we would love RI as our numbers seem like they would be lower than national?

Steve Brown: We can get you that if we do have it – I agree RI should have better numbers on dental caries than nationally.

Sarah Fessler: Currently no one pays for that screening?

Peter Hollman: No, they have to by law; BCBSRI does, for example.

Sarah Fessler: Okay.

Secretary Roberts: [On safe, affordable food metrics.] These are regulatory practice changes in the community that are not related to providers, and it strikes me that these are not as aggressive enough (i.e. handwashing in restaurants).

Dr. Alexander-Scott: True – and that is a big part that we want to check our data against national data. But sounds good, I can hear that push.

Sarah Fessler: How do you measure handwashing?

Dr. Alexander-Scott: Our food protection program works closely on that, but it is an area we need to improve upon; also have to work on ways of accounting for that properly.

Steve Detoy: The smoking metric brings up how do you do measures as well, [would we do it] as we do surveys?

Dr. Alexander-Scott: Right, these measures come from our behavioral risk factor survey.

Secretary Roberts: Our data is not new, baseline, in the RI based data do we have a plan to do a new behavioral risk factor survey, for example?

Dr. Alexander-Scott: Yes, each area has a different timeframe for when they will be done, and then they take time to receive the data output. On average, it is every other year, then the year or two lag to get the data to us.

### III. Group Discussion

Steve Detoy: We talked earlier about coordinating with SIM and other activities, the Department of Health is also close to releasing the survey data on capacity, so who would do all that work, and do we have the capacity in the system to meet these goals?

Dr. Alexander-Scott: It is very exciting to be able to share with you, or have another opportunity to come to you with our health inventory data that we have. Likely one of the first states in the country to accomplish what we do, have 12 domains across our healthcare system that were surveyed and accessed to see what our experiences are. Hopefully there are some key elements and lessons, such as identifying how many PCPs we have for each area. RI as a state is about 10% less than the goal is – thankfully not astronomically low, but certainly room for improvement. We are looking to align what we have on health inventory.

Steve Detoy: The slide that talked about increasing the number of people who do not put off healthcare access and decisions, we just went through a theoretic exercise with OHIC last year that the growing number of high deductible health plans is having on that issue. While too early to know, and we did not yet produce a definitive report, that is an impact which will be hard to turn around.

Dr. Alexander-Scott: That is the balance we have with that goal; want what is attainable with what is feasible. Need to keep it reasonable.

Secretary Roberts: Thus returning this to the input of you all, how does this impact a practice? I am interested in whether people were nodding when looking at these, or if you feel your practice is not well connected to items like these. Are these relevant?

Betsy Farnum: They do. I was surprised how low the goal for physically activity for Rhode Islanders is.

Dr. Alexander-Scott: It sounds as though your surprised comment highlights that there are some where all experiencing that you do connect with, whereas others you may say that they

are happening outside your setting. Would that accurately reflect how you interpreted these metrics or suggestions?

Claire Nadeau: On a personal level with the Electronic Health Records and meaningful use, the star metrics we want to strive for on disease entities, we are at the beginning of looking at how we are touching people in making a difference in value vs volume. I don't know that we have collectively done anything talking to other practices, or collecting the data to bring that forward, if there is any way to collate that. What are the statistics, how am I in my practice vis-à-vis another practice meeting those star metrics? I think those are touchpoints for meeting the goals for a healthier person in RI. We now need to think about how we put that information together, and who will do it.

Betsy Farnum: I have been tracking a lot of population health metrics since 2006, but it is hard to get a lot of data and reports. The amount of time I put in, and the amount of lost productivity and the minimal gains I have seen from this, as it is not actionable data, is frustrating. My productivity is really down to the point where I will be leaving primary care in July. I am in my third software; initially it felt finite, but I have been at my present site for 2.5 years, now just the new life of extra hours a day of data entry, or signing reports. I embrace population health management, yet it has driven me away from practice. Right now the software is an impediment, and the cost is also astronomical. Is it really changing health outcomes? It seems to be taking away from services we can provide; have people walking and moving more than 20% of them... that is huge. Yet now I spend more time a day sitting and doing data entry.

Steve Brown: That is a good point, how many providers have we lost in the profession due to new data entry requirements?

Betsy Farnum: We are 10% undersupplied, and yet many of our primary care providers in the state are over 60, which is a ripe age to begin leaving the practice.

Dr. Alexander-Scott: To clarify, the extra hours you are doing are meaningful use data related or..?

Betsy Farnum: I am at Thundermist so a lot of it is to structure data as well. Not a lot of communication between the IT folks and the clinical folks.

Karen Dalton: On the AFP national level, physician burnout is a huge factor. We were just at a national conference, and a big push to move away from this, but rather direct primary care. To get away from the administrative burden going on with physicians – a good thing to think about when implementing this. What is the patient engagement responsibility? If you look at health care and if you were to look at it like car insurance in which you are responsible for the maintenance of your car that may be it. We are asking physicians to do more and more, and many are losing their work life balance as a result.

Dr. Alexander-Scott: Yes, and to your point it is what I appreciate about being a part of providing some of these goals so that it is an attempt at collaborating on them. As we talk about patient responsibility, we do talk about the environment and the regulations needed to help the patient be more engaged and give them a chance at success which in turn can help support you.

Psychiatrist (*name not captured*): Many of these goals stated here have nothing to do with

medicine. As a psychiatrist only a few connect with psych. There seems to be a huge disconnect between the number of psychiatrists, and patients needed. We have an access issue, to incorporate all doctors into access, at least as it pertains to psychiatry, which could be part of the fix.

Sarah Fessler: And I don't know how you would move on dental care unless you can move some of the Medicaid population into dental offices and provide that care. That is a lot of our emergency room traffic. The other question I have is anyone looking at housing, homelessness, and security it has on health? I see that a lot at community health centers as a determinant.

Secretary Roberts: Yes. In our Medicaid world, for example, we have a housing stabilization initiative, and thus we are doing it across a number of programs, using dollars to do it, to see if we know what is true that if you have a stable home then it reduces costs in the health care system. We need to see if it is as simple as that. The good news is we are down to 5% of people without insurance; that is not an area that commercial insurance is engaged in at all.

Lynn Hob: I have this great tool in my practice that basically surveys patients on the social determinants of health before we see the patient. We could do a statewide sort of survey – the tool is called “How's Your Health” – and it addresses about 8 or 10 of these in hand that you are bringing up here. It is easy to use from a practice point of view, it is free. We recently joined the CTC, and what is required in the CTC is a lot of data, but using “How's Your Health” we are able to do that work quickly. A web-based patient entered survey, view of their health and their health care.

Dr. Alexander-Scott: With the years of using that, how have you felt on the action side?

Lynn: Incredible. It may spit out that the patient has pain, then have that conversation about what is bothering the patient, and where it may go together. The last big project it was used in was British Columbia, pulling up population health. Useful for primary care as well.

Secretary Roberts: Do you find the IT integration as challenging as your older colleagues? Do you see IT as insurmountable, or one that continues to improve and a part of what your work is, electronic health records, or what is at the practice levels?

Unidentified Medical Resident: I think electronic health records, using the system for records is fine, always a moment to learn a new system. I think that some of the goals to meet things at Thundermist, and you have 20 minutes to talk about a cold, but you have to do depression screening, etc., then you are gathering too much information.

Secretary Roberts: Interesting, when I go to CVS to go to get a flu shot, my primary care provider asks that I go see them instead so that they can talk to me about it. Important balance.

Unidentified Medical Resident: At the physical there is that, but in terms of gathering information and meet all the requirements, it is very time consuming. Also, I am uncertain yet what the templates are doing at this point.

Betsy Farnum: And the way they are implemented too, ten clicks for asthma and cessation. May be better if they were better processed. It is the implementation not the technology per say, but rather how they are implemented.

Philip Salko: I have trained in paper and dealt with electronic health records, there are still more clicks that I have to do every year, I consider myself very savvy with technology, but still time consuming for a physician. How many electronic health records systems in the state do we have?

Secretary Roberts: Four, I believe.

Philip Salko: And how do we measure them? When I am training in the emergency room, we would take note after note after note, and we are told for PQRS then they are entered into the electronic medical records. That seems insurmountable; entering excessive data and doing it with accuracy. I love the example of that program already mentioned – there are so many companies coming forward with these ideas. Can we look at that, can we monitor that so that it works better?

Secretary Roberts: I would love to mandate a single one, but I do not think the community would like that.

Dr. Alexander-Scott: The challenge I hear you saying I ‘I would love to collect this stuff on the electronic medical record so that I am not doing this when I should be really studying my patient.’ We are excited so much about the APCD, and what that will allow to get data in a more automated fashion, to demonstrate what population health data there is without you having to personally input it.

Claire Nadeau: The other point is how does the consumer feel about how you take all this information?

Gary Bubly: I want to support what you say here. My wife is a family medical doctor and feels that burden. Looking at your metrics, it does feel like there is a lot, hard to focus on. Perhaps narrow down and really focus on few. If any of these wind up with additional documentation requirements, I feel it may be another straw that might break the camel’s back.

Philip Salko: The statement volume *to* value, it is currently volume *and* value,

Betsy Farnum: And it is not that I do not feel comfortable with computers, but I would like to spend more of my time to practice in the way I would like to. I can type without looking down, but not click down and wait for boxes to load, and I want to have conversations with eye contact with my patients.

Peter Hollman: You started out listing these goals, and there are many here, we can sometimes see how they connect to health goals, but many are already in place. We do need to tie together with things we have already done. I do think it was only intended to have a few things relate to our everyday practice, and that is okay. It is housing, it is food, it is environment, etc.?

Steve Deto: Speaking of which, there are triangles out there on the various parts of life have an impact on, and at the top is a small percent which ‘medical’ has an impact on. Also, didn’t you answer a lot of questions by thinking about mining the APCD to get a large part of this?

Secretary Roberts: Yes, but you still need a functional way to manage your own patient population. You need a better solution than you have right now to manage your group of patients.

Steve Deto: Right, but it is a free market system out there, and you can get all the fixes you

want, and once again the cost burden in this case and the investment come down to the local small business man or woman running a health care business, and the benefit comes up elsewhere.

IV. Public Comment

V. Adjourn - Meeting adjourned. Secretary Roberts concluded that she is interested in specialty services and where that moves things in this environment, around behavioral health integration. Will reconvene in December.