Community Physician Partners Newsletter- June 2024

*****Save the Date:** *Community Physicians Partners Annual Business Meeting on* September 11, 2024, from 6-7pm via Microsoft Teams. Questions: kprimo@lifespan.org.

Member Practices: Community Physician Partners

Anchor Medical
Aquidneck Pediatrics
Atwood Pediatrics
Brown Medical
Children's Medical Group
DiCenso, Dr. Angelo
East Bay Pediatrics
Kingstown Pediatrics
PRIMA Pediatrics
Steigman, Dr. David
Medical Associates of Rhode Island
University Internal Medicine
Wayland Medical
Women's Internal Medicine

Dear Member of Community Physician Partners,

This newsletter is produced by the Lifespan Value-Based Contracting Department to provide you with updates affecting your practices.

With oversight from the CPP Board of Directors, we negotiate contracts with payors on behalf of CPP members. These contracts also include the Lifespan employed primary care practices [see list below]. These are risk contracts with shared savings, infrastructure, and quality incentive components. We appreciate this important partnership between CPP and the Value-Based Contracting Department.

Best regards,
Dan Moynihan, Lifespan Vice President, Contracting and Payor Relations

CPP Board of Directors

- David Marcoux, MD (University Internal Medicine) - President
- Christine Hebert, MD (University Internal Medicine)
- Diane Siedlecki, MD (Anchor Medical)
- Thomas Bledsoe, MD (Brown Medicine)
- Nathan Beraha, MD (Anchor Medical)
- Pamela Harrop, MD (Medical Associates of RI)
- Peter Hollmann, MD (Brown Medicine)
- James Ross, MD (Medical Associates of RI)
- Flora Treger, MD (Women's Internal Medicine) - recently exited Board following years of service-*Thank you, Dr. Treger!

Board Membership: If you have any questions regarding the CPP Board or interest in nomination to the Board, please email David Marcoux, MD: dmarcoux@lifespan.org.

Welcome

East Side Pediatrics: They are the newest member of Community Physician Partners.

Dr. William Morocco
Dr. Tracey Myatt
Dr. Amy Farb
Dr. Xenia Fernandez
Dr. Elizabeth Maranzano

In addition to CPP, our Lifespan System of Care-Primary Care Practices and Payors Includes:

Hospital-Based Clinics

Hasbro Pediatric Primary Care
Adolescent Healthcare Clinic
Medicine-Pediatrics Primary Care
Miriam Hospital Primary Care Clinic
Rhode Island Hospital Center for Primary Care
Lincoln/North Attleboro Pediatrics (LPG)

Coastal Medical, and now including:

LPG Primary Care - Cranston
LPG Primary Care – Warwick
LPG Primary Care - Metacom
LPG Primary Care - Newport
LPG Primary Care - Tiverton
Jamestown Family Practice (LPG)
Women's Medicine Collaborative

Our Value-Based Payor Partnerships:

Blue Cross Blue Shield Rhode Island
United Healthcare
Point32Health/Tufts
CMS [Primary Care First]
Medicare Shared Savings – Lifespan Health Alliance

QUALITY

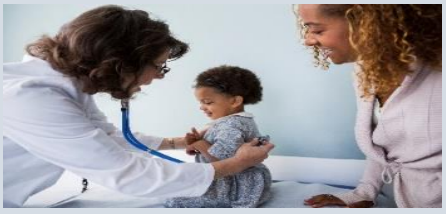
Recent CPP Quality Champions

The following List of practices and providers attained recognition for high quality scores within our payor incentive programs. The most recent data available for BCBSRI is from 2022, and for UHC is from 2023.

MEDICARE ADVANTAGE	COMMERCIAL – ADULT	COMMERCIAL - PEDIATRICS
BCBSRI 5 Star	**BCBSRI 5 Star**	**BCBSRI 5 Star**
Prema Daniel, NP	Dr. Kathryn Banner	Dr. Robert Eden
Dr. Alexander Diaz De Villalvilla	Dr. Matthew Brumbaugh	Dr. Casey Eldert
Dr. Laura Edmonds	Dr. Alexander Diaz De Villalvilla	Dr. Debra Filardo
Dr. Bruce Fischer	Dr. Heidi Dorris	Dr. Malini Gillen
Dr. Peter Hollmann	Dr. Laura Edmonds	Alexa Gladstone, NP
Jeanne Knight, NP	Dr. Bruce Fischer	Dr. Joshua Gutman
Dr. Warren Licht	Margaret Gagner, RNP	Caitlin Levesque, NP
Dr. Leah Marano	Dr. Pamela Harrop	Corey Mair, PA
Dr. Leslie Mohlman	Dr. Anita Kaul	Dr. Leslie Mohlman
Dr. Maria Molineros	Dr. Warren Licht	Dr. Carla Scarfo
Dr. Drew Nagle	Dr. Jennifer Maude	Practice: Children's Medical Group
Laura Runyan, PA	Dr. Felicia Meila	
	Dr. Jeanne Oliva	
UHC Highest Star Rating	Robyn Ostapow, PA	
Sydney Amado-Tuthill, NP	Dr. Quratul-ain Qaiser	
Dr. Rex Appenfeller	Dr. Sakeena Raza	
Abbey Barkley, NP	Dr. John M. Ryan	
Dr. Aditi Basnet	Dr. Mae Shen	
Dr. Thomas Bayer	Dr. Diane Siedlecki	
Dr. Avishek Chatterjee	Dr. Alane Torf	
Dr. Cassandra Constantino		
Alexa Gladstone, NP		
Dr. Kathleen Henderson		
LaNeir Johnson, NP		
Dr. Katie Kozacka		
Dr. Warren Licht		
Katherine Maiorisi, PA		
Kimberly Masood, PA		
Chelsea McKiernan, PA		
Dr. Leslie Mohlman		
Dr. Ashna Rajan		
Anthony Ramicocne, PA-C		
Derrick Robinson, PA		
Donna Rondeau Marzullo, NP		
Dr. Michael Stein		
Dr. Jackson Steinkamp		
Dr. Rohit Tyagi		
Paige Vetrano, PA		
Dr. Judith Westrickc		
Dr. Mitchell Wice		
Practice: Medical Associates of Rhode Island		

Quality Incentive Measures

2024 Quality Incentive Measures	
Breast Cancer Screening	Follow-Up After Hospitalization for Mental Illness (7 days)
Cervical Cancer Screening	
Child and Adolescent Well-Care Visits	Kidney Health Evaluations for Patients with Diabetes (KED)
Chlamydia Screening in Women	
Colorectal Cancer Screening	Lead Screening in Children
Controlling High Blood Pressure	Osteoporosis Management in Women Who had a Fracture
Diabetes Care: Eye Exam	
Diabetes Care: HbA1c <8	Transitions of Care Aggregate-noting admissions/discharges/engagement and medication reconciliation
Glycemic Status for Patients with Diabetes (A1c or glycemic management indicator)	
Immunizations or Adolescents – Combo 2	Social Determinants of Health Screening



Patient Experience CAHPS Questions (MA)	Member Reporting Outcomes (MA)
Getting Needed Care	Monitoring Physical Activity
Getting Appointments and Care Quickly	Reducing Risk of Falling
Rating of Healthcare Quality	Improving Bladder Control
Care Coordination	Advance Care Planning
	Activities of Daily Living

Priority: Focus on Performance Improvement

Q. What quality measure has the potential for the greatest impact?

A. The Annual Wellness Visit

Other *Priority* Measures to Discuss with your Care Team Include:

- **Transitions in Care-** multiple components!
    1. Notification of Inpatient Admission
    2. Receipt of Discharge Information
    3. Patient Engagement After Inpatient Discharge
    4. Medication Reconciliation Post-Discharge
    5. The Reconciling Provider Type
- **Child and Adolescent Well-Care Visits**
- **Immunizations for Adolescents - Combo 2**- (Meningococcal, Tdap, HPV)
- **Chlamydia Screening**

Incentives and Bonuses for CPP

Payor Incentives and Bonuses for providers are part of most contracts. Contracts include such areas as closing gaps-in-care for quality measures, doing annual wellness visits, screening for social determinants/drivers of health, and scoring well on patient experience and health outcomes surveys.

- The BCBSRI Provider Quality Incentive Program (PQIP) awards providers an incentive payment. The Program focuses on quality measures, patient experience, and member-reported health outcomes. PQIP incentive payments are based on an overall measure achievement score for each provider which affords you a means of understanding your performance relative to your peers.
- UHC Bonus for Medicare Advantage for annual wellness visits completed for High Priority Patients, in addition to preventive screenings and medication management.

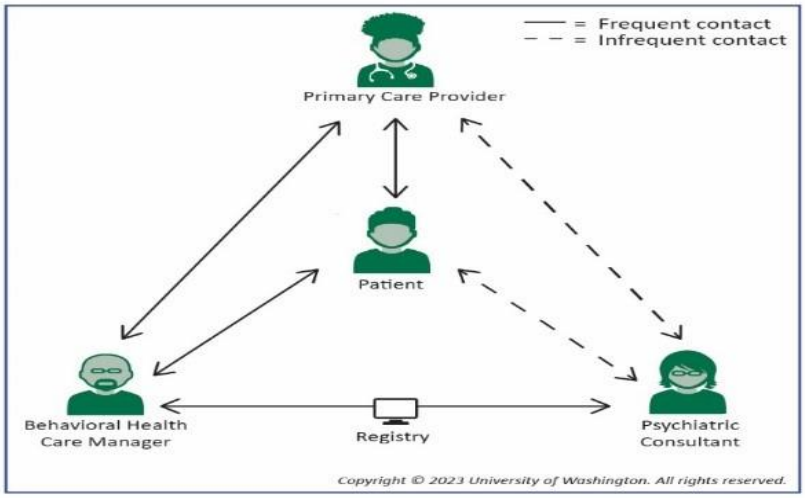
Quality Resources with Measure Definitions:

1. BCBSRI 2024 Provider Quality Incentive Booklet: 2024 PCP Quality Incentive Program Booklet Revised Version 4.4.2024.pdf
2. United Healthcare: Find Additional Information Here
3. OHIC Aligned Measures-ACO: OHIC Measure Alignment Annual Review_Measure Specifications_8-7-2023

Integrated Behavioral Health

Good News: Expansion of Integrated Behavioral Health in Primary Care: a group of Stakeholders with experience in IBH recently convened to assist with this expansion.

One example of an IBH Model: Collaborative Care Model



Lifespan
Delivering health with care®

Clinical Pathways

We continue to work on creating additional Clinical Pathways for CPP to make patient visits with Specialists more productive, and in doing that, we are consulting with various Specialists and seeking input on what PCPs can do in advance before referring patients to ensure referrals come with adequate information. Clinical pathways can help improve efficiency while being cost-effective. Sending patients to Specialists with the workup completed can ensure a better experience for our patients during their visit with the Specialist. After consultations with the Cardiologists, these are three areas we as PCPs can help and do in advance before referring patients.

Clinical Pathway Cardiac: Chest Pain, Syncope, Arrhythmia/Palpitations

Health Care Provider Suggested Tasks/Guidelines		
Evaluation for Chest Pain	• Send Cardiologist: o PCP's Progress Note with Primary Reason for Referral (include Physical Exam, Evaluation & History, and any Symptoms relevant to referral) o EKG o Stress Test Results- PCP to schedule Stress Test prior to referral; Results of Stress Test obtained by Primary Care Provider should be available to Cardiology at time of Cardiology visit. o Bloodwork: CBC, BMP, Lipid Profile	
Evaluation for Syncope	• Send Cardiologist o PCP's Progress Note with Primary Reason for Referral (include Physical Exam, Evaluation & History, Orthostatic Vital Signs, and list any additional symptoms relevant to referral) o Bloodwork: CBC and BMP o Transthoracic Echocardiogram (PCP to order prior to referral) o Zio Patch/Holter Monitor Results (PCP to schedule monitoring prior to referral)	
Evaluation for Arrhythmia/Palpitations	• Send Cardiologist o PCP's Progress Note with Primary Reason for Referral (include Physical Exam, Evaluation & History and list any additional symptoms relevant to referral) o EKG o Echocardiogram (PCP to obtain prior to referral) o Zio Patch/Holter Monitor Results (PCP to schedule monitoring prior to referral) o Blood work: CBC, BMP, and TSH	

Care Team Suggested Tasks/Guidelines (working with providers)		
Referral Options	• Weight Management Programs • Smoking Cessation/Tobacco Counseling • HouseCall Programs (if indicated) • Remote Patient Monitoring Programs (if available) • Home Care • Home Draws (as needed) • Social Work • Nutritionist/ Meals on Wheels • Cardiac Rehab • Mental Health Assessment (i.e., Mindfulness Stress Reduction)	
Nutrition	• Cardiac/Heart Healthy Diet (i.e., Low- Sodium) • Mediterranean Diet • My Heart Health Plan	
Nursing/Care Management	• Education tailored to patient's needs. • Care Plan (Goals, Tasks) • Coordinate appointments and testing • Following up on diet, nutrition, medications, and appointments • Transportation (MTM)	
Pharmacy	• Education on Medications (including OTC medications) • Review adherence techniques/importance of adherence • Pill-packing (Lifespan pharmacy offers for free; WhiteCross pharmacy) • Review ways to assist with adherence without having to utilize a pill packing pharmacy (i.e., using a weekly pill organizer) • Check for patient assistance through manufacturer if any is offered	
Care Transitions/ Transitions of Care	• Visit with ACO/SOC Patients at the Bedside: o Provide education to patient and families; Resources about Heart Health o Provide scales to patients who need them o Collaborate with Inpatient Case Management, TOC Pharmacy, and Social Work as needed/Communicate with PCP NCMs and Care Team	

Banner: Public Health Notes

Goals for Health Equity and the Social Determinants [Drivers] of Health [SDOH]

TO DO *For Practices*

1. **Standardized Reportable Data:** SDOH goals align with the CMS approach for SDOH.
   CMS Priority 1: "Expand the Collection, Reporting, and Analysis of SDoH Standardized Data".
   Standardized data includes using the CMS-5 Domains for SDOH screenings: (**1**) Food Insecurity (**2**) Housing Instability (**3**) Transportation Needs (**4**) Utility Difficulties (**5**) Interpersonal Safety

2. Standardized data includes the screening for the CMS-5 Domains for SDOH: (**1**) Food Insecurity (**2**) Housing Instability (**3**) Transportation Needs (**4**) Utility Difficulties (**5**) Interpersonal Safety

3. **Staff Education**: Continue with staff education regarding SDOH and the link they have to health inequities .

4. **Resources:** Patients with SDOH needs are linked to community resources. A sample of some Resources include:

   - ***The Lifespan Community Institute*** is an amazing resource that provides health screenings, youth programs, preventive health classes for both physical and mental health, nutrition classes and community navigation support. Call 401.4448009 or email Lifespancommunityinstitute.org

   - ***Health Source Rhode Island*** is available for help with health insurance and links to community services for you and your family. Call 1.855.840.4774 or email www.healthsourceri

   - **Unite Us-RI** is a care coordination network when looking for SDoH and other referrals. Click here for more information

   - **Rhode Island Office of Healthy Aging:** Health Care Cost Assistance, Home Care, Food and Nutrition, Public Benefits, Legal, Housing, Transportation, Senior Centers. Visit oha.ri.gov or call 401.462.3000

Notes from your Lifespan Value-Based Contracting Team

***Reminder: Save the Date:** *Community Physicians Partners Annual Business Meeting on* September 11, 2024, from 6-7pm via Microsoft Teams. Questions: kprimo@lifespan.org.

***Contract Update:** The Centers for Medicare & Medicaid Services (CMS) approved our application for the Medicare Shared Savings Program for **the Lifespan Health Alliance, LLC**. The program started on January 1, 2024, and we were approved to participate in **the ENHANCED track.**

***Coastal Medical Updates:** Coastal Medical, a member of the Lifespan health system, has several adult and pediatric practices.
Lifespan entered into "unified" contracts with Coastal Medical for UHC Commercial, UHC Medicare Advantage, and the Medicare Shared Saving Program.
Certain Lifespan Physician Group practice sites are now under the management of Coastal and will no longer be included in the populations where Coastal Medical has their own risk contract.
The Lifespan hospital-based primary care clinic practices and Lincoln Pediatrics will remain in the existing populations.

***Equity:** Language included in our communications: "Payor documents are forwarded to your practice by the Lifespan Value-Based Contracting Department as a source of information. We are pleased to collaborate with you. Our priority goal is healthcare equity for all regardless of insurance reports or a patient's insurance status."

***Patient Attribution:** If you have attribution issues with BCBSRI or UHC please feel free to contact our Contract Administrator, Krista Sevigny, at ksevigny@lifespan.org.

***Value-Based Contracting Contacts:** Dan Moynihan, V.P.- dmoynihan1@lifespan.org; Kathy Primo- kprimo@lifespan.org. Elizabeth Dennigan-edennigan1@lifespan.org; Krista Sevigny- ksevigny@lifespan.org.