HSTP AE Advisory Committee Meeting Minutes

Meeting Date, Time and Location: February 2, 2021, 9:00 a.m. to 10:30 a.m., Zoom Conference

Meeting Facilitators/Presenters: Director of Medicaid Benjamin Shaffer, Director of Health System Transformation Libby Bunzli, Dr. Jonathan Gates, MD and Lillian T. Nieves, PharmD

Committee Members: Carrie Bridges-Feliz; Barry Fabius; Scott Fraser; Chris Gadbois; Patrick Tigue; Jennifer Hawkins; Deb Hurwitz; Dr. Jerry Fingerut; Womazetta Jones; Linda Katz; Dr. Al Kurose; Jeanne Lachance; Ray Lavoie; Juan Lopera; Maureen Maigret; Roberta Merkle; John Minichiello; Dr. Nicole Alexander-Scott; Jim Nyberg; Steve Odell; Dr. Ottiano; Maria Palumbo-Hayes; Rebecca Plonsky; Katherine Power; Anya Rader-Wallack; Marti Rosenberg; Sam Salganik; Benjamin Shaffer; Sue Storti; Merrill Thomas.

Meeting Notes			
Agenda Item	***Time***	***Facilitator(s)***	***Meeting Notes***
Welcome & Introductions	**5 Minutes**	**Director Shaffer**	• Motion to approve the minutes from the Dec 5th AE Advisory Committee meeting ○ Motion Approved
Program Updates	**25 Minutes**	**Director Shaffer and Libby Bunzli**	• **Libby Bunzli**: Staff updates: a very warm welcome to Rosemary Mulandi, who is our new HIT staff person managing our HSTP/HIT projects, including the Community Resource Platform, otherwise known as E-Referral system, Care Management Dashboards and the Quality Reporting System. I wanted to make sure that we had a chance to welcome her to this committee. We have posted for another staff position to take on some of the equality and incentive program work as Debbie Morales, transitions away from the HST Program. • Certification deadline dead-line for new certification is March 15 and the deadline for AE's to be re-certified is March 1st. • The Community Resource Platform which I just mentioned, is one of our social determinants of health investments that we described in our investment strategy. The procurement is live, so I can't speak much to what's going on there, other than to say the application period is closed and applications are under review currently. • The second main investment that we described in our Social Determinants of Health Investment strategy is the Rhode to Equity. I'm very excited to announce that we've been working very closely with CTC- Rhode Island and Well Being and Equity in the World (WE) and have developed a Request for Applications (RFA) for teams to come together and apply to participate in that learning collaborative. • We expect to drop that RFA sometime this week. Teams will include Health Equity Zones, Community Health Teams and Persons with Lived Experience (PLE) with options

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			for additional team members to join on to that project. The RFA does describe a supportive role for our Managed Care Organizations to play in that project. CTC/WE anticipate to posting it this week with a deadline in May. • The last update I have for you is that you EOHHS has begun stakeholder activities for our Managed Care Procurement. Stakeholder input began in October of 2020 and the anticipated timeline is: o Jan 2021: Issue RFI and continue Stakeholder Engagement o Feb 2021: RFI responses due and continue Stakeholder Engagement o Aug 2021: Issue RFP and continue Stakeholder Engagement o October 2021: RFP Responses due o January 2022: Vendor Selected o July 2022: New Contracts begin • We're in the process of doing stakeholder engagement right now and I think it's really important to note that the sustainability of Accountable Entities and continued progression toward value based payment in Medicaid are some of the highest strategic priorities for this procurement, so we will continue to engage with our stakeholders to make sure that we are approaching that RFP in a very thoughtful and strategic manner. If you have any questions or inquiries or want to provide us with input for our procurement, you can reach out to Mark Kraics, Medicaid Managed Care Director or Kristin Sousa, Deputy Medicaid Director for Managed Care and Oversight.
PY2 Quality Outcomes	**30 Minutes**	**Libby Bunzli**	• Director Shaffer opened the conversation stating that this is a conversation that has been a long time coming. Director Shaffer reminded the committee that there has been a lot of conversation about the structure of the program, finances and the potential for cost savings over time, but we as of yet not talked about the quality outcomes in the program and what we are seeing over time, in terms of improvements in quality. That is something that we needed to quite frankly wait until we had more data. That's what we are prepared to present today, I would emphasize that a baseline level, we have one year of data. It's the first time, at least to my knowledge that we will look at this data together across AE's so we're excited to present that to see where we are and to see how folks reactions, ideas and questions on how we move these measures that really matter for our population of Rhode Islanders who are in the Medicaid Program. We certainly know that this conversation is tied completely to the design of the program, a program supported by HSTP funding, and designed to transition providers from less financial risk to more financial risk under the assumption that more risk leads to both greater accountability for costs and for quality, we think that this logic model assumption is accurate, the data on Medicare AE program and other programs bear that out and, overall, we see that improvements and costs do not come at the expense of quality. Nationally, 92% of eligible ACO's earn quality improvement rewards points, especially for in patient safety and care coordination. And

			ACOs in general did well or better on quality indicators than non-ACO counterparts. Our program obviously applies the quality performance directly to shared savings, because we want to make sure that there is investment in preventative care and chronic disease management and all those things that we believe will drive down costs while maintaining and improving quality; obviously, to Libby's' point on our social determinants of health work, the non- medical drivers of health. We've tried to structure the incentive program to that effect, but we certainly also believe in the continued move towards downside risk as CMS expects will continue to drive that and what we will continue to look for and understand in our own program. It is the idea that an AE cannot succeed in the program without attention to quality and care delivery improvements one, because they'll miss those kinds of benchmarks, but also because quality improvements are necessary to that cost control. • Libby Bunzli walked through the quality slides with the committee and meeting participants stating that the data is a review of PY2 from calendar year 2019. **Public Comment** • **Blood Pressure Screening Slide**: o We saw an improvement in our blood pressure control measure, while we were doing an external grant. A big piece of that was the education of our care teams on correctly checking blood pressure and checking it twice in the visit. Foresee difficulty in coordinating virtual visits and ensuring access to a blood pressure machine over the next year; trying to think of ways we can increase access to them. o COVID created significant barriers to management of this measure; access to BP machines difficult. Tele-health challenging as well. o We tried to focus on getting patients into the clinic in 2020 to get a blood pressure. We also started remote monitoring for a very small population at the end of 2020 and we expanded that 2021. It was very difficult doing Tele health and getting patients to give readings. We had a lot of patients that didn't have a reading, not that they weren't in control. A team of medical assistants and pharmacists and nurses will reach out to those patients to check in on them and get their blood pressure readings. o **Libby**: Good points about COVID and how we're having to adapt, given the constraints and what you can and can't do with a tele-health visit. o A team of medical assistance and pharmacists and nurses that reach out to those patients to check in on them and get their blood pressure readings. o **Libby**: Good points about covert and how we're having to adapt, given the constraints and what you can and can't do with a tele-health visit. • **Breast Cancer Screenings**:

        - Data for PY2 correct?
    - **Libby Bunzli**: Yes, pre-COVID.
        - One of the interventions that we do at United is to reach out to the high volume mammography centers and provide them with a list of their patients who are non-compliant to get them schedule breast cancer screening. I have heard that it was really hard to schedule a breast cancer screening, because when the State closed down for that first wave of COVID and then opened back up BSC centers had to backfill all of those appointments that had been missed, so they couldn't schedule any new appointments until the end of the year.
    - **Libby Bunzli**: I think that's probably going to be a common theme that a lot of these measures 2020 really flipped a lot of things on its head. It'll be interesting to compare over time as time goes on, and as we get more data recognizing those challenges.
        - Given some of the AE/MCO pairings may have small n's, whether that's the case or if there is a threshold, when you report in some of these based on a particular threshold and for any one measure just to not report on variation because of small numbers, just curious more of a general question as to how we report on this.
    - **Libby Bunzli**: That's a good point, we didn't include the numerator and denominator here because we didn't want to make it obvious which he was which. I'm not sure that we had any issues with small sample size here but I'll encourage my quality folks to speak up if I'm incorrect.
        - We were able to report out on every single measure, although when we compared our numbers to NHP, NHP does have a larger population than UHP, so their denominators are larger to your point.
    - **Libby Bunzli**: Right and that reminds me that there are other things, the demographics underlying each of the AE's are very different, some AE's have higher proportion of kids and some AE's have higher proportion of older people. That's a consideration, especially as we think about measures that are more specific to certain populations. It's hard to compare apples to apples, the risk profiles are different but for some of these measures that are standard clinical processes, we want to see all our AEs continue to improve.
        - UHC Interventions is to reach out to high-volume BCS centers and ask them to reach out to patients to get them in. COVID challenged this when the state shut-down and created a back-log.
        - I have heard people are getting refused appointments because they have a have record of no shows. I know at CTC when we were developing some of the quality benchmarks, we saw a distinct difference in FQHC

performance versus non-FQHC; we use the 50% Medicaid threshold. And how you recognize that I know the performance improvement methodology can help take that into account to, to a large extent. It is an important piece to try to learn "Best Practice".

- **Libby Bunzli**: I hear the concern about referral scheduling not being equitable and I believe this is a measure if I'm recalling correctly where there tends to be more racial disparities and I'm curious if this is a barrier that the AE's are facing and if there is a way to make this more equitable. What are your thoughts/recommendations on how we can address this?
  - Bilingual staff, better scheduling at the mammography centers.
  - We need better intake data so that we can identify these populations of color more reliably; we depend on a kind of an ad hoc calculation so we're using more zip codes and the prevalence of populations of color as substitutes. We did do a health equity initiative this year involving breast cancer screening in those zip codes with additional education and. interactions with this population through either phone call or texting to try and drive that population to get breast cancer screening, we did have some success.
  - I've been hearing a lot of childcare issues more so in 2020 because of COVID. Families were not able to bring their children to appointments so they weren't able to go, due to childcare issues. That's been a recurring theme, I would say across AE's as well.
  - I just want to shed some light on disparities, this is a measure that is somewhat unique. The lowest rate is for white non-Hispanic women, it's around 60% across our membership for African American women it's about 64% and for Hispanic women it's over 80% so very different pattern sort of the opposite of what you'd expect from a disparity and perspective but that's what we're seeing and has been consistent over the years.
  - This is what we're seeing at United as well.
  - In this age group are probably around 60-70% coverage for race and ethnicity.
  - Interesting, I guess that I would add that this is the cautionary tale of the screening measures that are more process related versus focusing on outcomes. I think there's been well documented research on disparities around outcomes for a number of conditions cancer, being one of them, so there's been an emphasis on screening, but if we look at outcomes, the outcomes are probably still disparate so just food for thought as we move beyond process measures. Because we've seen in aggregate similar

			things in the Tufts data, where some of the screening metrics that are more process related show the inverse of what you would expect about health disparities, but that's because we don't have as much of the information from the EMR that that would give us more of an outcomes view on topics like cancer, diabetes, you know we're ideally you'd have BMI data, etc. ▪ Referral scheduling is not equitable - we have instances of patients being outright refused because they have previously no-showed. There are also vast language barriers. ▪ Perhaps the mammography centers need some open scheduling time like our offices? ▪ Need a better scheduling system and bilingual staff. ▪ Study the barriers that lead to no-shows. ▪ Figure out why no-show and use CHW to help people keep appointments. ▪ We're seeing limited bilingual capacity at referral locations. ▪ My mammography provider provides evening appointments in East Greenwich, which I can drive to … but probably many people can't. ▪ Could a mammography truck come to larger places of employment? ▪ Are there cultural issues around breast cancer screening? ▪ In my previous position in Massachusetts, we found success in establishing walk-in hours on the evenings and weekends at Mammography sites. ▪ The 'accidental reassurance' of screening tests, and not all patients are equally willing and able to follow up. ▪ I agree with Dr. Gates. I have seen mobile mammography work well in another state. Rotating between communities. Staff on the van could be bilingual and focus on communities where language is a barrier. Patients in our communities do not like to leave their city. ▪ Some AE's are used to point of care testing - as are their patients - so with COVID, the need to go to a physical lab has a greater effect. ▪ What works: cleaning up problem lists, NCM education, affordable/accessible insulin, three-month check-ins (depending on severity). ○ **Libby Bunzli**: That's interesting and I think when I hear that I'm hopeful that I think there's a consistent desire to move toward more outcome based measures. As we've talked about in this forum before, we are making efforts to prioritize the collection of race, ethnicity and language data in a self- reported manner. I think

			our ability to not only track the disparities but to focus in on outcome based measures is improving, and hopefully we'll be able to tackle those things as we continue to shine a light on them.
			
			• **HBA1C Slide**
			  ○ **Libby Bunzli:** Moving to an outcome based measure on comprehensive diabetes control HBA1C. The data shows a lot of variability I wonder if this is reflective of differences in the populations or is this a result of logistical documentation issues? This one is a hybrid measure, and I know that there were some methodological and logistical things still being figured out but I'm curious what. did you find that worked to drive improvement on this measure.
			    ▪ I would point out that this was a pay for reporting measure and hybrid measure and collection was done in 2020 so not a lot of resources were available in all AE's to be able to collect and report additional hits. There's no point in reviewing a measure such as this, if it's just pay for reporting.
			  ○ **Libby Bunzli**: Have you seen in more recent data that the rates are higher?
			    ▪ We can't really tell what the A1C is in most claims, what the actual rate is a lot of offices will do finger stick point of care and it's collected and it's in the EMR. Most providers don't have the resources to check every single diabetic for A1C, in addition to all the pay for performance measures that they had to collect data on and submit that medical record data to us. I could see where AEs wouldn't bother collecting additional information for this measure in 2019 when there was no benefit to adding additional resources, especially in the middle of COVID.
			    ▪ We do have quite a few patients that have never been seen by us that we keep trying to reach out to, so I think that's a very small piece of it. But in 2019 I will say that we have a lot of patients that never went for their lab testing, even though we did multiple points of outreach to try to get them to go I think they were afraid to go and get blood work drawn.
			    ▪ I think what I see as a unifying feature of both breast cancer screening and diabetes screening or comprehensive diabetes care, is it requires the patients to go do something outside the office and so that's a barrier right there. I think there's probably a host of different reasons why patients are not going and I don't think it's laziness. I think it's fear. Fear of testing for something that could reveal cancer or fear of testing for something that reveals poor glycemic control that's just one, it could also be an issue of time, patients not able to take time off of work or do not have the

same mobility as other patients. What can we do differently, for this population when there are patients who can't, won't or don't use services traditionally as most of us buy into the model that we will go to our doctors. I think what's compelling to us is between eight and five Monday through Friday, most will get most of our care done there with specialists and primary care doctors under those contexts. Our experience has been that this population has more of the patients who can't won't or don't comply with that traditional model, and so what more can we do? I love the comment about point of care testing. I think it was Jay who commented on mobile mammograms units that are available in communities. I think we need to talk about strategies that aren't work harder but work smarter.

    - Covering the multi-use home A1c test machines would likely help a lot.
    - Costs about $100 a year - probably less than the lab fees and eliminates the transportation and other barriers patients have.
    - 2020 presented challenges, people were afraid to go to lab.
    - Streamline the transportation rules.
  - Libby Bunzli: I'm hearing a lot of you say we must think differently about how we engage this population. How we reach them, how we address certain barriers that that might be related to language transportation things like that so that's helpful and I think something for all of us to keep in mind.
- **MH 30 Day Follow-Up**
  - **Libby Bunzli**: I have heard from stakeholders regarding barriers and challenges around sharing of data and sharing of information for folks with mental illness and despite that, I was really heartened to see the level of performance on this measure. I think it goes hand in hand with the follow up after hospitalization within 30 days, and follow up after hospitalization for mental illness within seven days, where it seems like performance is not as high, but again I continue to hear about the barriers and challenges that the AE's experienced getting information about their members with mental illness when they're in these kinds of institutions so I'm curious what are your thoughts on the high performance on the 30 day measure vs low performance on 7 day measure?
    - When we talk about behavioral health we really talk about the connection to primary care, and I think that's the uncertainty around what can be shared and how it can be shared. I think the hit here can be with a behavioral health provider after a hospitalization that it doesn't necessarily mean that person is engaged in primary care and how that behavioral health provider connects to primary care is the issue because

				ultimately that's what we want to achieve with this program, a greater understanding of the population and a greater ability to take care of the population. The variety of ways in which people interpret part two, and what can be shared and how it can be shared creates gaps that you may or may not see through this measure. ▪ I think you are being generous when you say high performance on this measure. This is well below what we can achieve and have achieved for other populations on this measure. When we look at follow up after an Inpatient admission, we're looking at rates between 80 and 90%. there's more of a systemic reason why we can't achieve the same. So, the fact that all the associates are in a similar performance rate, I would just observe that it's still well below what we can achieve and what we have achieved and other populations, and I can only speak for coastal. ▪ Our problem is just as you opened with, we need to know who the patients are, we need to have transparency and we often find out by touching base with high risk patients. Or if they come into some sort of contact with our care management team, but we don't find out about the behavioral admission or the mental health illness. We fall backwards into it and I think that's why we have a better rate at 30 days, than we do at seven days. I think even the 30 day rate could look a lot more like the Inpatient follow up rate if our systems that are in place, had the information in a timely way like we do with ED and medical admission discharges. ▪ It would be great to develop a health equity dashboard with similar measures broken out by race/ ethnicity ▪ We found over 60% of our inpatient psych discharges are attributed but not seen. ▪ There, there are several barriers to success on this measure, but one of the key ones, is knowing when a patient has been discharged from. hospital, especially a psychiatric hospital or psychiatric service at the general hospital, those alerts do not come through the ADT system that RIQI supports, because the behavioral health hospitals and services don't participate in that. I believe United is a leveraging prior authorization information from their behavior health partner to provide those alerts to the AE's and other providers. Neighborhood is working to do the same thing, hoping to get that out to the AE's, knowing what members need to be followed up on is primary. The second is just getting a behavioral health appointment within seven days the access is better in Rhode

			Island than elsewhere in the US, so our rates should be better than benchmarks nationally. ○ **Libby Bunzli**: I'm glad to hear that United and NHP are both working on getting, that information to the AE's and that's something that I am interested in understanding more, the barriers around 42 CFR part 2 is one of my personal priorities. ▪ We know what the problem is, but we have difficulties taking down the systemic issues that really pins it in place. I've spoken with CMOs and mental health leaders in multiple institutions and 42 CFR is applied by our mental health hospitals here in a far stricter definition than is technically required So what we have, I believe, is a history, a tradition of or a precedent for over interpreting 42 CFR. In conversation with these providers, they have said to me that they want to relieve this restriction but it's just so systematically entrenched, they are not sure how. I think we should talk about it openly as this is the root of the problem. ▪ UHC has Butler and Bradley discharges on the iPCA tool. ▪ Connections with the in-patient places are different and availability of out-patient treatment is different. ▪ We also need to consider the state mental health law - not just 42CFR. ▪ Our state's mental health advocate has echoed these same concerns that facilities, providers are interpreting 42CFR too stringently ▪ 42CFR has also changed with the CARES Act: https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html ▪ Compliance officers really and I think providers would prefer to know their patients have good follow up plans. • **BMI Assessments** ○ **Libby Bunzli:** We have a weight assessment and counseling for nutrition physical activity for children, adolescents, that is a three part measure we have BMI, Physical Activity counseling and Nutritional counseling and the way that we do it in the program is they're consolidated into one composite measure within a weighted average across but we've broken it out here, so we couldn't compare it to the HEDIS or the Quality Compass benchmarks. I think the clear incentives are for AEs to focus on those kinds of high risk complex multiple comorbidity adults. I was really kind of heartened to see performance was high for some of our AE's, which I know, based on the conversations that I've had with the pediatric community is probably under-representing actual performance here. I think, this is a conversation for another time to ensure that children's health and

			well-being is not being overlooked in this program and that we're leveraging a real strength that Rhode Island has in our pediatric leadership and our pediatricians within the state that are very high performing. Before I pass us along to PCHC, any final thoughts or comments? ▪ The rates that we're comparing here are for the hybrid measures are self-reported rates and I think a lot of the variation is not necessarily difference in underlying performance but difference in in the capacity to access and interpret medical records and that was clearly more of a challenge for some AE's, as we work with them than others. Better when we start getting EMR data to measure it the level of an AE. ▪ We just must reflect that some have said they have a harder time getting this data to us maybe in PY3 we'll see we'll see some better data collection as a result. ○ **Libby Bunzli:** Exactly and as I said at the beginning, this is the beginning of this conversation, and we do intend to continue to bring programmatic data to this forum and continue talking about what's working what's not working and how are we are doing. ▪ HealthCentric Advisors did some work on this two years ago - pulling together folks to better utilize 42CFR. ▪ Of course, there is always patient consent to share information... ▪ BMI and Developmental screening are CTC PCMH Kids metrics. PCMH Kids practices see a very high % of Medicaid kids. ▪ Thank you for sharing the data and look forward to sharing identified information in the future. I encourage EOHHS to consider taking some of the measures off the list and to minimize the constant change in the quality and outcome measures to focus attention on improvement.
PCHC Presentation	**30 Minutes**	**Dr. Jonathan Gates**	○ **Dr Gates and Lillian Nieves presented on Diabetes Management and Avoidable ED visits**: ○ This is one of the most comprehensive approaches I've seen to focus in on the population that are using the ED and you know, just thrilled to see you engage pharmacy. This is perfect lead in because CTC is going to launch a pharmacist lead project projects to support that, in the best practice sharing to do just that, to focus on utilization so you all are ahead of that curve. ○ Great Report Dr. Gates Mrs. Nieves! Do you feel these could be socio economic patterns? ○ It has been very challenging to increase the number of bi-lingual CDOEs over the years. Still remains an issue.

			○ Great presentation - curious if you've been able to overlay SDoH data to understand root causes such as food insecurity, etc.? ○ Addressing workforce issues is important - identifying the gaps and then a strategy by state for workforce development. It'd be good to have a report from DLT soon about how the funds for workforce development are being used (as part of larger strategic plan to recruit multi-lingual health care providers across the spectrum of need, provide pathways to different health care jobs, etc. ○ Curious to find out if URI and other Pharm schools have acknowledged the care management career path for Pharm graduates. Pharmacists are highly trusted by patients and can be very effective counsellors as Lillian and Jonathan are showing. ○ Great work! This work is very detailed and positively impacting patients- thank you. Concrete actions (Sick kit) and professional engagement (PharmD, CDOE, MD) to simplify the patient experience and improve outcomes. ○ The URI Pharmacy school is an HSTP partner and would certainly be interested and available to work with AEs on diabetes education and related interventions. MJ Kanaczet runs their CE programs and would be a good person to contact. ○ Great work! A physician and pharmacist champion are key. ○ What about the TCOC benefit? It seems you are on track to go down that avenue. ○ Great work. Interested to know how age, living arrangement (alone, with other), language, etc. impacts the work… and outcomes ○ CTC and RIDOH have been collaborating with URI pharmacy, Steve Kogut and others to promote compacts as well as increased engagement of pharmacists - great info. ○ **Libby Bunzli**: I just want to say again, thank you, thank you so much, Dr Gates and Lillian for your willingness to present this to the Advisory Committee when we're reviewing the performance improvement plans we were really impressed by a number of things that kind of came together in this the use of data, the drilling down to very specific population that you chose to focus on, the robust engagement approach, the Multi-disciplinary care team and having a workforce that was multicultural, multilingual to really engage your members and meet them where they are so I'm very glad that you agreed to participate and share this with a wide audience, so thank you so much, I will pause and see if anyone has any final questions or public comment before we wrap up today's meeting. ○ The next obvious question is going to be the total cost of care benefit because you touched on just the ER and that's a drop in the bucket. Looking at the total cost of care I think you're on a roadmap to be able to take more risk in that avenue, because you have that proactive control of the members. Are you going to go down that avenue to work with the payers to get the complete picture on

			the total cost of care and that avenue, because I think there's some definite impact there. ○ **Dr. Gates**: I would like to sort this by the total cost of care, I think we came at it from a clinical perspective that the avoidable ER was really a byproduct of suboptimal management of those patients not being able to manage themselves well, to me that was the driver. I think you're right by reducing the number of medications that complexity and getting better outcomes on those quality measures should possibly impact the cost of care. Data has shown three to four hundred fewer limbs amputated within two years of putting this approach in place, so it has real benefit to people's lives and it does scale up. I think we will continue to push on this population with Lillian and more advanced efforts. I think this just underscores that in the right patients, it can make a big difference in total cost of care, as well as their quality of life, so I hope see more of this kind of intervention being recognized and supported fiscally by these kinds of arrangements and contracts.
Adjourn			Meeting adjourned at approximately 10:30 a.m. The next AE Advisory Council Open Discussion Meeting is scheduled for Thursday, April 1, 2021 8:30-10:30 a.m. Venue to be announced.

Meeting Participants: Marti Rosenberg (EOHHS), Barry Fabius (UHC), Matthew Harvey (Integra), Shamus Durac (RIPIN), Mellissa Campbell (RIHCA), Kristin Sousa (EOHHS), Ray Parris (PCHC), Sandy Pardus (BVCHCM), Holly Garvey (Integra), Debra Hurwitz (CTC-RI), Garry Bliss (PHSRI), Shannon Boyd (Coastal Medical), Lori Meo (UHC), Rick Brooks (EOHHS), Domenic Delmonico (Tufts Health Plan), Linda Cabral (CTC-RI), Stacey Aguiar (UHC), Marea Tumber (OHIC), Chris Dooley (Prospect CharterCARE), Sam Salganik (RIPIN), Susanne Campbell (CTC/PCMH Kids), Donna Marshall (UHC), Merrill Thomas (Providence Community Health Centers), Nancy Sutton (RIDOH), Chris Gadbois (CareLink), Sandy Curtis (UHC), Beth Marootian (NHPRI), Patrice Cooper (UHC), John Minichiello (Integra), Pano Yeracaris (CTC-RI), Al Kurose (Coastal Medical), Jill Glickman (CTC-RI), Jonathan Mudge (Blackstone Valley Community Health Center) Libby Bunzli (EOHHS); Amy Katzen (EOHHS), Jennifer Marsocci (EOHHS), Debbie Morales (EOHHS); Ryan Erickson (BHDDH); Pano Yeracaris (CTC); Yajaira Almonte (Coastal Medical); Donna Marshall (UHP); Olivia King (BHDDH); Randi Belhumeur (RIDOH); Monica Broughton (UHP); Debra Reakes (Coastal Medical); Jerry Fingerut (EOHHS); Christopher Ottiano (NHPRI); Gary D'Orsi (IHP); Samantha Morton (MLPB); Chris Ausura (RIDOH); Jeannine Casselman (MLPB); Emily Corbett (FSRI); Juan Lopera (Tufts); Rebecca Plonsky (IHP); Steve Odell (Prospect); Marie Palumbo-Hayes (FSRI); Pam Jennings (PBC)