



# Transforming Primary Care in Rhode Island



2015 Annual Report

We dedicate this report to Deidre Gifford, MD, the founder of our Collaborative, whose dedication from 2006-2015 led us to becoming the longest-running multi-payer patient-centered medical home initiative in the country.

We are forever grateful for your leadership and commitment to transforming care in Rhode Island.



*“Whatever we do, with whatever we have, we leave behind us a legacy for those who follow.”*

*Stephen Covey*

## Celebrating a year of transformation and impact

Thank you for taking the time to join us as we reflect on 2015, and provide an update on the progress of the Care Transformation Collaborative of Rhode Island.

Since our initial five pilot practices launched in 2008, we have grown to include more than 80 primary care practices of all sizes across the state.

We have proudly grown to include pediatric practices, by integrating with the patient-centered medical home pediatric initiative, PCMH-Kids. We now have an increased focus on supporting the health care needs of children and families as our nine new pilot practices work to transform pediatric primary care.

Throughout the year, our efforts were focused on finding new and effective ways to support the needs of all patients – particularly those with complex care needs, like multiple medical, behavioral health, and social service needs.

By integrating behavioral health clinicians into the primary care setting, we have begun moving toward reducing behavioral health disparities and increasing access to behavioral health services for thousands of Rhode Islanders.

We have also extended the reach of the primary care team into the neighborhood. Our Community Health Teams are in the field focused on addressing social determinants of health, often for our most vulnerable populations. The impact of this work has been life-changing for some, and we look forward to expanding this model state-wide.

Our Collaborative is not just making waves in Rhode Island – our success has been recognized nationally.

The Centers for Medicare & Medicaid Services' April 2016 report, *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration*, highlights the return-on-investment for states involved in the Multi-Payer Advanced Primary Care Practice Demonstration, which evaluates whether advanced primary care practices reduce unnecessary utilization and expenditures, and improve the safety, effectiveness, timeliness, and efficiency of health care. Rhode Island

demonstrated the second highest return on investment when comparing Medicare expenditures and utilization rates for the first two years of the evaluation.

Further, the Commonwealth Fund's 2015 report, *Scorecard on State Health System Performance*, shines a spotlight on Rhode Island's advancing primary care efforts. After evaluating all states, Rhode Island was ranked among the top ten states overall across all 42 measures of primary care performance, with noteworthy rankings in prevention and treatment (3rd leading state) and care access and affordability (4th leading state), among others.

In this annual report, we are pleased to share evidence of our success at the state level, like reduced inpatient hospitalizations and increased tobacco cessation counseling. But it's not just numbers that indicate our efforts are working. Our care teams have shared countless stories that demonstrate the first-hand impact of our programs, and we look forward to sharing some of these with you.

Thank you to all who have played an important role in the development and progress of this Collaborative. With every new idea and effort, together, we are re-defining primary care in Rhode Island through practice transformation.

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# Shaping Rhode Island's primary care landscape

## Who We Are

The Care Transformation Collaborative of Rhode Island is working with all major health care stakeholders to transform primary care in our state. Initially convened by the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, we promote the patient-centered medical home, a model of primary care that provides patients and families with care that is accessible, focused on their needs, supported by a primary care team and is coordinated with the medical neighborhood.

## What We Do

We provide technical assistance and training to promote integrated, patient- and family-centered care, data driven quality improvement, and prepare practices to perform successfully under Alternative Payment Models. As a statewide learning collaborative, we facilitate the sharing of best practices in primary care and integration with specialists/health systems and provide a platform for testing and evaluating new models that improve population health. We strive to align our primary care program with State, Federal and public/private initiatives and inform health care system transformation.

## Our 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.

## Our Mission

To lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations we serve.

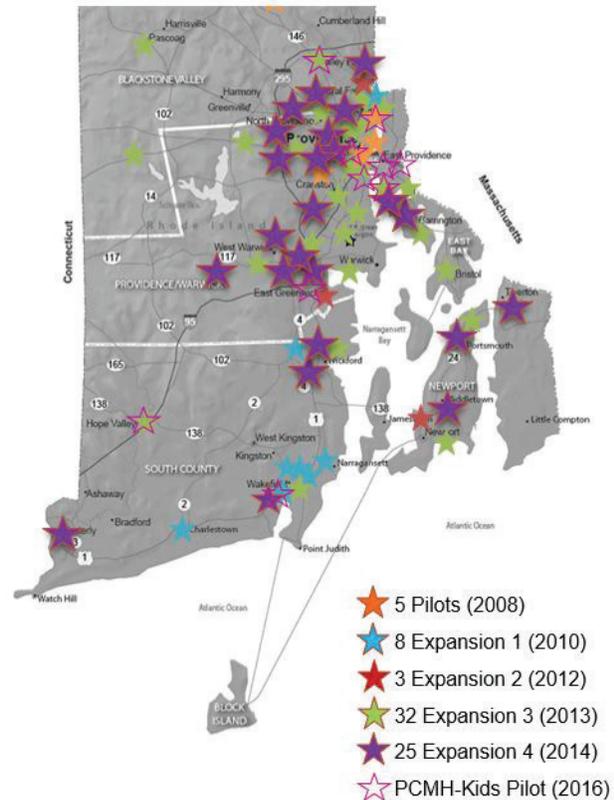
## 2015 Priorities

- **Improving the cost of care and efficiency** – through new programs like our Advanced Collaborative, practices developed and implemented projects focused on improving quality and reducing costs of care.
- **Evaluating, refining and scaling our Community Health Teams** – we evaluated the progress of these pilot programs and look forward to building off their successes and lessons learned.
- **Expanding to include additional practices** – we have proudly expanded our Collaborative to include pediatric practices, with an increased focus on the needs of children and families.
- **Integrating behavioral health care** – we took big steps forward to improve access to behavioral health services within primary care.
- **Expanding our learning curriculum** – through ongoing best practice sharing, learning sessions and workshops, we continue to advance our Collaborative through shared learning, leadership development, collaboration, and growth.
- **Improving data analytic capability** – we began working toward transitioning to an all-payer claims database to evaluate our practices and programs, increasing actionable reports to practices to support continued progress.

# Growing access to patient-centered medical homes across Rhode Island

In 2015, our Collaborative supported the delivery of high-quality patient-centered care across more communities in Rhode Island.

- ✓ 73 adult primary care practice sites
- ✓ 9 pediatric pilot practices
- ✓ 522 providers across our adult and pediatric practices
- ✓ Supporting patient-centered medical homes in 26 cities and town
- ✓ More than 300,000 adult patients
- ✓ 30,000 pediatric patients
- ✓ Includes all R.I. Federally Qualified Health Centers



- Affinity Brookside Family Medicine
- Affinity Primary Medical Group
- Affinity-Family Medicine at Women's Care
- Anchor Medical Associates (Lincoln, Providence, Warwick)
- Anchor Medical Associates Pediatrics
- Arcand Family Medicine
- Associates in Primary Care Medicine
- Barrington Family Medicine
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- Charter Care Medical Associates
- Coastal Medical (East Providence, Narragansett, Pawtucket (Hillside), Providence, and Wakefield)
- Coastal Narragansett Bay Pediatrics
- Coastal Waterman Pediatrics
- Comprehensive Community Action Program (Cranston, Coventry, Warwick)
- Coventry Primary Care Associates
- East Bay Community Action Program (East Providence, Newport)
- East Greenwich Pediatrics
- Family Health and Sports Medicine

- Hasbro Pediatric Primary Care
- Hasbro Medicine-Pediatric Primary Care Clinic
- Internal Medicine Partners
- John Chaffey, DO, Ltd.
- Kristine Cuniff, MD
- Medical Associates of Rhode Island (Barrington and Bristol)
- Memorial Hospital Family Care Center
- Memorial Hospital Internal Medicine Center
- Nardone Medical Associates
- North Kingstown Family Practice
- Ocean State Medical
- Pediatric Associates
- Primary Care of Barrington
- Providence Community Health Centers (Capitol Hill, Central, Chad Brown, Chafee, Crossroads, North Main St., Olneyville, and Prairie Ave.)
- Richard Del Sesto, MS, MD, Ltd.
- Solmaz Behdash, DO
- SouthCoast Health System Linden Tree Health Center
- SouthCoast Health System Tiverton Family Practice
- SouthCoast Health System Family Medical Middletown
- SouthCoast Health System Family Medical Center

- South County Hospital Family Medicine
- South County Hospital Primary Care and Internal Medicine (Wakefield and Westerly)
- South County Internal Medicine
- South County Walk-In and Primary Care
- Stuart Demirs, MD
- Thundermist Health Center (Wakefield, West Warwick, Woonsocket)
- Tri-Town Community Action Program
- University Family Medicine
- University Internal Medicine
- University Medicine (Pawtucket, Governor St., North Main St., East Ave., East Providence, Plain St., Warwick)
- University Medicine-Aquidneck Medical Associates (Newport and Portsmouth)
- WellOne Primary Medical and Dental Care (Foster, North Kingstown, and Pascoag)
- Wickford Family Medicine
- Women's Primary Care, Women's Medicine Collaborative
- Wood River Health Services

## Expanding in pediatrics



### PCMH-Kids Pilot Practices Selected

In April 2015, nine primary care practices joined the pilot cohort of PCMH-Kids to spread the CTC collaborative model of transformation to practices serving children.

A sub-group of the PCMH-Kids Stakeholder Committee, including physicians, payers, community organizations, state agencies, and consumer representatives, reviewed applications and selected the diverse pilot cohort. The practices represent a mix of Federally Qualified Health Centers, hospital-based clinics, and small and large physician practices throughout the state. Totalling 70 providers serving approximately 30,000 children, the practices support a significant proportion of the Medicaid population (approximately 14,000 children) and children with special health care needs.

### Establishing a Pediatric Common Contract

The most significant accomplishment of 2015 was the establishment of a pediatric 'Common Contract.' The pilot cohort came together with the health plans to negotiate payment for and expectations of transformation. PCMH-Kids used the construct and experience of the CTC Developmental Contract as a base, while making adjustments to best reflect pediatric care. For example, the greater needs of children are often less dependent on a medical diagnosis and more about the social and behavioral needs of the family unit. Therefore, PCMH-Kids established expectations of care coordination that may be filled by a variety of roles, like a licensed social worker or peer navigator.

The PCMH-Kids Common Contract will be effective January 1, 2016 – December 31, 2018. Through payment incentives, practices are expected to hire or designate staff to coordinate care; achieve National Committee of Quality Assurance (NCQA) PCMH recognition; engage in learning and training; report on two clinical quality measures from the electronic health record; and improve on measures of clinical quality, patient experience, and utilization.

### Supporting Transformation

In fall 2015, the pilot practices began to engage in practice facilitation with Healthcentric Advisors coaches. Among many on-site support services, coaches help practices achieve NCQA PCMH recognition, produce clinical quality reports, and integrate a care coordinator, to name a few.

Practice facilitation services will continue throughout each practice's term in the Common Contract, depending on their transformation needs. In 2016, practices will join existing CTC collaborative learning opportunities, such as best practice sharing meetings and annual learning collaboratives. Practices will also begin to report and target quality improvement efforts on clinical measures regarding childhood obesity and early developmental screening.

### Addressing the Community Health Needs of Children

To improve care coordination for the neediest children and their families, PCMH-Kids worked with the state Medicaid Office to improve the relationships between the pediatric offices and the Cedar Family Centers. As the state-designated health homes, Cedars are multi-disciplinary teams that can serve as an extension of the primary care office (also termed a "community health team") to coordinate care for children and youth with special health care needs and their families. Practices and Cedars are developing collaborative and co-located relationships to co-manage shared patients.

## Hasbro Pediatric Primary Care Clinic provides new levels of support

The Hasbro Pediatric Primary Care Clinic – located within Hasbro Children's Hospital – serves roughly 10,000 children, of which more than 90% are low-income and covered by Medicaid.

For years, the practice has intentionally focused on building up its partnerships and resources to best support their low-income families. A lawyer and paralegal work within the practice, for example, to help address issues that affect families' welfare, like access to housing and benefits. On-site Brown University undergraduate students work to connect families with existing community resources, like daycares, summer camps, or nutrition assistance programs.

A new partnership with Cedar Health Home services is helping families address challenges that affect their health care. Previously, clinicians at Hasbro would refer families to Cedar externally. Left to navigate the system on their own, less than half of the referrals followed through. Pediatricians often wondered if families ever made it there or how Cedar may be addressing their needs.

Now, two Cedar clinicians, a psychologist and a social worker, are directly imbedded into the pediatric practice. They take a hands-on community approach to supporting families that struggle with different life circumstances. The staff meets jointly with primary care providers and families to help formulate care plans and set goals.

*"It's allowed us to have a tremendous, different approach to supporting our families," said Dr. Patricia Flanagan, Provider Champion at Hasbro Pediatric Primary Care Clinic. "Having Cedar staff here has been a game changer."*

Each month, the integrated Cedar staff supports the special health care needs of about 60 families. One patient story, on the right, helps showcase this critical support.



Cedar clinicians, Richard Archambault, MS Ed. D and Maura Taylor, PT, MBA meet with pediatrician Dr. Patricia Flanagan to discuss a patient care plan.

### Addressing a child's health needs through family support

A single mother ("Carla") with five children who attends Hasbro Pediatric Primary Care Clinic feels she has now become a more active participant in her children's welfare.

One of her elementary school-aged children ("Sam") was struggling significantly in school. Intimidated by the school system, Carla was unsure how to address this struggle that was impacting Sam's overall wellness and success. But between balancing several part-time, unpredictable job schedules, and caring for her five children, following-up on Sam's school problem was tough to manage.

The primary care team introduced Carla to the on-site Cedar clinician to discuss Sam's challenge. Within two weeks, Cedar staff met with teachers at Sam's school alongside Carla, helped coordinate a learning assessment, an IEP meeting, and a neuropsychic evaluation. The Cedar clinician and Carla outlined a plan to help Sam succeed in school and avoid repeating a grade again.

This support empowered Carla to ask questions about Sam's condition, advocate for his needs, and feel more comfortable interacting with the school system. She is learning her child's strengths and weaknesses, and importantly, feels like she is finally being heard.

## New pilot program seeks to remove behavioral health barriers, serve more patients

For some Rhode Islanders living with depression, anxiety or substance-use disorder, communicating a need for help – or finding help – is not always easy. That’s why in 2015, the Care Transformation Collaborative of Rhode Island, with funding from Tufts Health Plan, began planning a new approach to addressing patient barriers to behavioral healthcare by identifying and treating patients in the primary care setting.

Patients living with unidentified behavioral health conditions experience safety risks, avoidable and costly emergency department visits and hospitalizations, and a negative impact on their quality of life. Through our efforts, we hope to increase access to screening and therefore identification of individuals who suffer from untreated behavioral health conditions.

The Rhode Foundation’s Fund for a Healthy Rhode Island provided our Collaborative with a \$600,000 grant to take these efforts a step further and launch a two-phased pilot program in 2016. The pilots recognize and build off of the trusted relationship patients have with their primary care teams, and introduce behavioral health treatment into the primary care setting.

Six participating practices have begun universal screenings for mental health and substance-use disorders for all patients in their practices. Those who are identified as having moderate depression, anxiety, substance-use disorder, or co-occurring chronic conditions are then connected to a behavioral health provider within the practice. Patients receive treatment, and if they are in need of ongoing care, are connected with the appropriate long-term treatment team.

Our Collaborative hopes to help patients overcome obstacles that have previously stood in the way of behavioral health services. Examples of individuals who may benefit from the pilot program may be a patient with diabetes who is struggling to cope with motivation to change, or a patient with increased anxiety who would not typically follow through on a referral to a traditional therapist.

Working with researchers at Brown University, data from the pilot program will be evaluated to understand potential cost savings, efficiency, and improved access to behavioral health services. Importantly, evaluations will also help determine overall quality of care and improvement in quality of life for patients. Pilot results will help determine if similar efforts should be expanded throughout the state.

### Pilot Phase 1 (January 2016 launch):

- Associates in Primary Care Medicine
- East Bay Community Action Program – East Providence
- East Bay Community Action Program – Newport
- Providence Community Health Center – Chafee
- Tri-Town Community Action Agency
- The Women’s Medicine Collaborative

### Pilot Phase 2 (November 2016 launch):

- Affinity – Family Medicine at Women’s Care
- Coastal Medical – Hillside Family Medicine
- Family Care Center – Memorial Hospital of RI – Capitol Hill
- Providence Community Health Center – Prairie Avenue
- University Medicine – Governor Street
- Wood River Health Services

*“Through this new pilot program, we’re sending the message that behavioral and physical health are equal contributors to a patient’s overall health.”*

*Nelly Burdette, PsyD*

*Integrated Behavioral Health Practice Facilitator, CTC  
Director of Integrated Behavioral Health, Providence Community Health Centers*

## Empowering patients at the Women's Medicine Collaborative

At the Women's Medicine Collaborative, a large multi-disciplinary practice in Providence that has entered the first phase of the pilot program, primary care patients obtain universal behavioral health screening and are connected with Ph.D.-level behavioral health clinicians. The program also has an active residency program with The Warren Alpert Medical School of Brown University.

"I have worked with numerous patients in the primary care office who were experiencing depression triggered by work difficulties," said Margaret Bublitz, Ph.D., a psychologist in Women's Behavioral Medicine at the Women's Medicine Collaborative. "Patients were either in very stressful jobs or struggling to find a job. Their depressive symptoms made it very difficult for them to make a change because they had difficulty concentrating, were excessively fatigued, and felt hopelessness. In primary care, patients are receiving behavioral health interventions that enabled them to reduce stress, improve sleep, and decrease their depressive symptoms to an extent that they felt capable of finding new jobs."

"What is really exciting about this initiative is our ability to work as a team to improve patients' overall wellbeing in a primary care setting," said Joanna MacLean, M.D., a psychiatrist in Women's Behavioral Medicine at the Women's Medicine Collaborative. "We're offering patient-centered behavioral health treatment in collaboration with primary care to help patients achieve their individual goals. As a result, we're able to provide both physical and mental health care in a setting that's comfortable for patients and increases engagement and improves outcomes."



Margaret Bublitz, right, a behavioral-medicine psychologist at the Women's Medicine Collaborative, speaks with a care team member. Photo by Michael Salerno.

## Expanding integration at Associates in Primary Care Medicine

At Associates in Primary Care Medicine in Warwick, before entering the first phase of the pilot program, the mid-sized private practice recognized a need for some patients to receive on-site behavioral health services. They welcomed a psychologist to their office for a half-day every couple of weeks to do intake referrals, and patients would then follow-up off-site. Now, through CTC's pilot program, a psychologist is at Associates in Primary Care Medicine three half-days each week. As a member of the care team, the psychologist sees about eight patients daily, makes notes directly into patient electronic medical records, and even offers same-day visits.

*"The integrated behavioral health program has greatly improved the care we are providing to our patients. Our patients are more comfortable with a mental health referral after meeting the specialist and being introduced by their primary care provider," said Martin Kerzer, D.O. at Associates in Primary Care Medicine. "Being able to stay in their medical home has greatly improved access, and we are now able to address barriers in our patients' physical health through the integrated behavioral program."*

## Growing the success of Community Health Teams

Our Community Health Team pilots were launched in 2014 to address the challenges many practices faced supporting patients with complex care needs, like those with multiple medical and social needs, or behavioral health service needs.

Funded by the state's health insurers, the program consisted of two pilots located in South County (10 participating practices) and Blackstone Valley (5 participating practices).

The Community Health Team (CHT) program deploys care coordination teams to help connect and engage patients with their primary care teams, social service providers, behavioral health providers and other care providers. Through the CHTs, practices can better care for patients needing extra support, particularly those with consistently high spending patterns, like frequent ED visits and hospitalizations.

In 2015, we contracted with Brown University's Warren Alpert Medical School faculty member, Dr. Roberta Goldman, and May Street Consultants to evaluate the CHT pilot program. According to the evaluation, patients received an abundance of support from the CHTs, such as:

- Moral support and anxiety reduction through home visits, phone calls, preparing patients for medical visits, and accompanying patients at medical and legal appointments
- Connection to basic needs support, like food, transportation, and clothing
- Application assistance (i.e. housing, health insurance, social security, welfare, food stamps, long-term disability)
- Connection to behavioral health support (for help with alcohol abuse, tobacco cessation, stabilizing home situations, and improving healthy relationships)
- Emergency department avoidance strategies, or home contact following ED visits or hospitalizations
- Encouragement to ask for help, and coaching to deal with the medical system and speak to providers

### Supporting a family through difficult times

A man in his 40s ("Michael"), faced an array of challenging health conditions, including diabetes, obesity, asthma, hypertension, anxiety, and depression. Michael, his wife, and their three children were homeless, and temporarily staying with family.

Michael's health conditions prevented him from working. His family relied on DHS and SNAP benefits, as well as his wife's inconsistent part-time income, though she faced possible deportation.

Michael showed acute stress, which interfered with his diabetes management and exacerbated his depression and anxiety. He suffered multiple episodes of hypoglycemia each week – some so severe he was found unconscious and rushed to the ED.

After moving into a small apartment, Michael's family could not afford furniture and slept on the floor. After a Community Health Team (CHT) was engaged, the family received free mattresses and furniture from a community agency. Unfortunately, his family's SNAP

benefits were discontinued and they did not have enough food. Michael began skipping meals after administering insulin and experiencing hypoglycemia. The CHT assisted Michael with applications to local food banks, and a nurse care manager helped instruct Michael on a proper insulin routine.

Michael's family struggled particularly in the winter months. They relied on a space heater to stay warm, which led to their electricity being shut off when the bill became unaffordable. This put Michael's family at risk, and kept his insulin from refrigeration. The CHT helped Michael submit documentation for service reinstatement, and apply for public housing. They also helped connect Michael's family to legal services, which eventually helped grant his wife permission to stay in the country.

Now, Michael reports to be doing better. His glucometer readings are less variable, but still faces some low readings. He is scheduled for a re-assessment with his CHT, where his health and life conditions will be further evaluated and supported.

*\*Names in stories have been changed to protect the identity of individuals.*

## Teaching self-management to reduce ED usage

A middle-aged, commercially insured patient (“Tim”) living alone, has been unemployed in recent years due to a back injury. Tim has a wide-range of health challenges related to uncontrolled diabetes, alcohol addiction, and pancreatitis. In just two years, Tim visited the emergency department 25 times and had 17 inpatient hospitalizations related to problems regulating his diabetes and alcohol abuse, complicated by chronic pain. He was not adhering to self-care steps, and had poor follow-through with needed at-home skilled nursing support. This led to a severe injury and partial foot amputation.

A community health team (CHT) engaged Tim and coordinated with his primary care team, a pharmacy team, and diabetes clinic. Support for Tim was shifted to

prioritize self-care, diet, nutrition, disability application support, overall treatment adherence, and support for addiction. The CHT began organizing frequent meetings with nearby family members to help support Tim at home. This led to him becoming more cooperative with home care, leading to more consistency with in-home skilled nursing, wound care, and physical therapy, which helped with gastrointestinal issues and wound healing.

Less than a year later, Tim was abstinent from alcohol, and had monthly CHT visits to help learn better self-management strategies. He became more compliant with an insulin regimen, leading to fewer episodes of hypo/hyperglycemia. The following year, Tim had just three ED visits and no inpatient hospital admissions.

## Helping an elderly woman regain her independence

An elderly woman (“Nancy”) with a complex medical history was referred to a Community Health Team (CHT) for support.

Once an independent business woman who served in the military, as she aged, Nancy moved into subsidized elderly housing. She suffered from coronary artery disease, high blood pressure, neuropathy, alcohol abuse, and chronic back pain. Caring for herself and managing her pain proved challenging.

As she struggled with her health conditions, Nancy also had difficulty completing applications, which jeopardized her Medicaid eligibility. She was also at risk of losing her vehicle registration because she could no longer afford automobile insurance.

A CHT stepped in, and helped Nancy apply for transportation assistance and services through the Veterans Administration and Meals on Wheels. Nancy now receives home-based medical support, personal care, and housekeeping help.

After screening positive for depression, Nancy was offered health coaching through Pro-Change, a program that allows phone-based counselors to easily provide behavior change guidance.

Nancy is now on track to better manage her health. From a new pill box to assist with medication compliance to a swimming routine (with transportation provided by her CNA), Nancy has already begun losing weight and enjoying a more active lifestyle.

*\*Names in stories have been changed to protect the identity of individuals.*

**After 18 months, the Community Health Teams have estimated nearly \$379,000 in cost avoidance.**

**Moving forward, to build on and expand CHTs in Rhode Island, we will focus on:**

- Introducing centralized program management to provide consistent oversight and create capacity for expansion

- Standardize policies and procedures for CHTs to better support consistency and evaluation
- Launch a centralized data infrastructure to enhance and maintain CHT service documentation and data analysis

### Community Health Teams Cost Avoidance (Over 18 Months)

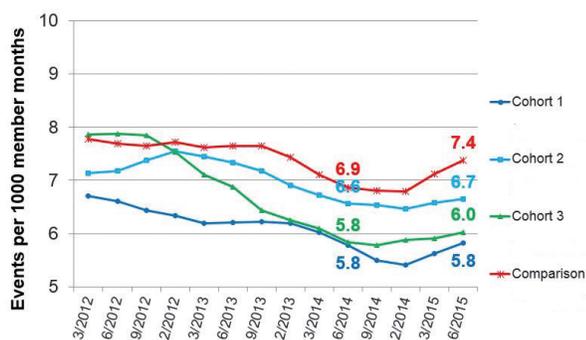
Community Health Teams	Crisis Interventions	ED Diversions	Average Cost Per Inpatient Admission	Average Cost Per ED Visit	Inpatient Cost Avoidance	ED Cost Avoidance	Total Cost Avoidance
Total Cost Avoidance	30	27	\$12,000	\$700	\$360,000	\$18,900	\$378,900

## 2015 Highlights by the numbers

The Rhode Island Quality Institute works with our Collaborative to implement a dedicated measurement and reporting infrastructure for our practices, which supports practice efforts to meet performance benchmarks and collaborate around best practices. Below are some 2015 CTC data highlights.

### Reduced Inpatient Hospital Admissions

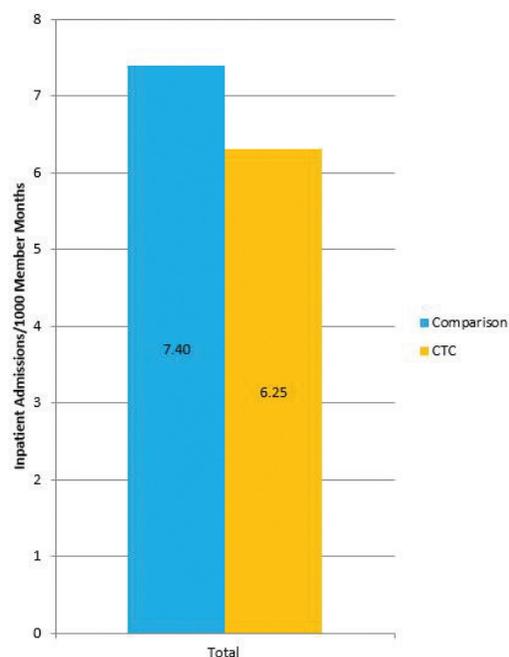
Since 2012, we have tracked the number of inpatient hospitalizations attributed to our practices, organized in three cohorts. Compared to non-CTC practices, all three cohorts March 2012-June 2015 have greater reduction rates of patient hospital admissions (from all causes) than the comparison group.



\*Includes Blue Cross and Blue Shield of Rhode Island, UnitedHealthcare, and Neighborhood Health Plan of Rhode Island data. Does not include Medicaid or Medicare FFS data or RHO Dual Eligible NHP members.

### Inpatient Hospital Cost Savings

CTC practices also demonstrated inpatient savings for Fiscal Year 2015. Practices have shown less inpatient hospitalizations than the comparison group, translating to significant cost savings shown below.



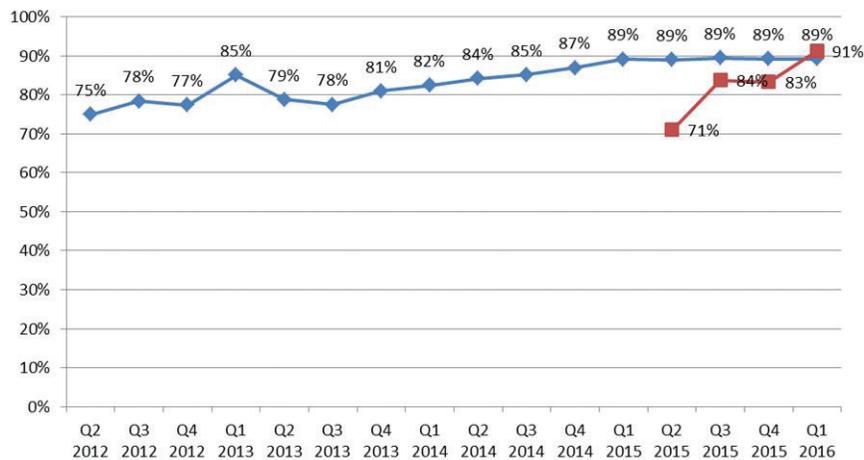
### “Transitions of Care” program reducing hospital re-admissions

At Coastal Medical, which has four practices in CTC, they realized how much time nurse care managers were spending managing transitions of care for patients who frequented the hospital. Coastal developed a new Transitions of Care (TOC) program that utilizes a multi-disciplinary team of nurse care managers, clinical pharmacists, nurses, and medical assistants to coordinate the care of patients discharged from hospitals and skilled nursing facilities. The TOC team enhances communication between clinicians, which in turn reduces care fragmentation and improves a patient’s care experience. Leading goals of the program are effective and timely follow-up with patients after hospitalizations, coordination of follow-up office visits, and medication reconciliation. Through these efforts, Coastal hopes to demonstrate a 10% decrease in hospital readmissions. The TOC program also allows the office-based nurse care managers to focus more exclusively on management of their care of high risk patients.

Difference in Admissions/1000 MM	1.15
Total CTC Member Months	1,538,538
Difference in number of Admissions (1.15 x 1,538,538 MM/1000)	1769
Average Cost per Admission*	\$12,000
<b>CTC Savings</b>	<b>\$21,231,824</b>
Total Program costs (2015-2016)**	\$15,754,793
<b>Net Savings</b>	<b>\$5,477,031</b>

\*Cost per Admission = 60<sup>th</sup> percentile; vs mean=\$14k; Median=\$10k  
\*\*Total Program Cost include CTC Admin, CHTs and Practice Payments paid by health plans

## Practices demonstrate greater tobacco counseling / cessation rates



(Blue = CTC practices average, red = Dr. Behtash's practice)

Effective tobacco cessation interventions help advance our state's overall health care system by improving the health of individuals, and reducing costs.

To gauge tobacco usage in our practices, we collect practice data on patient tobacco usage and cessation counseling.

### Small practice tackles tobacco cessation

A single-physician practice in Pawtucket, R.I. led by Dr. Solmaz Behtash, joined the Care Transformation Collaborative of R.I. in January 2015.

Concerned by the number of patients that were significant smokers, Dr. Behtash wanted to do more than recommend counseling to help her patients quit. After one patient mentioned his past success in a group-structured environment, Dr. Behtash began searching the area for support groups he could join to help quit again, with no luck.

That's when Dr. Behtash decided to form her own tobacco cessation group within her practice. With the support of her nurse care manager, they began compiling lists of known patient smokers. They outreached directly to the patients through letters and messages on the patient portal, and personal phone calls to those who would potentially be interested.

Soon after, with eight interested patients, her first tobacco cessation support group launched in her practice, meeting every Saturday morning for several months. Consistently, a couple of patients attended and the dynamic worked well.

The group took a team-based approach to cessation, providing an avenue to discuss common challenges, new strategies, and successes. *"We were lucky – they had a lot in common," said Dr. Behtash, referring to the participants. "They were committed, and they were able to quit together."*

For one patient in particular, quitting smoking provided a new path toward greater self-improvement. The patient began focusing on nutrition, exercise, and independence.

*"His whole life has since changed," said Dr. Behtash. "It all started with him throwing his pack of cigarettes away."*

Through the group sessions and weekly curriculum, Dr. Behtash believes she has further developed her own counseling skills, which she can apply across her practice to help support all of her patients and their diverse health needs. Now, one patient who found success through the support group would like to help others quit smoking. Dr. Behtash plans to launch another tobacco cessation group soon, led by her motivated patient.

## Practices show greater behavioral health comprehensiveness

Our practices utilize a uniform healthcare survey designed to evaluate a patient's primary care experience. The survey covers topics that are important to patients, like provider communication skills or ease of access to services, and helps evaluate practices on a wide-range of issues.

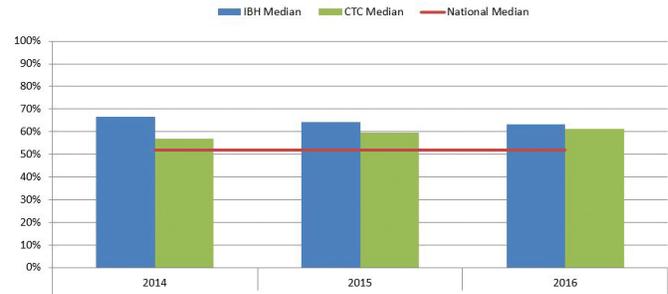
Regarding patient comprehensiveness in behavioral health, patients are asked questions to determine if providers have engaged with them regarding feelings of sadness or depression, and things that may cause stress, drug use, and more.

Compared to the national benchmark, CTC practices excel in this category. More specifically, when reviewing our practices that participated in a pilot integrated behavioral health program in 2015, these practices were the highest performing.

## Teaming up to reduce unnecessary health care costs

In addition to identifying and working toward reducing significant cost drivers, like avoidable inpatient hospitalizations, many CTC practices are working to find more ways to reduce costs for patients and providers at the practice level.

### Comprehensiveness - Adult Behavioral CTC practices (particularly those with Integrated Behavioral Health) outperform national benchmark



Through Tufts Health Plan funding, select practices were given support to improve their staff capacity to provide integrated behavioral health services through new education and training opportunities. Advanced technology tools were made available to target behavioral change and improve patient engagement. Further, this work supported an expansion of the state's behavioral health referral network, used by primary care teams to refer patients to behavioral health specialists or addiction disorder specialists.

## Pharmacy partnership works to cut prescription price tag for patients

Patients living with high cholesterol are at risk of serious heart conditions. Statins, a class of drugs prescribed to help combat this condition, can help reduce a patient's risk of heart attack and stroke when diet and exercise alone are not enough.

Current guidelines recommend dosing statins based on the intensity level needed by each individual patient, and place statins into classes based on their varying potency. CRESTOR®, a statin prescription medication commonly dosed at moderate intensity, can be quite costly for patients compared to other moderate intensity statins.

South County Family Care East Greenwich, a small, private "Advanced Collaborative" CTC practice affiliated with South County Hospital, launched a unique pharmacy partnership in 2015 to help reduce the overall cost of prescription medications.

Through the collaboration, pharmacists review patient charts to determine potential candidates who may benefit from converting from moderate intensity CRESTOR® to another moderate intensity statin with a lower price tag. The pharmacists then consult the patient candidates on the opportunity to save money while remaining on the appropriate statin level.

Once patients are comfortable with converting, the pharmacists then work with the primary care practice providers to convert the medication when acceptable. Once a switch is made, the pharmacists follow-up with each patient on their medication compliance, ensure follow-up blood work is taken, and support their clinical success.

This innovative pharmacy conversion collaboration has helped 19 patients successfully convert off of moderate intensity CRESTOR®, saving each patient roughly \$2,400 annually, with a \$45,000 total annual cost savings.

## Developing best practices through shared learning and collaboration

### Annual Learning Collaborative brings together local and national experts

In November 2015, we hosted our annual Learning Collaborative, which brought together national and local health care experts focused on patient engagement and empowerment, identification of patients with complex care needs, and shared decision making. As an integral component of our primary care practices, a patient-focused approach to care can increase the likelihood patients will stick to treatment recommendations, and improve health outcomes.

Among the many insightful presentations and workshops, speakers focused on best-practice sharing, and included experts from Mayo Clinic, Cambridge Health Alliance on building a complex care management program, and Boston Children's Hospital on engaging children and families in care plan development.

As our practices provide care for Rhode Islanders throughout the state, and are increasing our focus on children and families, learning from regional experts provided care teams with valuable insight and tools to that could be integrated into their individual practices.



*CTC practice care team members shown above at the November 12, 2015 Learning Collaborative*

### Leading the state in collaborative learning to advance primary care

Collaboration and best practice sharing play an integral role in our Collaborative, providing opportunities to help advance our work and discover new approaches to complex care system challenges.

In 2015, the "Advanced Collaborative" was formed with representatives from the initial 15 CTC practices. These practices meet monthly at the Clinical Strategy Committee to focus on sharing of best practices and improve their performance in contracts with responsibility for total cost of care and population health. These Advanced practices, in partnership with the health plans, will help chart the course for greater payment reform and clinical care improvements.

The Clinical Strategy Committee also guides the agenda for the "Breakfast of Champions" where clinical and office management leadership from our practices meet quarterly to learn about ways to apply the latest knowledge in advanced primary care, and stay informed on the state and federal regulatory environment.

In addition to this learning opportunity, in 2015, we committed to supporting nurse care managers (NCMs) by expanding opportunities for collaboration. During Nurse Recognition Week in May, in partnership with Blue Cross and Blue Shield of Rhode Island, CTC hosted a conference to support new and experienced NCMs in their evolving roles. NCMs also meet monthly to discuss new strategies and ways to tackle complex challenge experienced in many practices.

## Payment reforms drive progress

### State adopts new standards to improve care delivery and payment systems

In July 2015, the Office of the Health Insurance Commissioner (OHIC) announced the adoption of standards to “significantly align health care payment methods with efficiency and quality by setting targets for commercial health care payment reform and for continued investments in the primary care patient-centered medical home.”

The new standards stemmed from advisory committee recommendations to increase payment methods that move away from volume-based payments and reward efficiency and quality. The changed standards with options for infrastructure payment will help increase

the number of insurer-contracted primary care practices that operate as patient-centered medical homes.

Specifically, the new plan requires insurers to increase the percentage of their primary care network functioning as patient-centered medical homes by 5% for 2016, and sets a target of 80% of R.I. primary care clinicians utilizing this model by 2019. OHIC has also established payment reform targets for commercial insurers, aiming to have 30% of insured medical payments made through an alternative payment model by 2016.

These new standards are a leap forward to help improve costs, care quality and outcomes through the patient-centered medical home model of care in our state.



*Dr. Kathleen Hittner, Health Insurance Commissioner, speaks at a 2015 Care Transformation Collaborative of Rhode Island event.*

## 2015 Board of Directors

Our board of directors is responsible for setting the strategic direction and providing overall governance of our Collaborative.



*Members of the CTC Board of Directors meet in 2015*

### **Conveners/Co-Chairs**

Tom Bledsoe, MD, University Medicine (president)  
Anya Rader Wallack, Ph.D., Executive Office of  
Health and Human Services (co-chair)  
Kathleen C. Hittner, MD, Office of the Health Insurance  
Commissioner (co-chair)

### **Health Plan Representatives**

David Brumley, MD, Tufts Health Plan  
Neal Galinko, MD, UnitedHealthcare  
Gus Manocchia, MD, Blue Cross and Blue Shield of R.I.  
Tracey Cohen, MD, Neighborhood Health Plan of R.I.

### **Hospital Representatives**

Lou Giancola, South County Hospital

### **Provider Representatives**

David Bourassa, MD  
Maureen Claflin, MSN, RN (secretary)  
Patricia Flanagan, MD  
Elizabeth Lange, MD  
Al Puerini, MD  
Ken Sperber, MD  
Puneet Sud, MD

### **Employer Representatives**

Al Charbonneau, Rhode Island Business Group on  
Health (treasurer)  
Howard Dulude, Lifespan

### **At Large Representatives**

Jeffrey Borkan, MD, PhD, Alpert Medical School,  
Brown University  
Al Kurose, MD, Coastal Medical

## 2015 Staff

Responsible for the day to day management of our Collaborative.

**Debra Hurwitz**, MBA, BSN, RN Co-Director

**Pano Yeracaris**, MD, MPH Co-Director

**Susanne Campbell**, RN, MS, Senior Project Director

**Hannah Hakim**, MPH, Senior Project Manager, PCMH-Kids

**Michael Mobilio**, BS, Project Coordinator

**Michele Brown**, MPA, Project Coordinator

**Candice Brown**, BS, Project Coordinator

## Looking Ahead

2015 was an incredible year of innovation and impact for our Collaborative. As we look ahead to 2016, our work will be driven by five goals:

### **1. Assist Rhode Island's health plans in increasing the number of primary care practices that meet state PCMH Standards.**

The PCMH Standards by the Office of the Health Insurance Commissioner require insurers to increase their primary care network functioning as patient-centered medical homes by 5% for 2016, and a target of 80% of primary care clinicians in the state utilizing this model by 2019. To help meet this goal, our Collaborative will aim to support 38 practices to complete our CTC Common Contract and meet the state's PCMH standards by December 2016. We will also work to recruit 30 new adult and pediatric primary care practices in 2016 for the following year.

### **2. Participate in workforce development to increase the number of individuals qualified to become PCMH care team members.**

To meet this goal, we will develop a robust curriculum for our physician champions, enhance a new curriculum for nurse care managers and care coordinators to support patients with complex care needs, and collaborate with outside organizations, like colleges and agencies, to develop new training and certification programs for members of patient-centered medical home care teams (i.e. physicians, nurse practitioners, medical assistants, nurse care managers, physician assistants, and community health workers).

### **3. Maintain an effective multi-payer program that benefits all key stakeholders.**

We will seek approval from the Centers for Medicare and Medicaid Services for ongoing Medicare participation in multi-payer PCMH, to include all practices under our CTC Common Contract or who meet the state's definition of PCMH and accept Medicare FFS. Further, we will expand our Advanced Collaborative to include practices that meet the state's definition of PCMH.

### **4. Expand services in primary care to enhance the delivery of high-quality care that addresses physical, behavioral, and social determinants of health.**

We will pilot an integrated behavioral health business model that includes universal screening for depression, anxiety, and substance use disorders, and improves access to behavioral health. This effort will work to reduce ED visits and help discover ways to sustainably fund on-site integrated behavioral health services. We will also strengthen and expand our existing Community Health Teams program.

### **5. Increase patient experience ratings in our practices.**

Through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, our patients evaluate their health care experiences, covering topics like provider communication skills or ease of access to services. We will aim to meet or exceed 75% of the regional benchmark.

## Committees and Workgroups

Our committees and workgroups are an integral part of our Collaborative. They provide opportunities to collaborative, innovate, share best practices and discover new ways to improve primary care in Rhode Island.

### **Community Health Team Planning Committee**

Plan the implementation and evaluation of Community Health Teams in Pawtucket and South County.

### **Contracting Committee**

Responsible for contract development, attribution, and looking at alternate payment models and PCMH as part of a delivery system.

### **Data and Evaluation Committee**

Lead performance improvement; measure selection and harmonization; develop goals and benchmarks, evaluation, and research.

### **Integrated Behavioral Health Workgroup**

Lead the transformation of primary care in the context of an integrated health care system.

### **Nurse Care Manager and Care Coordinator Best Practice Sharing Workgroup**

Support best practice sharing, workforce development and role of care manager in improving population health and care coordination.

### **Practice Reporting Committee**

Review, validate and report practice data quarterly; support quarterly performance improvement and data sharing meetings.

### **Practice Transformation Committee**

Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice-based coaching and technical assistance; and support workforce development for PCMH.

### **Steering Committee**

Provide guidance and insight for strategic direction and long-term strategies; monitor and review performance of the Collaborative; and provide a learning forum for all members.

## Thank you to our partners who helped make 2015 a year of incredible progress.

- Blue Cross and Blue Shield of Rhode Island
- Brown University
- Care New England
- Executive Office of Health and Human Services
- Healthcentric Advisors
- Lifespan Corporation
- Medicaid and Medicare
- Neighborhood Health Plan of Rhode Island
- The New England States Consortium Systems Organization
- Office of the Health Insurance Commissioner
- Rhode Island Business Group on Health
- Rhode Island Department of Health
- Rhode Island Foundation
- Rhode Island Quality Institute
- RIGHA Foundation Fund
- State Employees Health Benefits Program
- Tufts Health Plan
- UnitedHealthcare



## 2015 Annual Report

Care Transformation Collaborative of Rhode Island

[www.ctc-ri.org](http://www.ctc-ri.org)

