CARE
TRANSFORMATION
COLLABORATIVE
RHODE ISLAND

pcmh kids
patient-centered medical home
Rhode Island

Strengthening Primary Care and Reducing Health Costs in the State of Rhode Island

A 2016-2017 **Report**

https://www.ctc-ri.org

Welcome To
Our 2016-2017 Report

We dedicate this report to Dr. Kathleen Hittner, who has retired from her position as the Rhode Island Health Insurance Commissioner in June 2017.

A long-time champion for our Collaborative, Dr. Hittner was originally appointed as Health Insurance Commissioner in June 2013. Through her years of leadership, her office has maintained some of the lowest health insurance rate increases in the country during a time of uncertainty in the future of American healthcare. Notably, she strengthened the state's Affordability Standards, putting measures in place to contain medical cost growth and invest in our state's primary care infrastructure, which has allowed patients and our primary care system to thrive.

We thank Dr. Hittner for her years of leadership and dedication.

A Message From the President

The Care Transformation Collaborative of Rhode Island (CTC) has made an incredible impact on the state's health care community — not just within primary care — but also within our communities. This work has been made possible thanks to the collaboration between our state agencies, health plans, and primary care providers to drive the transformation of primary care.

Why does investment in primary care matter? According to a 2017 Commonwealth Fund report, when stacked against other states — Rhode Island rose to fourth in the nation on more than 40 measures of health system performance, including health care access, quality, avoidable hospital use and costs, health outcomes, and health care.[1] It is clear that on a national level, our state is being recognized.

A July 2017 Health Affairs article noted the positive results of the R.I. Office of the Health Insurance Commissioner's regulatory authority through its enactment of the Affordability Standards. Over the course of six years, commercial health plans were required to nearly double

their investments in primary care (from approximately 5% in 2008 to nearly 11% in 2014).[2] As a result of these investments in primary care, overall health spending in Rhode Island grew slower than all other New England states during this time except New Hampshire. Further, data from the state's All Payer Claims Database demonstrated that total cost of care spending in 2016 for patients followed at CTC practices was more than $217 million less than spending attributed to non-patient centered medical homes in Rhode Island.

1 D.C. Radley, D. McCarthy, and S. L. Hayes, Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance, 2017 Edition (The Commonwealth Fund, March 2017).

2 Health Spending by State 1991-2014: Measuring Per Capita Spending By Payers and Programs, June 2017, Health Affairs

CTC, through its multi-payer platform, was instrumental in having Rhode Island selected as one of 14 U.S. regions to join Medicare Comprehensive Primary Care Plus initiative sponsored by the Center for Medicare and Medicaid Innovation, providing selected practices across the country with the additional financial resources and flexibility to make investments that will improve quality of care and reduce the number of unnecessary services their patients receive.

Rhode Island's impressive investment in primary care has been highlighted by the National Committee for Quality Assurance, with our state ranking the third highest for patients being served in advanced primary care patient-centered medical homes. As a result of both a January and July 2017 expansion, CTC is on track to help the state reach its goal of 80% of primary care physicians utilizing a PCMH by 2019.

Importantly, this work serves as a platform for allowing the PCMH model — together with CTC's payment for performance incentives — to serve as a foundation for improving primary care. CTC has launched pilot programs to strengthen this patient-centered foundation, including programs aimed at effectively identifying and managing high-risk patients, addressing behavioral and substance use disorders, and providing community-based services and supports. CTC has received significant financial support to further develop and evaluate these efforts.

In early 2017, our Collaborative won a $7.5 million grant from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to expand our Community Health Teams and integrated behavioral health work. Aimed at reducing substance, opioid, and alcohol use, and reduce costly health care utilization, the grant will fund new Community Health Teams in targeted regions of the state, and Screening, Brief Intervention, Referral and Treatment (SBIRT) for substance use and mental health disorders throughout Rhode Island. Through this work, we hope to improve access to treatment and reduce the stigma associated with treatment of behavioral health and substance use disorders.

CTC is committed to workforce development in Rhode Island, specifically by increasing the number of qualified PCMH team members to fill existing and future jobs. Our newly launched Nurse Care Manager training program is a powerful example of our ability to recognize the value of the Nurse Care Manager role, and provide a structured professional development program to fill a void and strengthen the nursing workforce in Rhode Island. Throughout this report, we are proud to share more examples of our programs and success stories.

Thank you to all who have committed to the Care Transformation Collaborative of Rhode Island. We are pushing primary care to new levels that are leading to better health and wellness for thousands of Rhode Islanders.

Sincerely,

Thomas Bledsoe, MD, President
Board of Directors
Care Transformation Collaborative of Rhode Island

About the Care Transformation Collaborative of Rhode Island

Mission

The Care Transformation Collaborative of Rhode Island's (CTC-RI) mission is 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; patient experience of care; and the affordability of care for the populations we serve. CTC-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care.

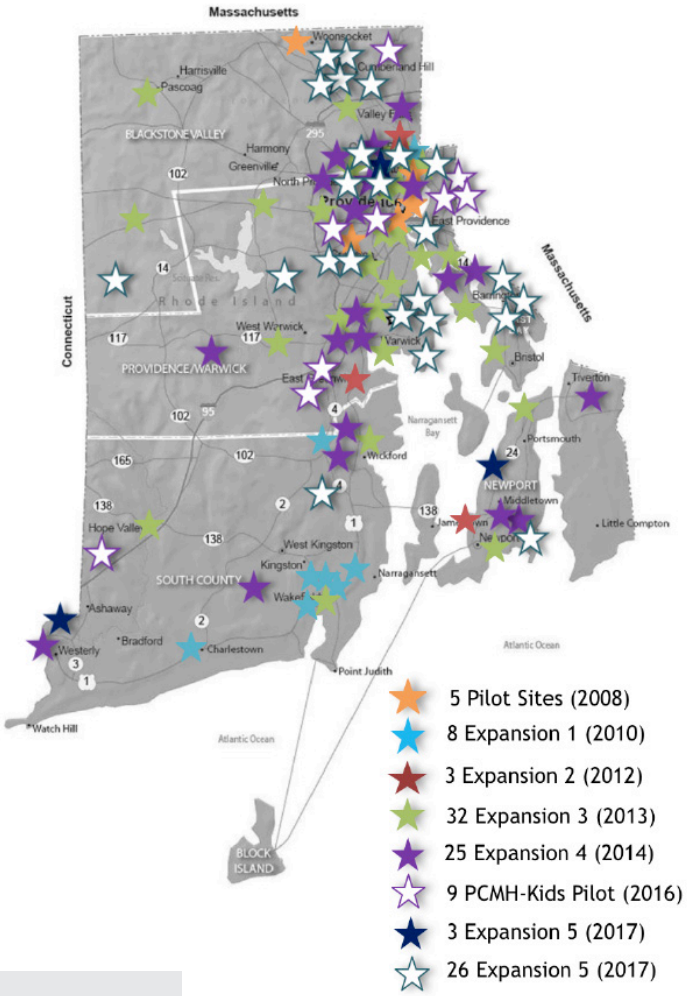
History

Convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS), the Care Transformation Collaborative of Rhode Island began with five pilot sites and has grown to 106 adult and pediatric primary care practice sites and 665 providers, serving approximately 550,000 Rhode islanders, including internal medicine, family medicine, and pediatric practices.

In 2015, CTC-RI incorporated as a 501(c)(3), establishing a Board of Directors as its governing body. CTC-RI is supported by funding from public and private payers in Rhode Island, along with grant funding from government and non-governmental sources. Four major health plans in Rhode Island provide direct support for the practices through our Common Contract, an agreement negotiated between the health plans and the participating practices under the auspices of OHIC and EOHHS. The contract includes supplemental per member per month payments designed to drive practice transformation and quality improvement. These payments allow the practices to make structural enhancements to apply for national PCMH recognition, hire on-site care management/coordination to impact the patients with the highest needs, and enhance data capabilities to manage and improve population health.

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

- 106 primary practices, including internal medicine, family medicine, and pediatric practices.
- Approximately 550,000 Rhode Islanders receive their care from one of our practices.
- 659 providers across our adult and pediatric practices.
- Investment from every health insurance plan in Rhode Island, including private and public plans.
- All Federally Qualified Health Centers in Rhode Island participate in our Collaborative.
- Demonstrated a $217 million total cost of care cost difference reduction in 2016 (compared to non-patient centered medical homes in Rhode Island), according to data from the state's All-Payer Claims Database.



2017 Strategic Priorities

- Improve efficiency and total cost of care
- Expand Community Health Teams
- Integrate behavioral health in Primary care
- Patient Engagement
- Support workforce development
- Support training, learning collaboratives, and program evaluation
- Improve data analytic capacity
- Increase standardized actionable reports to practices

Our Practices

Current Practices (adult and pediatric)

- A to Z Primary Care (Warwick)
- Anchor Medical Associates (Lincoln)
- Aquidneck Pediatrics (Newport)
- Atwood Pediatrics (Johnston)
- Barrington Family Medicine: Adult and Pediatrics (Barrington)
- Barrington Pediatrics (Barrington)
- Brookside Medical Associates (Cumberland)
- Care New England Medical Group: Arcand Family Medicine (West Warwick)
- Care New England Medical Group: Brookside Family Medicine (Coventry)
- Care New England Medical Group: Family Medicine at Women's Care (Pawtucket),
- Care New England Medical Group: Primary Medical Group (Warwick)
- Charter Care Medical Associates (Cranston)
- Charter Cate Physicians (Lincoln)
- Children's Medical Group (Providence)
- Coastal Medical (East Providence, Narragansett, (2) Warwick)
- Comprehensive Community Action Program (Warwick)
- Coventry Primary Care Associates (Coventry)
- Cranston (Park) Pediatrics (Cranston)
- East Bay Community Action Program (East Providence and Barrington)
- East Greenwich Pediatrics (East Greenwich)
- East Side Pediatrics (Providence)
- Gilbert Teixeira, MD
- Hasbro Medicine-Pediatric Primary Care Clinic (Providence)
- Hasbro Pediatric Primary Care (Providence)
- John Chaffey, DO, Ltd
- Kingstown Pediatrics (North Kingstown)
- Lincoln Primary Care (Lincoln)
- Memorial Hospital Internal Medicine Center
- Michelle C. VanNieuwenhuize, MD, LLC (Lincoln)
- Nardone Medical (Providence and Pawtucket)
- North Kingstown Family Practice (North Kingstown)
- Northern Rhode Island Pediatrics (Cumberland)
- Ocean State Primary Care Center of Coventry (Coventry)
- Ocean State Primary Care Center of Westerly (Westerly)
- Pediatric Associates (East Providence)
- Primary Care Barrington (Barrington)
- Providence Community Health Centers (8 sites in Providence)
- Richard Del Sesto (East Greenwich)
- Richard E. VanNieuwenhuize, MD, LLC (Lincoln)
- Robert A. Carrellas, MD (Middletown)
- Solmaz Behtash, DO (Pawtucket)
- South County Hospital Primary Care and Internal Medicine (Wakefield and Westerly)
- South County Walk-In and Primary Care (Narragansett)
- SouthCoast Health System (Linden Tree Health Center, Tiverton Family Practice, Family Medical Middletown, Family Medicine Center)
- Thomas D. Puleo, MD (Cranston)
- Wayland Medical Associates (Providence)
- Wickford Family Medicine (North Kingstown)
- Women's Primary Care, Women's Medical Collaborative (Providence)
- Wood River Health Services (Hope Valley)

Primary Care Practices that have successfully completed the Care Transformation Collaborative Contract (as of July 1, 2017)

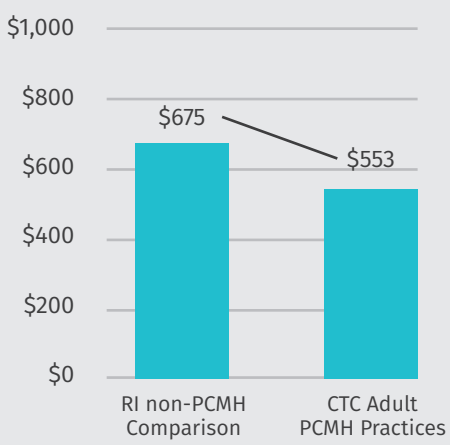
- Anchor Medical Associates (Lincoln, Providence, Warwick)
- Aquidneck Medical Associates (Newport and Portsmouth)
- Associates in Primary Care Medicine (Warwick)
- Blackstone Valley Community Health Center, Inc. (Central Falls and Pawtucket)
- Coastal Medical, Inc. (Greenville, Narragansett, Hillside, and Wakefield)
- Comprehensive Community Action Program (Family Health Services of Coventry, Family Health Services of Cranston, Wilcox Health Center)
- East Bay community Action Program (Newport and East Providence)
- Family Health and Sports Medicine, LLC (Cranston)
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Medical Associates of RI (Bristol and East Providence)
- Memorial Hospital Center for Primary Care (Family Medicine)
- Ocean State Medical, LLC (Johnston)
- South County Hospital Family Medicine (East Greenwich)
- South County Internal Medicine (Wakefield)
- Stuart Demirs, MD (Charlestown)
- Thundermist Community Health Center (Wakefield, West Warwick and Woonsocket)
- Tri-County Community Action Agency (Johnston)
- University Family Medicine (East Greenwich)
- University Internal Medicine (Pawtucket)
- University Medicine (8 sites – East Providence, Newport, Portsmouth, Providence and Warwick)
- WellOne Primary Medicine (Foster, North Kingstown, and Pascoag)
- Wood River Health Services (Hope Valley): Adult

Investments in primary care transformation show substantial difference in cost

In 2016, the total cost of care for CTC adult practices was 18% lower than a non-patient-centered medical home comparison group in Rhode Island (according to data from the Rhode Island All Payer Claims Database).

The charts here compare the risk-adjusted average Per Member Per Month costs (PMPM) for all medical care (Total Cost Of Care) for CTC adult PCMH practices versus the RI non-PCMH comparison group. These efforts at providing patient-centered, team-based care are associated with a combined cost reduction totaling $217 million in 2016 for patients cared for in PCMH practices when compared to patients seen non-PCMH practices. Program costs for 2016 totaled $15.9 million resulting in a net cost difference of $201.1 million.

Significant Lower (18%) Average Total Cost of Care for CTC Practices in 2016



Total Member Months (MM)

1,779,085 MM

Total Annual Cost Difference $122 PMPM x MM

$217 Million

Total Annual Program Costs and Practice Payments 2016

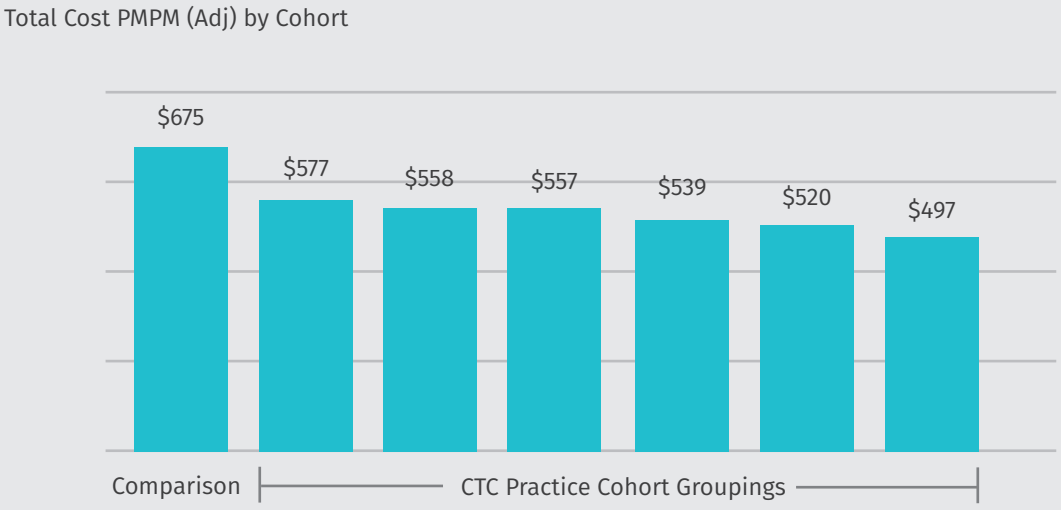
$15.9 Million

Net Difference (Total Cost of Care Difference - Total Program Costs)

$201.1 Million

Data Source: Rhode Island All-Payer Claims Database 2016

CTC Practices Out Perform the Comparison Group



Data Source: Rhode Island All-Player Claims Database 01/01/2016 through 12/31/2016

Integrating behavioral health into the primary care setting

The Care Transformation Collaborative of Rhode Island has laid the groundwork for the state to continue breaking down behavioral health barriers by identifying and treating patients living with depression, anxiety, or substance use disorders in their own familiar primary care setting through an Integrated Behavioral Health (IBH) initiative, originally launched in 2015.

Initial funding provided by Tufts Health Plan allowed CTC to successfully launch the IBH initiative. CTC provided selected primary care practices with on-site behavioral health practice facilitation and a program to educate and train practice staff to provide IBH services in primary care. In 2016, the Rhode Island Foundation's Fund for a Healthy Rhode Island enabled the IBH initiative to expand to a two-phased pilot program, allowing CTC to build more IBH capacity, and evaluate its impact. In 2017 CTC was awarded funding through the State Innovation Model (SIM) contract, made possible through federal Centers for Medical and Medicaid Services funding, to conduct a robust program evaluation.

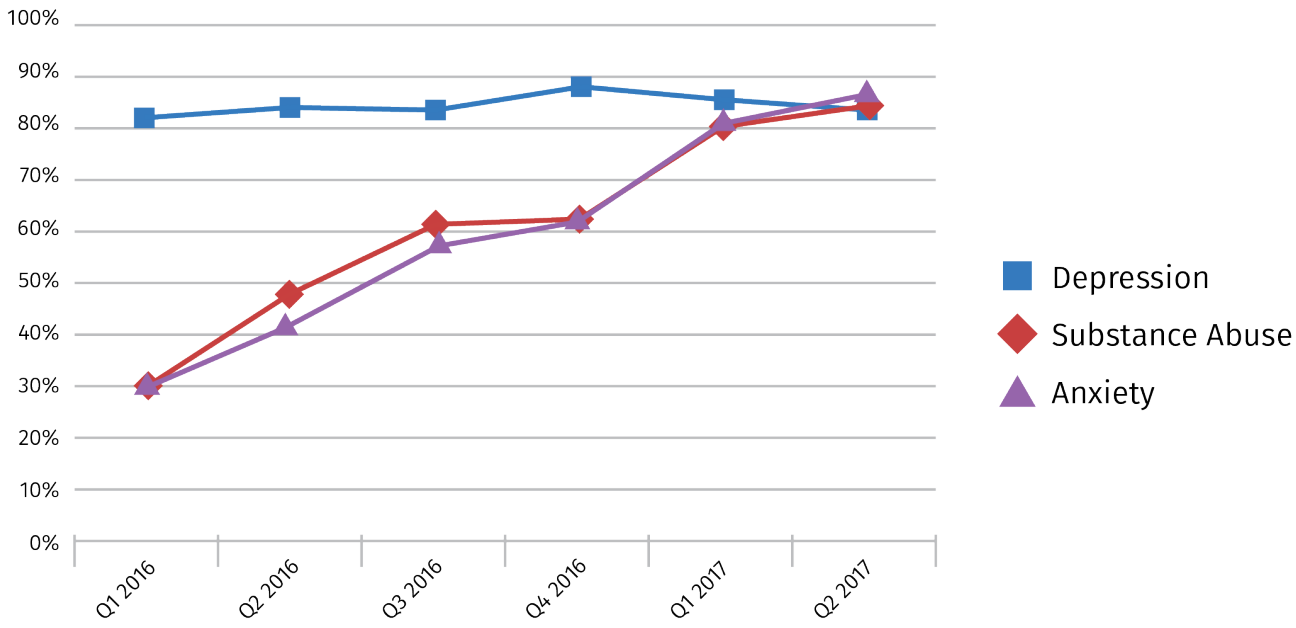
In November 2016, a second cohort of primary care practices sites offering on-site IBH was launched.

Together, these pioneering primary care practices continue to advance their use of on-site behavioral health screening tools with timely, convenient connection to behavioral health services within the patient-centered medical home. The IBH initiative has resulted in patients being universally screened for depression, anxiety, and substance-use disorders, and connected to onsite behavioral health clinicians embedded in the primary care practices.

Early results from this program are promising. A June 2017 Special Edition of Family Systems and Health, a publication of the American Psychological Association, a peer review journal, highlighted the impact seen through this work. Focused on real-world data from the Collaborative's IBH initiatives, "Integrated Behavioral Health Practice Facilitation in Patient Centered Medical Homes: A Promising Application, provides "the first quasi-experimental/pretest-posttest evidence utilizing real-world data that the practice facilitation method is an effective solution towards increasing the degree of BH integration change in PCMHs when using a practice facilitator with content expertise in BH integration within primary care."[3]

3 Integrated Behavioral Health Practice Facilitation in Patient Centered Medical Homes: A Promising Application, Families, 2017, Systems & Health

Integrated Behavioral Health Pilot Program (Cohort 1) Screening Rates Q1 2016 - Q2 2017



This important IBH work is being expanded to PCMH-Kids, the pediatric branch of the Care Transformation Collaborative. Throughout the spring and summer of 2017, practices participated in learning workshops on evidence-based practice guidelines and behavioral health strategies to support families and improve care for children with ADHD/ADD and maternal depression. In addition, in partnership with Bradley Hospital, throughout the month of June, training was available for medical assistants, receptionists, practice mangers, and community health workers on mental health first aid to help support an individual who may be developing a mental health problem or experiencing a crisis.

CTC's IBH practices continue to advance their on-site behavioral health screening tools, care, and coordination of services, to support a sustainable, integrated primary and behavioral health care delivery system.

Behavioral health integration helps patients and lowers ER visits at Associates in Primary Care Medicine

Associates in Primary Care Medicine (APCM), a small Warwick-based practice participating in CTC's Integrated Behavioral Health initiative, wanted to determine if an intervention with the in-house psychologist or working with the Nurse Care Manager could decrease the number of these visits, and decided to launch a concentrated effort.

Over an 11-month period, APCM identified patients with behavioral health and medical needs who had three or more emergency room (ER) visits. Based on review of the patient data, 22 patients were identified for more intensive on-site team intervention. Patients were asked how the practice could better meet their needs and team strategies to improve outreach, communication and care coordination were initiated. Alerts were also entered into the patient's electronic medical records to assist practice team members with recognizing patients who may need additional support when calling for appointments and being seen by providers, psychologist or the Nurse Care Manager. Bi-monthly meetings were held between the provider, nurse care manager, and practice manager to further discuss ways to improve care and engage the identified patients.

"About a couple of months into the quality improvement cycle, we felt we had made a breakthrough with one patient in particular," said Jamie Handy, Practice Manager at APCM. "We noticed in our follow-up work that this patient had not returned to the ER since being provided with an action plan by the Nurse Care Manager. Most of his ER visits were due to anxiety symptoms. This was a great success, since prior to this effort, he was seen on a weekly basis at the ER. We believe that the patient now felt some empowerment about his healthcare, as he now knows what to do should he have anxiety symptoms."

As a result of these efforts to engage and educate patients, two patients saw the psychologist, two patients were counseled by their provider, and eight patients developed an 'ER action plan' with the Nurse Care Manager. Through the eight-month course of APCM's intervention work, 63 ER visits were prevented. APCM's preliminary evaluation in March 2017 demonstrated that 17 of the 22 patients had not been back to the ER.

Now at APCM, as the practice looks to expand on this impactful work, patients who utilize the ER for non-urgent matters are given a survey at their follow-up primary care visit. The practice is working to better understand why patients may go to the ER rather than the office for a same-day sick visit.

"The biggest take away so far has been the idea that small changes can make big differences," said Handy. "We understand that this process will always be a challenging effort, but one we feel is worthwhile. Many factors can be involved in the overuse of the ER by patients, including transportation, mental health issues, and financial difficulties to name a few."

APCM will continue to monitor its identified patients, and is implementing this protocol practice-wide to support others that may be over-utilizing the ER. With an established team to work with and support its identified patients (including its receptionists, medical assistants, providers, practice manager, nurse care manager, and psychologist) the APCM team is now meeting monthly to monitor their patients' progress, and believes more questionnaire data and time will help identify continued strategies for improvement and progress.

"If we are able to reduce the unnecessary ER visits, we are cutting costs, providing better care, and ultimately empowering patients to be a more active participant in their healthcare," said Handy.

Expanding care into the neighborhood with Community Health Teams

Two pilot Community Health Teams (CHT) were launched by the Care Transformation Collaborative in 2014, one in Blackstone Valley and one in South County. The intent of the pilot initiative was to explore ways to address the unique challenges many practices faced supporting high-risk patients with complex care needs, especially those with multiple medical, social and behavioral health service needs. Working with primary care providers, CHT care coordinators assess and address needs with the patient in the community and implement a community-based action plan, addressing needs such as housing, food-insecurity, transportation and behavioral health needs.

From their initial launch through 2017, these pilot programs have demonstrated powerful impact. In 2017, outcome highlights showed success in immediate follow-up with patient after hospital activity, providing primary care team members with reports on patient needs based on seeing the patient in the home environment and tapping into health plan resources. The CHTs began implementing a centralized management/data system to track its progress and impact on a more advance scale, now delivering monthly reports on key metrics and quarterly meetings with health plans to discuss outcomes.

After demonstrating continued impact and success, the Care Transformation Collaborative of Rhode Island received $2.2 million from the Rhode Island State Innovation Model (SIM) and $7.5 million from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to expand the impact of CHTs in Rhode Island and implement screening for substance use disorders. With this funding support, new Community Health Teams are now being launched in Providence, West Warwick, and Woonsocket. Further, with an additional funding support from UnitedHealthcare, a CHT will launch in Newport to support patients in need on Aquidneck Island. By expanding this work statewide, our Collaborative aims to better improve the health of Rhode Islanders by targeting and addressing the social, behavioral, and environmental needs of vulnerable individuals.

Acknowledgement of the work of CTC's Community Health Teams has expanded beyond Rhode Island, and is gaining national recognition. A study[4] submitted by a team of individuals from our Collaborative and 4 partners (including Brown University, May Street Consultants UMass Medical School, Blackstone Valley Community Health Center, and South County Health) was published in a June 2017 edition of Internal Medicine Research – Open Journal. The study, based on CTC's Community Health Teams work, was focused on the evaluation of a Community Health Teams structure, process, and outcomes related to intervention for high-risk and high-cost patients in patient-centered medical homes, and provides recommendations to guide future implementation efforts of Community Health Teams.

Susanne Campbell, Liz Fortin, and Marie Padilla presenting on CTC's Community Health Teams work

4 Reaching Beyond Patient-Centered Medical Home Walls: A Mixed-Methods Evaluation of A Community Health Team Intervention, May 2017, Internal Medicine Research — Open Journal

Community Health Team in South County helps turn a patient's life around

Paul was referred to the South County Community Health Team because of multiple chronic and poorly controlled medical conditions, including diabetes, kidney disease, heart programs, and high blood pressure. In a challenging living situation with no family support, Paul resided in a single room on the third floor of a rooming house, where he shared a bathroom and a hot plate. He needed to climb three flights of stairs just to access his room.

Apart from his living conditions, many challenges disrupted Paul's health. Though eligible for Medicaid-funded transportation services, he struggled to physically wait outside for transport and often missed rides, resulting in frequently skipped medical appointments. He had trouble with his health insurance — being dropped more than 10 times — and was not taking his medications regularly. His primary care physician was concerned, and the South County Community Health Team (CHT) was engaged.

Shortly after the CHT met Paul, he had two strokes within a few months of each other, leaving him with mobility and speech difficulties. In between two skilled nursing and rehabilitation stays, Paul's CHT worker, Marie, helped him apply for and move into subsidized housing, regain stable health insurance, and engage in managing his own health, including taking medications as prescribed. Paul began turning the corner.

"I wouldn't be living here at this point if it wasn't for her," said Paul, of his CHT worker, Marie. "This team was receptive enough to when I should and shouldn't do things for myself, or when I would need advice and counsel. They weren't trying to control everything. They encouraged me to be more productive and self-aware and solve problems for myself."

Paul's diabetes, blood pressure, and cholesterol have stabilized. He has now lost more than 40 pounds, and rides a stationary bike regularly to build his strength. Paul has become more social, and has shown great appreciation to Marie and his CHT. On two separate occasions, Paul has proudly and generously donated, from his own modest income, to the CHT program to assist others in need.

"I suspect a lot of people are shutting down and giving up out there," said Paul. "I hope they get to use this opportunity locally with South County Hospital."

Patient Paul hands his donation to South County Community Health Team lead, Marie Padilla

Building Rhode Island's nursing workforce to meet patient needs in primary care

As baby boomers age and the need for health care grows, a projected shortage of nurses is expected to intensify.[5] In Rhode Island, this shortage will come in the form of 350 fewer nurses in the next 10 years, resulting in over 700,000 hours of missing clinical time.[6] As the demand for care and capacity rises, nursing schools may struggle to expand their capacity to meet demand.

Recognizing the critical role nurses play in the delivery and transformation of primary care, the Care Transformation Collaborative of Rhode Island committed to addressing this challenge. After extensive research, our Collaborative recommended the launch of a new nurse care manager/care coordinator (NCM/CC) on boarding program aimed at providing NCMs with a standardized learning curriculum coupled with coaching by NCM/CC faculty to develop skills in providing care management interventions for patients with complex needs. Intended outcomes include increased patient engagement with NCM/CC, improved knowledge of community resources to meet patient needs and a strengthened competency in what is for many nurses and care coordinators a new area of practice.

Thanks to a $150,000 grant from UnitedHealthcare, a new NCM training program was launched in spring 2017 with selected NCM/CC faculty members being trained in the standardized curriculum and applying adult learning principles. In June 2017, over 70 NCM/CCs were assigned to a group, and on a weekly basis complete web-based interactive learning modules and participate in NCM/CC Faculty facilitated telephonic collaborative sessions. This combination of learning experiences assists NCM/CC with developing and immediately applying a working knowledge of care management strategies and using Rhode Island resources to meet patient needs.

Many thanks are extended to UnitedHealthcare whose commitment to helping build healthier communities made this effort possible. The grant has helped address an important workforce development need. Our expanded nurse care manager learning curriculum is accessible, provides a standardized approach, and is focused on the needs of complex patients supported by a primary care team and coordinated within the medical neighborhood.

5 American Association of Colleges of Nurses
6 Report by Stepping Up Rhode Island

Nurse Care Manager Faculty:

Jayne Daylor, Gloria Rosem, Linda Hughes, Carol Falcone, Reena Jariwala

(missing from photo: Kateri Chappell and Karolyn McKay)

Nurse Care Manager shares her passion with others as new faculty trainer

Kateri Chappell's patient was declining. She was unable to come visit her primary care practice as frequently as her provider wanted her to. Struggling with reliable transportation, the patient often relied on a friend to take her to and from appointments. In her capacity as a Nurse Care Manager, Kateri referred her patient to the "Coastal @ Home" team, resulting in a home visit to the patient just two days later.

Kateri and her care team thoroughly reviewed the patient's medications, set up visiting nurse services for both physical and occupational therapy, and organized home care service, all while assessing the patient appropriately in the comfort of her home.

As a Nurse Care Manager (NCM) at Coastal Medical, Kateri enjoys helping her patients and giving them an outlet — someone at the end of the line they know will help them or direct them where to go. She believes her work drives patient satisfaction and outcomes, and can in turn, decrease costs and improve the quality of her patients' care.

Day-to-day, NCMs like Kateri work collaboratively with a team of specialists, referrals, doctors, pharmacists, visiting nurses and many other important resources to ensure patients get the care they need when they need it. She works directly with her patients to develop their care plans, provides important resources for them, and works with them to ensure they get the care they need despite any barriers they may have.

Kateri's role as a NCM in a patient-centered medical home is relatively new in the nursing profession in Rhode Island primary care, and professional development opportunities tailored to this niche career were not available, until now.

"Many of us were not trained to be nurse care managers," said Kateri. "We rely on our strengths as patient advocates and care coordinators to provide the services our patients need. However, there is still a gap — which is why training programs are so important."

The Care Transformation Collaborative of Rhode Island committed to expanding the role of NCMs in Rhode Island by establishing a new Nurse Care Manager Training Program, utilizing a program by xG Health Solutions to provide a blended learning experience.

When Kateri first saw the outline for the program's curriculum and its goals, she was immediately intrigued.

"As nurse care managers we are focused on providing seamless care coordination for our high-risk patients. This program was a way to learn more about this model of care and teach others what I am so passionate about," said Kateri.

Following her passion for teaching and preventative medicine, Kateri became faculty NCM for the new program. She now leads a group of NCMs that meet weekly (virtually) and discuss their assigned module readings from the training program.

"It is imperative that NCMs see the relationship between care management and how it plays a role in achieving the triple aim. I believe the Care Transformation Collaborative and xG training sessions do just that," said Kateri. "They highlight how to case manage effectively, how to prioritize patients, and when to refer to someone for more help. These tools and resources are so needed to provide the patients of Rhode Island with the best possible care.

Though every patient case is unique, the NCM Training Program has afforded NCMs throughout Rhode Island the unique opportunity to share best practices and adapt them at their own sites to increase patient engagement and satisfaction, provide higher quality of care, and to reduce unnecessary costs.

"Being a faculty member is very inspiring and I am hopeful for the future of healthcare," said Kateri.

Mastering the skills needed to support better coordinated patient care

As a Nurse Care Manager in a six-physician practice, Mary Brady of South County Internal Medicine practice knows her team is committed to the needs of their patients, including internal medicine, preventative health, acute care, and complex care management. A 2016 “graduating practice” of the Care Transformation Collaborative program, the practice is now part of Rhode Island Primary Care Physicians Corporation.

Mary was first interested in CTC’s new NCM training program because she felt it would help optimize her care management skills, and obtaining Continuing Education Credits and a certificate of completion was an added bonus.

Mary agrees with data that points to a nationwide nursing shortage — a result of an aging patient population, rising levels of chronic diseases, an aging nursing work force, and limited capacity of nursing schools. She turned to CTC’s new NCM training program, a local solution to expand Rhode Island’s nursing field capacity, to advance her training and capacity.

Through the program’s step-by-step learning, she said the program has been “a great experience.” NCMs, like Mary, are being trained to provide health care services needed by their patients efficiently and effectively within their patient-centered medical homes. On a broader level, NCMs are advancing Rhode Island’s primary care industry by mastering the skills needed to help navigate care for the adult Medicaid population with chronic conditions.

Mary believes this work will translate to better supporting patients at South County Internal Medicine, like those living with mental illness and substance use disorder. She recalled a recent patient who returned back home to Rhode Island after a lengthy out-of-state stay. With a dual diagnosis of bipolar disorder and substance abuse, she avoided her medication and turned to alcohol to self-medicate. By the time the patient returned to Mary's practice, she was assisted with obtaining an in-patient psychiatric stay. Once discharged, the patient's mental health care was fragmented, leaving the patient frustrated. Mary was able to coordinate a social worker to visit and assess the patient at home, and then coordinated care via Health Path for mental health and addiction treatment covered by the patient's insurance. Today, Mary's patient is well-managed and receives coordinated care — including psychiatric treatment, therapy and counseling, health and wellness support, and medication management — while maintaining her sobriety and attending daily AA meetings.

"It's the job of the Nurse Care Manager to help reduce gaps in care, to coordinate care as well as help reduce duplication of services which translates into quality of care for the patient and cost saving," said Mary.

Pediatric practices thrive under patient-centered model

PCMH-Kids, the pediatric branch of the Care Transformation Collaborative, has successfully moved through its first full year of operation. Originally launched with nine primary care practices, the pediatric initiative includes a total of 70 providers, serves approximately 30,000 children, and supports a significant proportion of the Medicaid population and children with special health care needs.

Under a Common Contract, the nine participating practices are expected to hire or designate staff to help coordinate care; achieve National Committee of Quality Assurance (NCQA) Patient-Centered Medical Home Recognition (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.

Each practice has achieved Level 3 NCQA PCMH Recognition, demonstrating a commitment to quality improvement within their practices and a patient-centered approach to care that result in better outcomes. Further, the practices' commitment to and demonstration of quality can be measured through a variety of ways. PCMH-Kids practices have demonstrated positive results in their CAHPS surveys, a tool that asks patients to report on and evaluate their health care experiences, specifically addressing topics related to quality, from the timeliness of appointments, care and information to how well providers and the office staff communicate with patients. Data from 2016 show impressive results, such as a 90% rating in provider communication.

As efforts grow in the Care Transformation Collaborative's adult practices to integrate behavioral healthcare into the primary care setting, PCMH-Kids has also been working to integrate behavioral healthcare into six of its practices, with the practice sites demonstrating improvements. These practices have demonstrated improvements in key areas. Outside of the integrated behavioral health pilot sites, seven of the nine PCMH-Kids practices are also now screening for postpartum depression.

The PCMH-Kids practices work with the Cedar Family Centers, the state's multi-disciplinary teams (community health teams) that serve as an extension of the primary care office to coordinate care for children and youth with special health care needs and their families. PCMH-Kids and Cedars teams have developed and maintained invaluable collaborative and co-located relationships to co-manage shared patients.

In early 2017, aimed at supporting work to transform the delivery and payment of healthcare across the state, Rhode Island became one of 24 states in 2015 to receive a State Innovation Model grant from the federal Centers for Medicare and Medicaid Services. In an effort to further advance the impact of the state's patient-centered medical home (PCMH) model of primary care, this year, $870,000 of the grant has been awarded to the Care Transformation Collaborative of RI (CTC), the State's multi-payer organization focused on advanced primary care delivery.

A portion ($370,000) of the SIM funding was allocated to support PCMH-Kids by supporting practice-based facilitators to work closely with practice staff to redesign work flows to facilitate patient-centered care.

After a successful launch of this pediatric primary care transformation initiative, in summer 2017, PCMH-Kids began reviewing applications from outside pediatric practices to join and expand its initiative, anticipating adding 10 additional practices.

Pediatric Associates demonstrates practice transformation, progress in first year of program

Pediatric Associates, Inc. is a well-established pediatric group founded in 1969. With six physicians on staff, the practice prides itself on providing quality medical care, and being at the forefront of new models of healthcare delivery.

Pediatric Associates has served as a pilot practice for many primary care initiatives, including integrated behavioral health, "Screen to Succeed," and the placement of in-office counselors from the Rhode Island Parenting Network. With pediatricians on staff who were used to providing patient-centered comprehensive care in their medical home, and having already implemented many of the required services needed to obtain NCQA PCMH recognition, applying to join PCMH-Kids seemed like a natural fit.

"NCQA certification was something we wanted to achieve, but the application process seemed daunting," said Dr. Kimberley Townsend. "Having resources through PCMH-Kids helped us come up with a strategy and roadmap to achieve Level 3 certification in August 2017."

As an active participant in the pediatric primary care transformation initiative, Pediatric Associates has participated in the behavioral health initiatives offered around ADHD and postpartum depression, while expanding our screening and follow-up around these disorders. Dr. Townsend credits PCMH-Kids with substantial changes to their office.

First, creating a position for a patient care coordinator has allowed her practice to follow-up on all patients who are hospitalized or go to an ER or Urgent Care. The new care coordinator also supports a group of high-risk patients (for either medical or behavioral needs) to help the parents navigate the healthcare system and anticipate any upcoming needs to prevent a future crisis.

Dr. Townsend also noted an increased sense of teamwork in her office, following newly implemented, regularly scheduled meetings for the entire staff and individual departments. The physician care teams have daily morning huddles, and overall, their meetings and huddles have allowed all staff to become more involved in planning how to better meet the needs of their pediatric patients and families.

Thanks to PCMH-Kids, Pediatric Associates has also now established a Parents Council. A group of caregivers are invited in quarterly to give their opinions on how things are going from the family view point and make important suggestions on practice improvements.

Dr. Townsend credits PCMH-Kids for supporting a significant challenge the practice experiences that stem from quality improvement and monitoring: obtaining data. A practice can be providing high-quality care, but if they do not have the ability to run reports they will not be able to show it. Dr. Townsend and her team and Pediatric Associates have spent the last year setting up structured data fields, standardizing documentation and working on running meaningful and accurate reports, allowing the practice to document the quality of their work and follow trends.

The ability to track the success or failure of changes we implement at the practice is a key factor in quality improvement, according to Dr. Townsend. “When we first began the pilot all of our numbers for the reportable measures were low. Over the course of the year we were able to show significant improvement in all measures as we began documenting in structured data fields.

Pediatricians as a specialty have been focused on education and prevention. Pediatricians have introduced patients and families to patient centered care which will now continue throughout their lifetime, even as they transition to adult providers.

“Adding the PCMH-Kids pilot under CTC has enabled pediatricians to collaborate not only with other pediatric practices but with internal medicine and family medicine practices as well,” said Dr. Townsend. “Through CTC, physician groups are working together to meet the triple aim of improving the patient’s experience in health care, improving the health of Rhode Islanders and hopefully reducing the rate of increase in the cost of care for the state.”

Rhode Island selected as one of 14 U.S. regions to join CPC+ initiative

In April 2016, the Centers for Medicare and Medicaid Services (CMS) launched a historic opportunity for multi-payer primary care initiatives to apply to be part of a public-private partnership program, the Comprehensive Primary Care Plus (CPC+), aimed at strengthening primary care.

CTC was successful in bringing together health plans and primary care practices to apply for CPC+, and in September 2016, Rhode Island was selected as one of 14 regions to participate. CMS selected 31 Rhode Island primary care practices to be part of CPC+ and based on this selection and meeting of service delivery requirements, are now eligible to receive added financial resources and flexibility to make investments that will improve quality of care and reduce the number of unnecessary services that patients will receive.

CTC used this opportunity to align with CPC+ service delivery requirements with the CTC Common Contract requirements for both the January and July CTC expansion.

Looking ahead

As the Care Transformation Collaborative of Rhode Island moves through the end of 2017 and into 2018, we are driven by our goals:

- Support our newly added practices following our July 2017 expansion, which added 14 adult and 12 pediatric practices, as they transform into high-performing NCQA-recognized patient-centered medical homes.
- Increase our multi-payer, multi-organization collaboration with Accountable Care Organizations/Accountable Entities to continue strengthening primary care and best practice sharing for specialist/hospital collaboration.
- Strengthen our business case for Integrated Behavioral Health as critical component of advanced primary care.
- Leverage Rhode Island's All Payer Claims Database to improve data available to practices, and to support evaluation of our Community Health Teams and Integrated Behavioral Health programs.
- Expand geographic-based Community Health Teams and implement the SBIRT grant (Screening, Brief Intervention and Referral to Treatment) for substance use disorders.
- Expand our Rhode Island workforce development efforts through continued Nurse Care Manager/ Care Coordinator training opportunities.
- Advance efforts to engage patients in our systemic primary care transformation efforts.

Leadership

BOARD OF DIRECTORS

Responsible for setting the strategic direction of the Care Transformation Collaborative of Rhode Island, and providing overall governance. Board listing below is active as of July 2017.

STAFF

Responsible for the day-to-day management of the Care Transformation Collaborative of Rhode Island.

Debra Hurwitz, MBA, BSN, RN, Executive Director

Pano Yeracaris, MD, MPH, Chief Clinical Strategist

Susanne Campbell, RN, MS, Senior Project Director

Michele Brown, MPA, Project Coordinator

Candice Brown, BS, Project Coordinator

Jennifer Capewell, BA, Project Coordinator

CO-CHAIRS

Marie Ganim, PhD., Office of the Health Insurance Commissioner

Patrick Tigue, MPP, Executive Office of Health and Human Services

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Secretary Maureen Claflin, MSN, RN, University Medicine Governor Street Primary Care Center

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Neal Galinko, MD, UnitedHealthcare

Tracey Cohen, MD, Neighborhood Health Plan of Rhode Island

Matthew Collins, MD, Blue Cross and Blue Shield of Rhode Island

Albert Puerini, MD, Rhode Island Primary Care Physician Corporation

Christine Hansen, EMHL, Prospect Medical Systems

David Bourassa, MD, Thundermist Health Center

Dale Klatzker, PhD, Care New England

Elizabeth Lange, MD, FAAP, Waterman Pediatrics - Coastal Medical

Patricia Flanagan, MD, Hasbro Pediatric Primary Care Clinic

Louis Giancola, South County Health

Steven Lampert, MD, MBA, Lifespan Physician Group

Howard Dulude, Lifespan

Jeffrey Borkan, MD, Brown University

G. Alan Kurose, MD, MBA, FACP, Coastal Medical

Deborah Masland, Rhode Island Parent Information Network

Puneet Sud, MD, Internal Medicine Partners

Committees and Workgroups

Thank you to the individuals who have served on our dedicated committees and workgroups. They are an integral part of our Collaborative, providing opportunities to collaborate, innovate, share best practices, and discover new ways to improve primary care in Rhode Island.

Practice Reporting Committee

Co-chairs: Patty Kelly-Flis, RN, WellOne; Andrea Galgay, RIPCPC

Charged with: reviewing practice data quarterly; performing data validation; public reporting through the CTC web portal; supporting quarterly performance improvement and data sharing meetings with practice staff; and assisting with EMR/IT issues where possible.

Nurse Care Manager/Care Coordinator Best Practice Sharing

Co-chairs: Susanne Campbell, RN, MS, CTC; Debra Hurwitz, MBA, BSN, RN

Charged with: best practice sharing amongst CTC Nurse Care Managers and Care Coordinators.

Data and Evaluation Committee

Co-Chairs: Peter Hollmann, MD; Jay Buechner, Neighborhood Health Plan of Rhode Island

Charged with: leading performance improvement; measuring selection and harmonization; developing goals and benchmarks; evaluation; research; and serving as a liaison with the All-Payer Claims Database.

Practice Transformation Committee

Co-Chairs: Sarah Fessler MD; Charlotte Crist, RN, Blue Cross and Blue Shield of Rhode Island

Charged with: supporting practice transformation through conferences; convening best practice learning collaborative sessions; supporting practice-based coaching and technical assistance; and supporting workforce development for patient-centered medical homes. This committee is tasked with deploying resources to practices for items such as practice coaching, Nurse Care Manager training, and NCQA application assistance.

Integrated Behavioral Health Workgroup

Co-Chairs: Matt Roman, LICSW, MBA , Thundermist Health Center; Rena Sheehan, LICSW, Blue Cross and Blue Shield of Rhode Island

Charged with: leading the transformation of primary care in Rhode Island, in the context of an integrated health care system.

Contracting Committee

Chair: Mary Craig, UnitedHealthcare

Charged with: contract development and attribution; and looking at alternative payment models and patient-centered medical homes as part of a delivery system.

Clinical Strategy Committee

Co-Chairs: Matt Collins, MD; Debra Hurwitz, MBA, BSN, RN, CTC; Pano Yeracaris, MD, MPH, CTC; Susanne Campbell, RN, MS, CTC

Charged with: best practice sharing in an ongoing multi-payer, multi-practice/ organizational learning environment that supports innovation in primary care and health system improvement. Areas of focus include advances in high-risk stratification/ care management, primary care/specialist collaboration, and leveraging technology for success.

Community Health Teams: Operation Workgroup Committee and State Wide Collaboration Committee

Co-Chairs: Liz Fortin, LICSW, CTC Community Health Teams; Nancy Sutton, MS, RD, R.I. Department of Health

Charged with: identifying opportunities for alignment in identification of high-risk individuals in need of services and interventions, sharing best practices, and aligning on key metrics of performance and reporting.

Finance Committee

Chair: Al Charbonneau, Rhode Island Business Group on Health

Charged with: recommending financial policies, goals, and budgets that support the mission, values, and strategic goals of the organization. The committee also reviews the organization's financial performance against its goals and proposes major transactions and programs to the board.

PCMH-Kids Stakeholder Committee

Co-Chairs: Pat Flanagan, MD; Elizabeth Lange MD

Charged with: providing input and recommendations to the Executive Office of Health and Human Services/Office of the Health Insurance Commissioner on all aspects of the development and implementation of a pediatric patient-centered medical home pilot. The committee ensures the development of a model pediatric PCMH contract includes elements of quality measures, performance requirements, milestones, and payment.

Thank you to all of our partners in the greater health care community who have supported the success of the Care Transformation Collaborative throughout the state of Rhode Island.

- Blue Cross and Blue Shield of Rhode Island
- Brown University
- Care New England
- Coastal Medical
- Executive Office of Health and Human Services
- Healthcentric Advisors
- Lifespan Corporation
- Massachusetts League of Community Health Centers
- Medicaid and Medicare
- Memorial Hospital of Rhode Island
- Neighborhood Health Plan of Rhode Island
- The New England States Consortium Systems Organization
- Office of the Health Insurance Commissioner
- Onpoint Health Data
- Rhode Island Business Group on Health
- Rhode Island Department of Health
- Rhode Island Health Center Association
- Rhode Island Foundation
- Rhode Island Quality Institute
- State Employees Health Benefits Program
- Tufts Health Plan
- UnitedHealthcare
- University of Rhode Island — R.I. Geriatric Education Center

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