CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Community Health Teams Expansion

PCMH Kids Stakeholder Meeting
October 3, 2019

Community Health Team Model – an extension of primary care

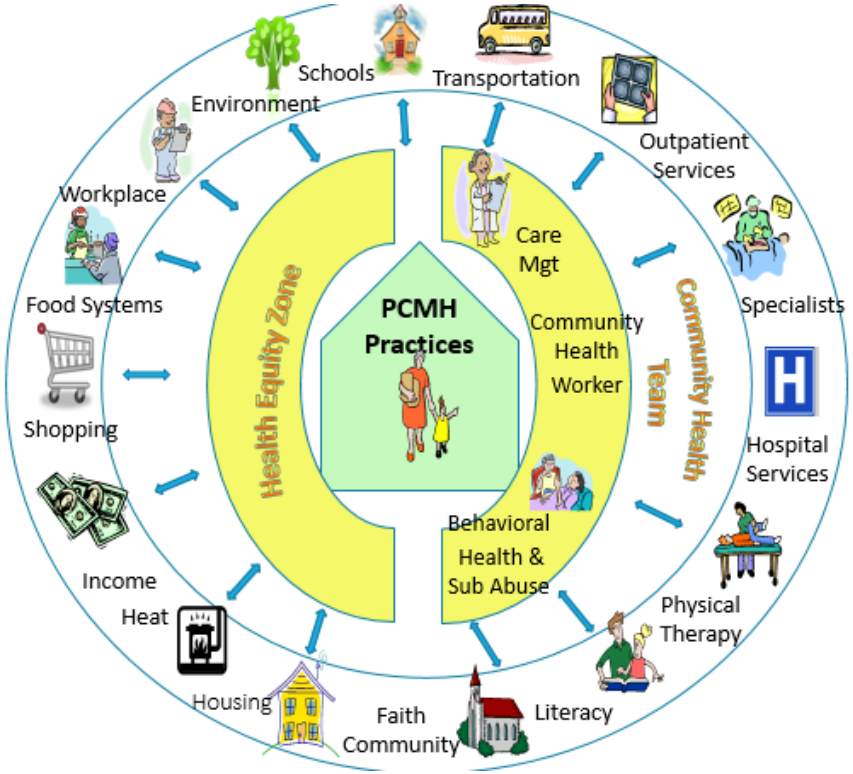
Use care management processes to address

- Physical health needs
- Behavioral health/SUD needs
- Health education needs
- Social determinants of health needs

Community Health Team

Community-Based Licensed Health Professional (At least one)	SBIRT Screener (At least one)	Community Health Worker (CHW) (At least two)

Community-Based Specialty Consultants or Referrals
(Pharmacy, Nutrition, Legal)



Statewide Community Health Team Network - Enhanced Model

Enhance current statewide Community Health Team (CHT) network serving high risk adults by bringing an "integrated family health" approach to best serving individuals and families who are "high" or "rising" health risk due to significant social and/or behavioral health needs.

- Expand geographic reach and clients served through AEs
- Support increased connection with PCMH kids and CEDAR; add new level of coordination to ensure seamless hand offs to best serving team for specialized support (Family Home Visiting, etc. as needed)
- Serve families affected by substance use (target those who do not meet requirements for services from Family Home Visiting or other existing programs)
- Tailor existing CHT services/configuration to meet needs of added target populations

Expansion Model: Relationships and Resources

- Primary Care Practices and Accountable Entities/ Systems of Care
- PCMH-Kids
- Women and Infant's Family Care Unit
- OB-GYN Providers/Practices
- MAT Programs
- DCYF - FCCPs
- RIDOH Programs - Family Home Visiting programs & MOMS-PRN
- Medicaid

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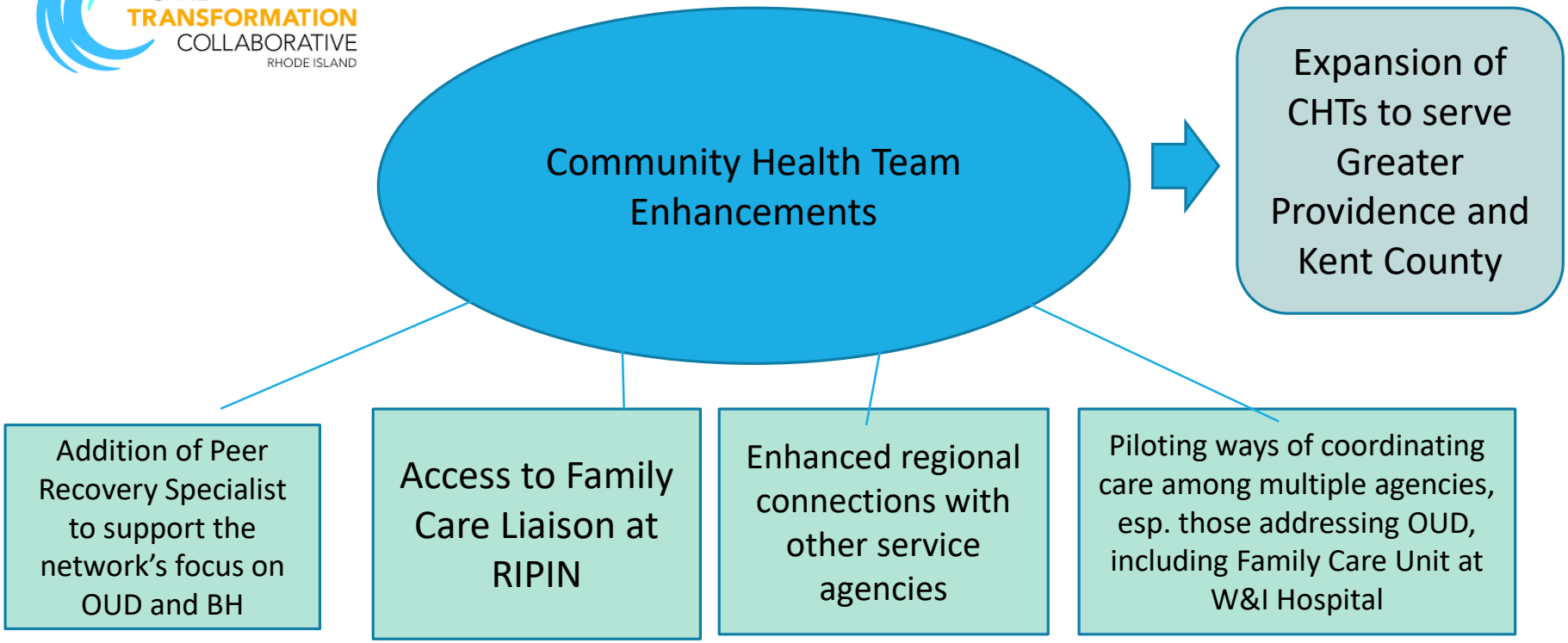
RHODE ISLAND



GOAL: Develop and implement a patient-centered, comprehensive, aligned, value based, sustainably funded program to support a multi-payer, statewide CHT network. Through an "integrated family health" approach, work with existing resources, individuals (adults/children) and families who are "high" or "rising" health risk due to significant social and/or behavioral health needs. Use braided funding from HSTP, SOR, SBIRT and CTC multi-payer contributions to expand the geographic reach of the existing CHT's to cover a larger geographic area, strengthen connections with Medicaid Accountable Entities, add recovery coaches to the team to better serve the needs of individuals and families, and; develop stronger relationships with pre-natal providers, hospitals, home visiting services and pediatric referral systems. Utilize CTC-RI as a central, coordinating body in this work.

Current CHTs

South County Health

Team serving Washington County; serving multiple practices in the region; expanding to Kent County 10/1/19

Blackstone Valley Community Health Care

1 team serving Pawtucket/Central Falls; serving BVCHC and other practices in the region

Thundermist Health Center

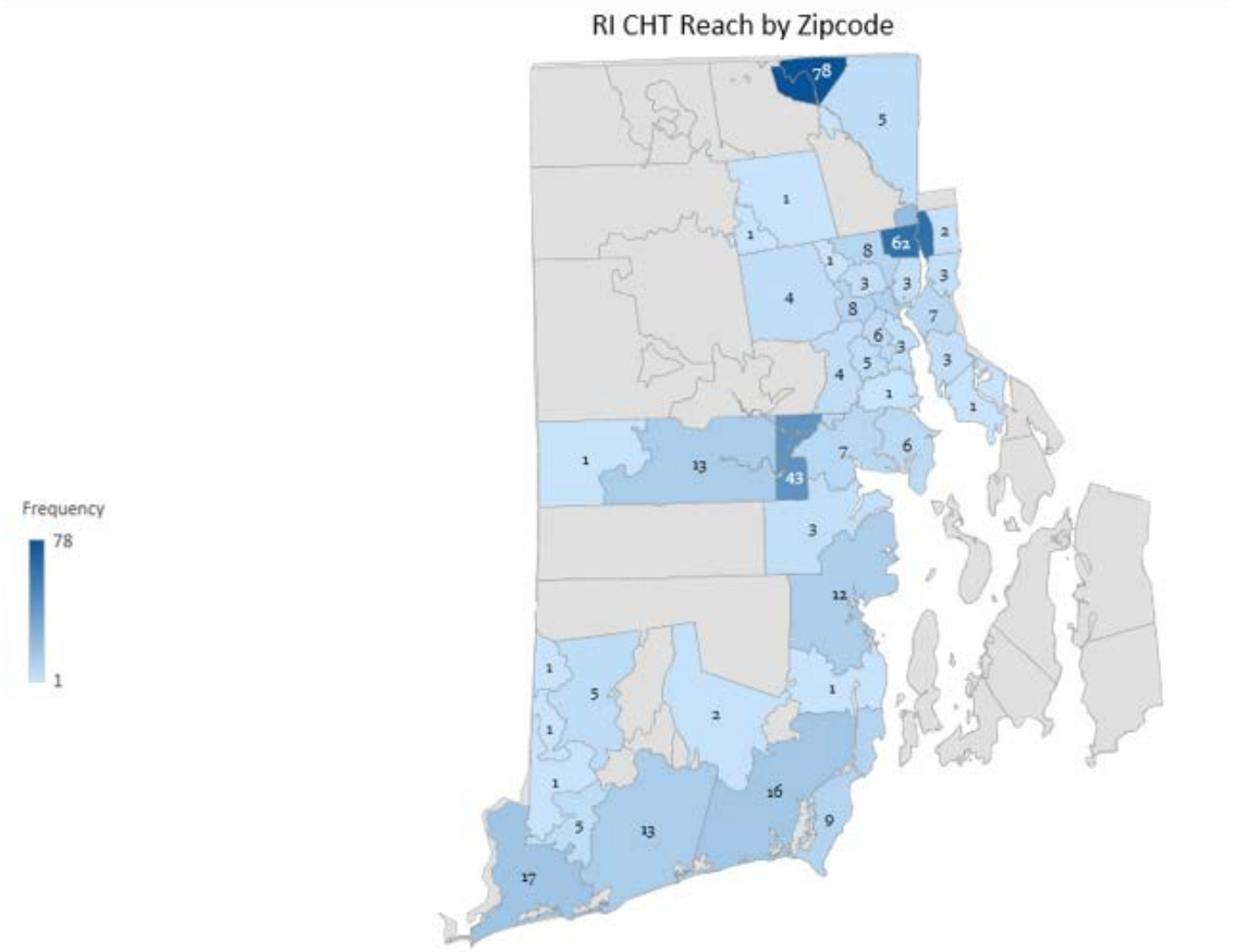
Using funding for 1 team to support 2 teams - W. Warwick and Woonsocket; primarily serving their own patients

FSRI Family Service of Rhode Island
healthy families · strong communities

Expanded to two teams to serve Greater Providence region; serving multiple practices

east bay community action program

1 team serving primarily internal clients in Newport and a small number in East Providence


RI CHT Reach by Zipcode
Frequency
78
1
78
5
1
1
62
2
8
1
3
3
3
4
8
7
6
3
5
3
4
1
1
1
13
43
7
6
3
12
1
5
1
2
1
16
9
3
13
17

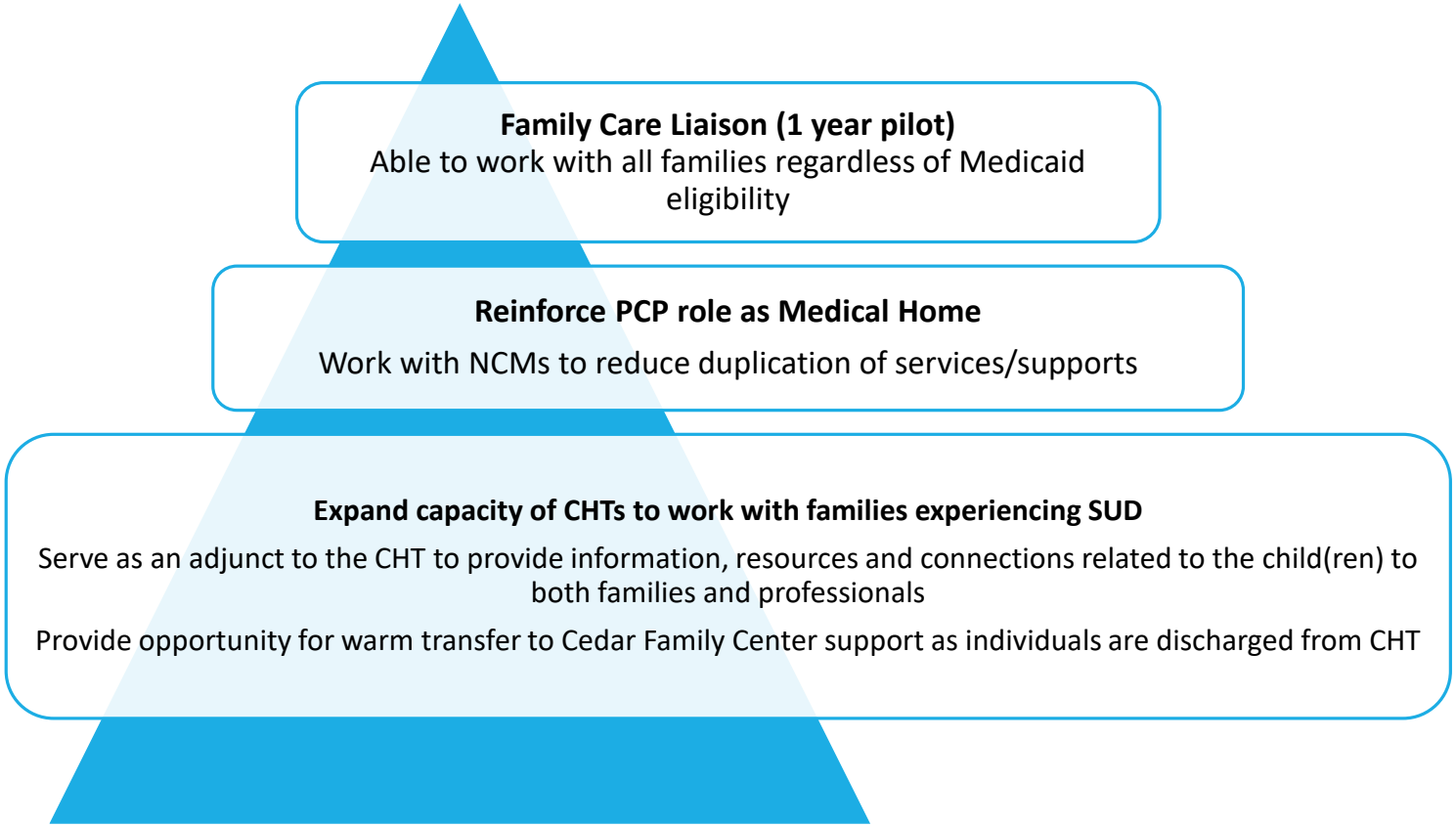
New Role: RIPIN Family Care Liaison

One year, SOR-funded position focused on increasing access to care, capacity building and strengthening coordination among partners.

Main roles:

1. Partner with CHTs to support families, especially those impacted by OUD.
2. Serve as a resource to subset of PCMH kids practices
3. Participate as part of a multi-disciplinary team pilot approach to family care
4. Collect data qualitative and quantitative to inform future planning

Expanding CTC-RIPIN Partnership



Leveraging Cedar

Cedar Family Centers provide intensive care coordination for families with children, ages birth – 21, who have special healthcare needs.

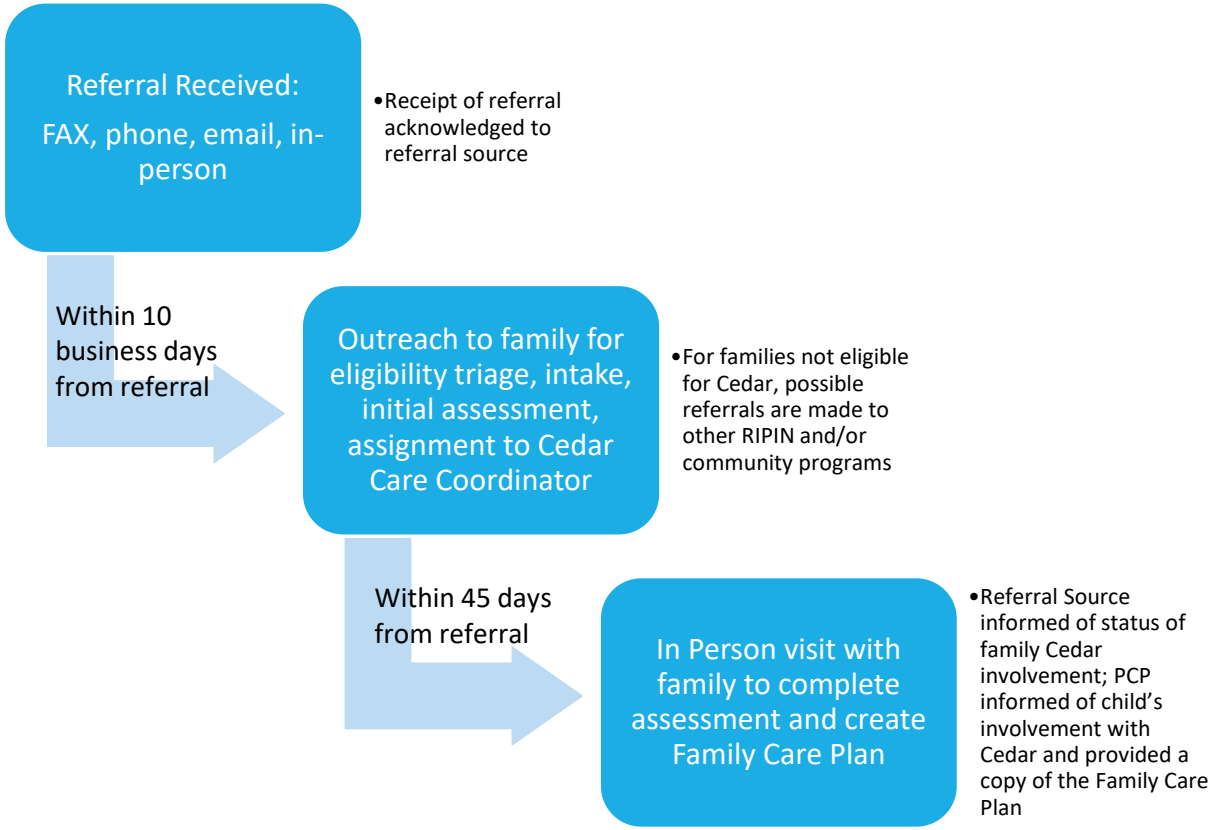
- Locating clinical services (medical and behavioral)
- Referrals to community and social supports
- Health education and prevention
- Screenings for physical and mental health
- Assistance with changes between levels of service
- Supporting families

Eligibility for Cedar Support

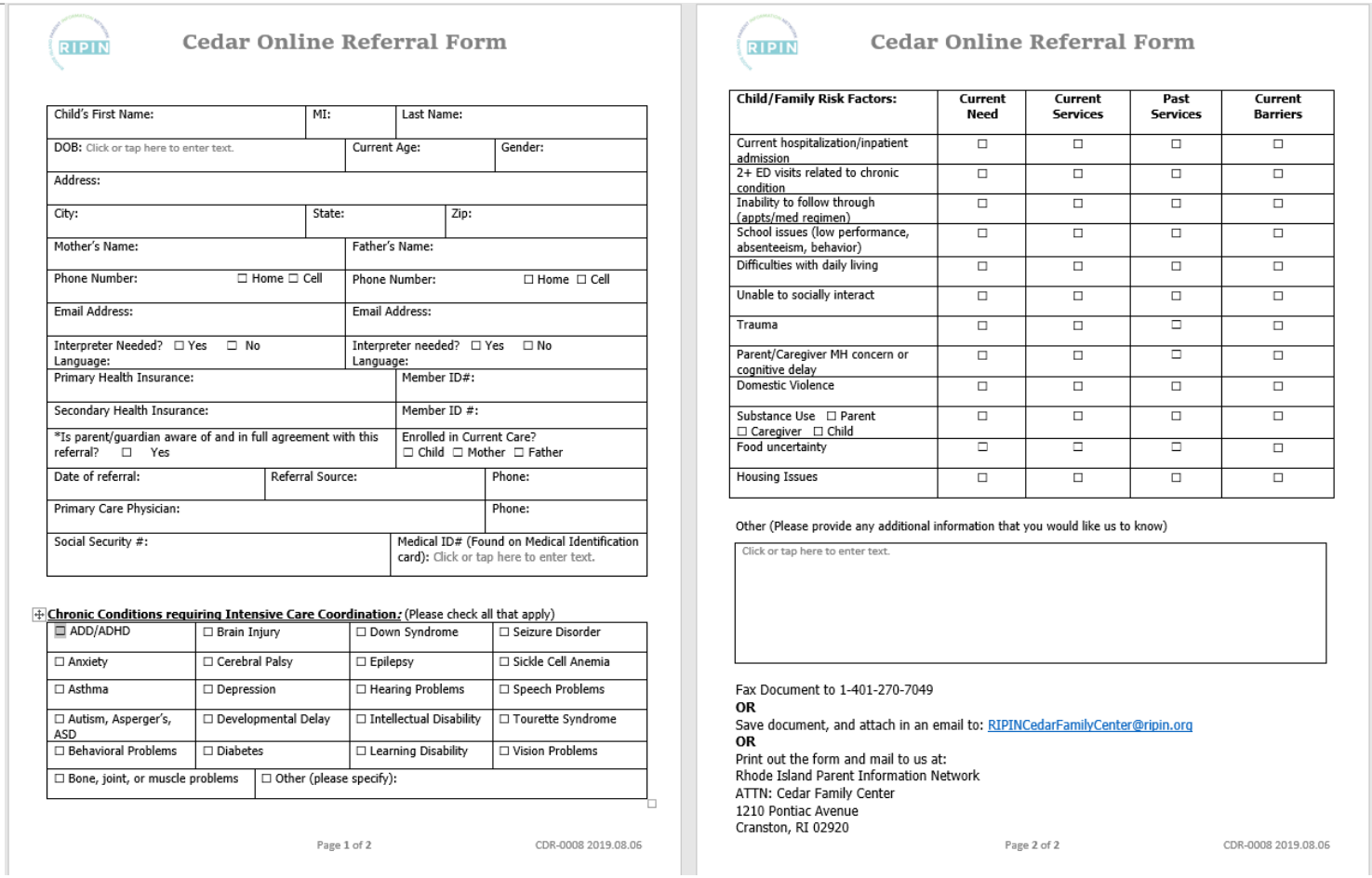
Who is Eligible for Intensive Care Coordination?

- Families of children birth to age 21 with two or more chronic conditions or have one chronic condition and are at risk of developing a second
- Children having a severe mental illness or severe emotional disturbance
- Children must be Medicaid-eligible

RIPIN Cedar Referral Process



Cedar Triage Tool



Cedar Online Referral Form

Child's First Name:	MI:	Last Name:	
DOB: Click or tap here to enter text.	Current Age:	Gender:	
Address:			
City:	State:	Zip:	
Mother's Name:		Father's Name:	
Phone Number: ☐ Home ☐ Cell		Phone Number: ☐ Home ☐ Cell	
Email Address:		Email Address:	
Interpreter Needed? ☐ Yes ☐ No Language:		Interpreter needed? ☐ Yes ☐ No Language:	
Primary Health Insurance:		Member ID#:	
Secondary Health Insurance:		Member ID #:	
*Is parent/guardian aware of and in full agreement with this referral? ☐ Yes		Enrolled in Current Care? ☐ Child ☐ Mother ☐ Father	
Date of referral:	Referral Source:	Phone:	
Primary Care Physician:		Phone:	
Social Security #:		Medical ID# (Found on Medical Identification card): Click or tap here to enter text.	

Chronic Conditions requiring Intensive Care Coordination: (Please check all that apply)

☐ ADD/ADHD	☐ Brain Injury	☐ Down Syndrome	☐ Seizure Disorder
☐ Anxiety	☐ Cerebral Palsy	☐ Epilepsy	☐ Sickle Cell Anemia
☐ Asthma	☐ Depression	☐ Hearing Problems	☐ Speech Problems
☐ Autism, Asperger's, ASD	☐ Developmental Delay	☐ Intellectual Disability	☐ Tourette Syndrome
☐ Behavioral Problems	☐ Diabetes	☐ Learning Disability	☐ Vision Problems
☐ Bone, joint, or muscle problems	☐ Other (please specify):		

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Cedar Online Referral Form

Child/Family Risk Factors:	Current Need	Current Services	Past Services	Current Barriers
Current hospitalization/inpatient admission	☐	☐	☐	☐
2+ ED visits related to chronic condition	☐	☐	☐	☐
Inability to follow through (appts/med regimen)	☐	☐	☐	☐
School issues (low performance, absenteeism, behavior)	☐	☐	☐	☐
Difficulties with daily living	☐	☐	☐	☐
Unable to socially interact	☐	☐	☐	☐
Trauma	☐	☐	☐	☐
Parent/Caregiver MH concern or cognitive delay	☐	☐	☐	☐
Domestic Violence	☐	☐	☐	☐
Substance Use ☐ Parent ☐ Caregiver ☐ Child	☐	☐	☐	☐
Food uncertainty	☐	☐	☐	☐
Housing Issues	☐	☐	☐	☐

Other (Please provide any additional information that you would like us to know)

Click or tap here to enter text.

Fax Document to 1-401-270-7049
OR
Save document, and attach in an email to: RIPINCedarFamilyCenter@ripin.org
OR
Print out the form and mail to us at:
Rhode Island Parent Information Network
ATTN: Cedar Family Center
1210 Pontiac Avenue
Cranston, RI 02920

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Questions?