CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home Rhode Island

CTC-RI Strategic Plan Review of Accomplishments 2018 FYTD

CTC-RI BOARD OF DIRECTORS
FEBRUARY 22, 2019

Strategic Plan Accomplishments 2018 FYTD

Table of Contents

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim.

Overview

1. **Integrated Behavioral Health in Primary Care**
2. **Statewide CHT network - 6 geographic regions - extension of primary care.**
3. **PCMH-Kids sustainability and expansion**
4. **Clinical Strategy Committee**
5. **CDC initiative on hypertension, pre-/diabetes, and cholesterol management**

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Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

1. **Integrated Behavioral Health in Primary Care**
   - Successfully concluded 3 -year IBH pilot project that tested universal screening for depression, anxiety and substance use disorder.
   - This intervention demonstrated an average $45 PMPM lower total cost of care than our CTC practices and $63 PMPM lower cost of care than the non-PCMH comparison group.

- **SBIRT** Exceeded Year 1 SBIRT screening targets by 52%
  - 7858 screens completed across 20+ sites
  - Follow-up screens 74% (target 75%)

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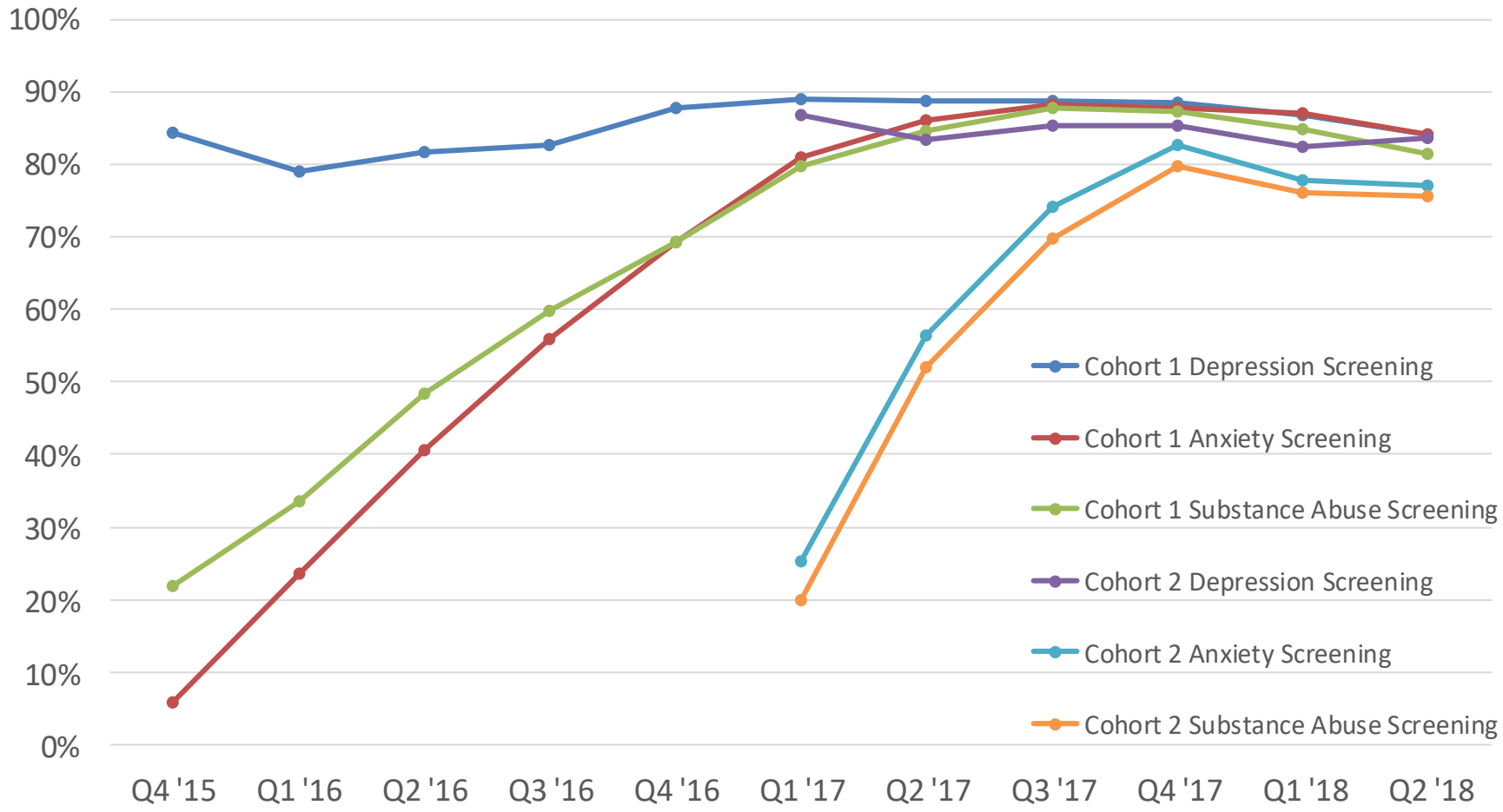
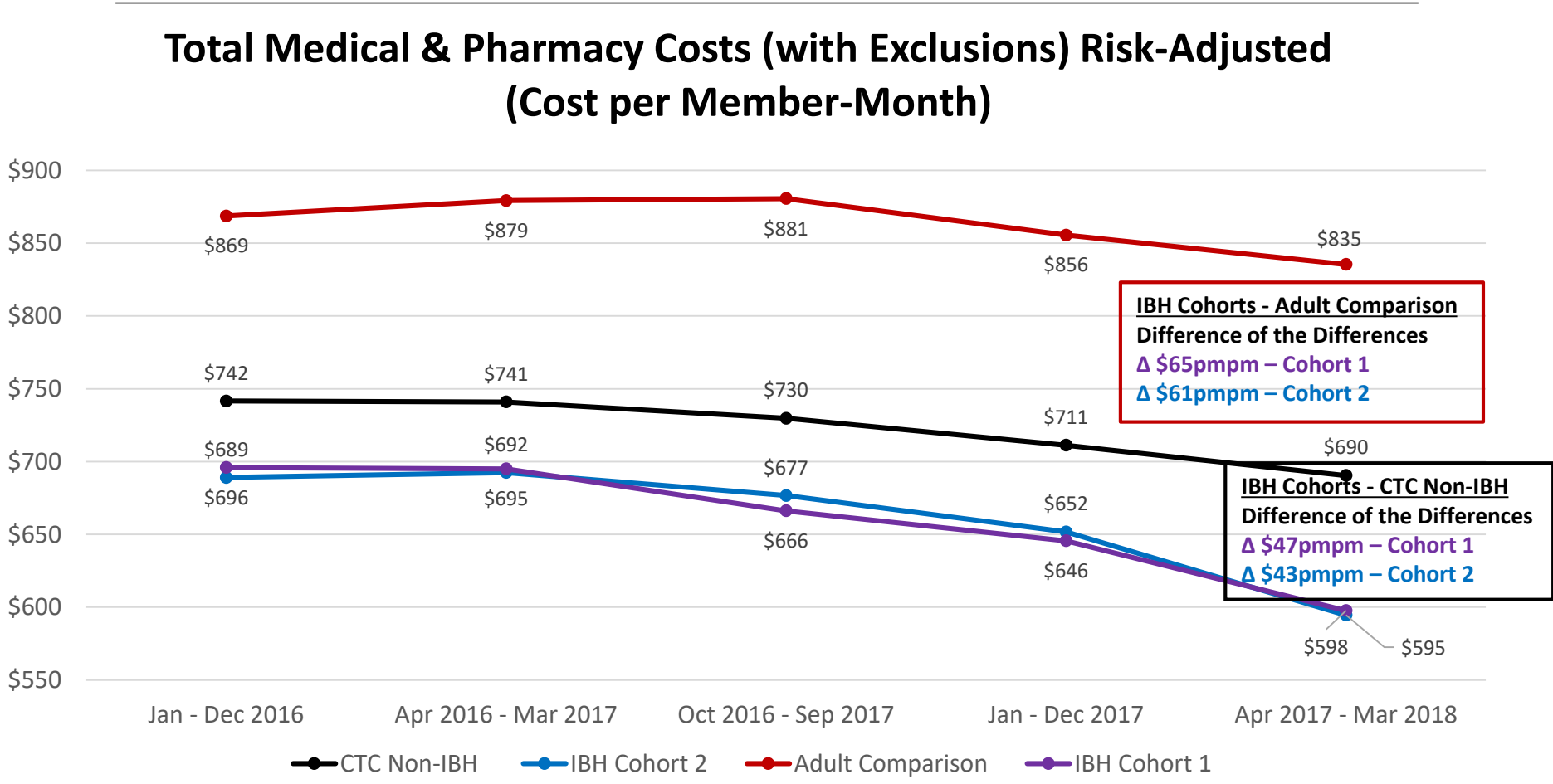
IBH Pilot Results: Universal Screening Cohort 1 & 2



IBH Pilot Results:
Better Care - Lower Costs



Data Source: Rhode Island All Payer Claims Database

CELEBRATING 1 YEAR OF RI-SBIRT!

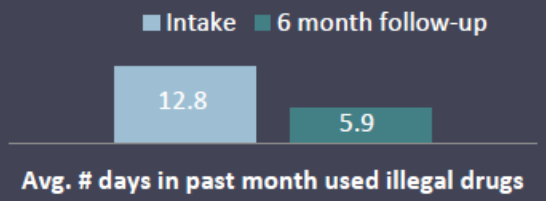
September 2017 - September 2018

7,858 Screens Completed

1,460 interventions

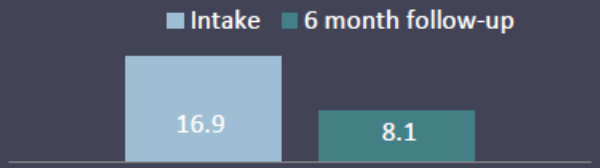
9 out of 10 people at risk received an intervention.

Clients who received an intervention for drug use reported a significant decrease in the average number of illegal drug use days at follow-up.



Avg. # days in past month used illegal drugs

Clients who received an intervention for risky alcohol use reported a significant decrease in the average number of alcohol use days at follow-up.



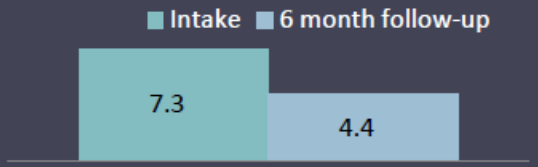
Avg. # days in past month used alcohol

1 of every 2 (53%) clients who reported illegal drug use at intake reported no use 6 months later.

Of those selected for follow-up, only 15% of clients who reported opiate use at intake reported use at follow-up.

20 clients at intake → 3 clients at follow-up

Clients who reported marijuana use at intake reported significantly fewer marijuana use days at follow-up.

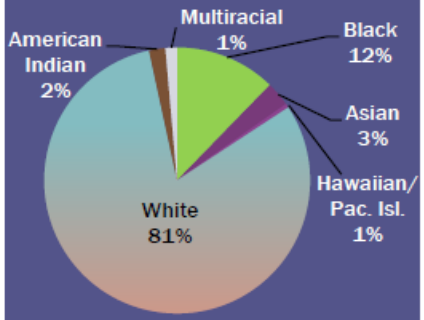


Avg. # days in past month used marijuana

There was a significant decrease (49%) in the number of clients who reported past month alcohol use from intake to follow-up.

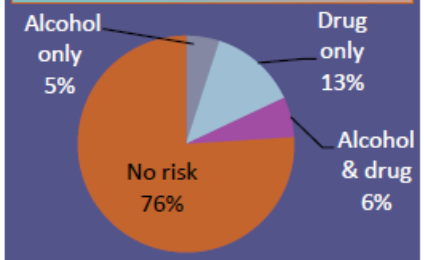
2 out of 5 (40%) clients who reported binge drinking in the month before intake reported no binge drinking at follow-up.

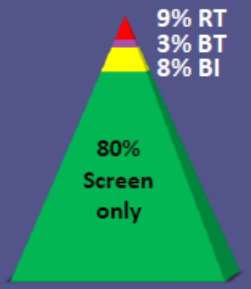
WHO WE SCREENED



- *18% of clients were Hispanic*
- *59% of clients were female*
- *Average age = 47*

Percent of clients who reported risky use of alcohol and/or drugs





20% of clients received an intervention

Murphy, L., Bassett, S.S., & Stein, L.A.R. (2018). *Celebrating one year of RI-SBIRT* [Handout]. Kingston, RI: University of Rhode Island.

RT = referral to treatment; BT = brief treatment; BI = brief intervention

Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

2. **Statewide CHT network established covering 6 geographic regions working as an extension of primary care.**
   - Teams have significantly reduced the high-risk patients risk scores by 42% from intake to discharge.
   - Depression and anxiety scores significantly reduced from intake to discharge.
   - Total cost of care analysis for South County Hospital shows early data - small N - not significantly, but directionally correct. Adding Thundermist data to increase sample size for analysis.
   - URI conducting quality of life and patient satisfaction evaluation for Q3/4 2019
   - Sustainability planning continues:
     - Completed sustainability plan with Day Health Solutions,
     - In discussions with Medicaid,
     - Working with Medicaid to convene a meeting with AE's.

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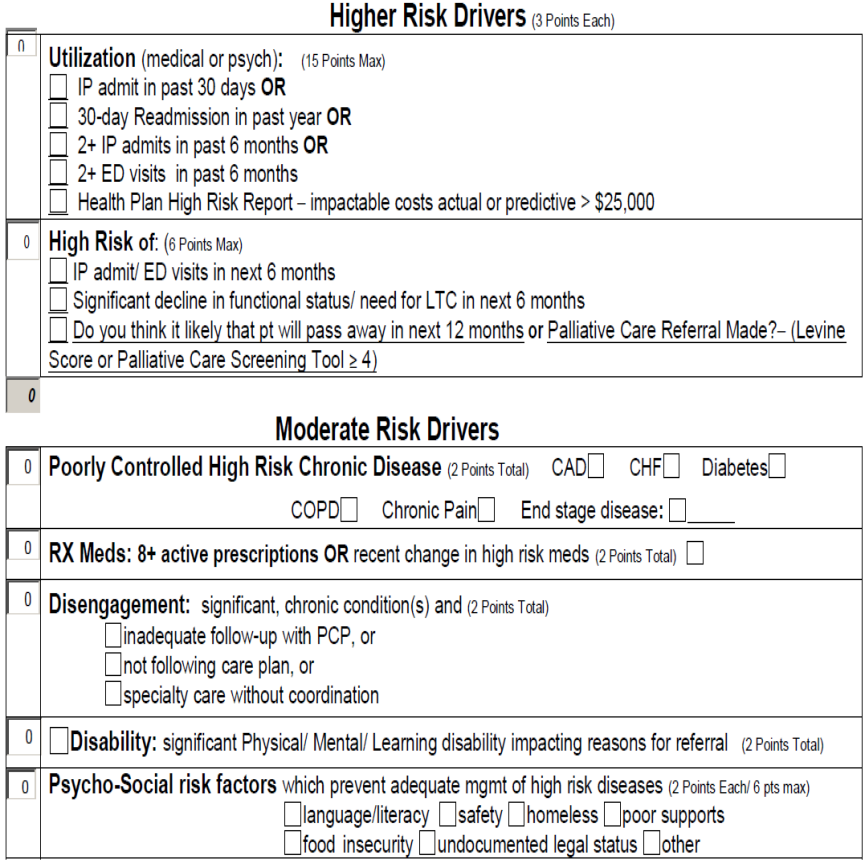
CHT Results to Date: Clients Served and SDOHs

N = 202
CHT Intakes
10/01/18-
12/31/18

Demographics	
Gender	63% Female
Age	Mean = 54
English Speaking	35% Non-English Speaking
Hispanic	22%
Non-white	25%
Social Determinants of Health Present at Intake	
Housing	44%
Finance	44%
Transportation	38%
Food	29%
Caregiver Support	20%
Interpersonal Violence	18%

CHT Referral Triage Tool Mechanism by which PCPs Identify High-Risk Referrals to CHTs



Higher Risk Drivers (3 Points Each)

0 **Utilization** (medical or psych): (15 Points Max)
- ☐ IP admit in past 30 days **OR**
- ☐ 30-day Readmission in past year **OR**
- ☐ 2+ IP admits in past 6 months **OR**
- ☐ 2+ ED visits in past 6 months
- ☐ Health Plan High Risk Report – impactable costs actual or predictive > $25,000

0 **High Risk of**: (6 Points Max)
- ☐ IP admit/ ED visits in next 6 months
- ☐ Significant decline in functional status/ need for LTC in next 6 months
- ☐ Do you think it likely that pt will pass away in next 12 months or Palliative Care Referral Made?– (Levine Score or Palliative Care Screening Tool ≥ 4)

0

Moderate Risk Drivers

0 **Poorly Controlled High Risk Chronic Disease** (2 Points Total) CAD☐ CHF☐ Diabetes☐ COPD☐ Chronic Pain☐ End stage disease: ☐____

0 **RX Meds: 8+ active prescriptions OR** recent change in high risk meds (2 Points Total) ☐

0 **Disengagement:** significant, chronic condition(s) and (2 Points Total)
- ☐inadequate follow-up with PCP, or
- ☐not following care plan, or
- ☐specialty care without coordination

0 ☐**Disability:** significant Physical/ Mental/ Learning disability impacting reasons for referral (2 Points Total)

0 **Psycho-Social risk factors** which prevent adequate mgmt of high risk diseases (2 Points Each/ 6 pts max)
☐language/literacy ☐safety ☐homeless ☐poor supports
☐food insecurity ☐undocumented legal status ☐other

0 **Substance Abuse:** Actively using, newly sober, motivated to change (2 Points Total)
☐Alcohol ☐Opioid ☐Benzodiazepine ☐Other

0 **Mental Health DX** that is severe, persistent, and uncontrolled: (2 Points Total) ☐Schizophrenia
☐Major Depression ☐Bipolar ☐Debilitating Anxiety ☐Other _____

0

Fundamental Risk Drivers (1 Points Each)

0 **Chronic Disease/ Co-morbidities** – not well controlled/ not noted above (1 Point)☐

0 **Functional Impairments** – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point Each)☐

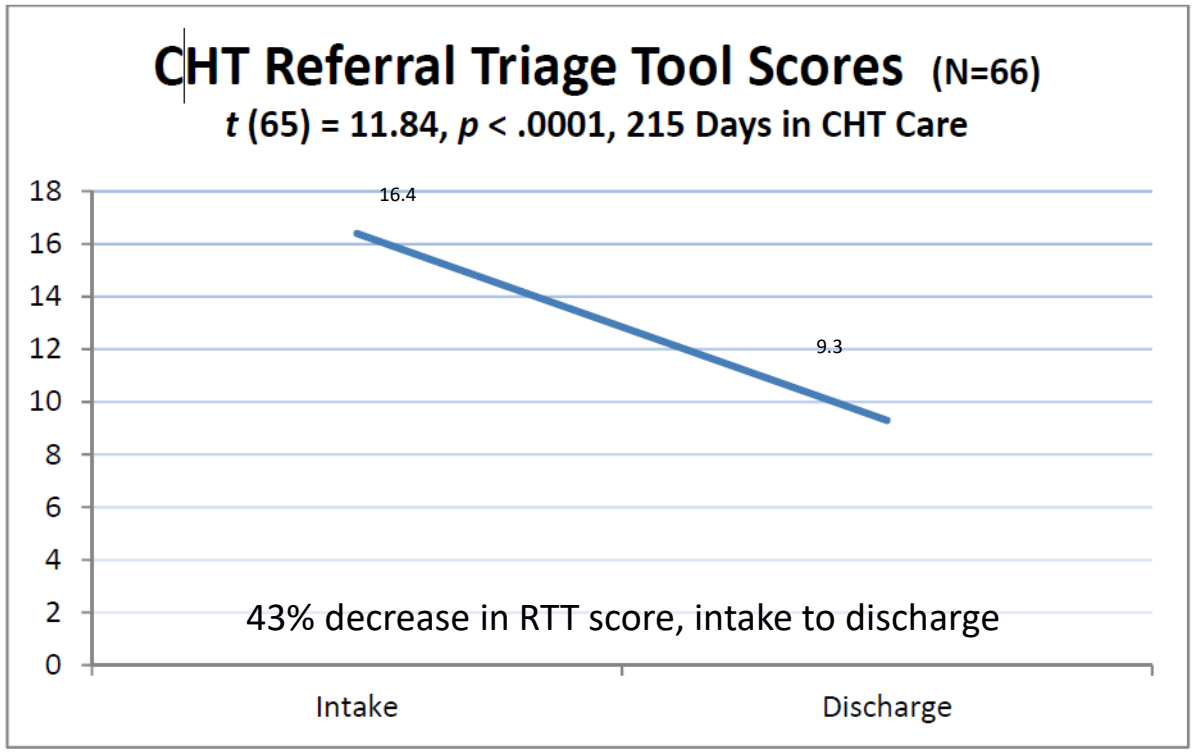
0

Eligibility Determination for CHT

- >15 = High-Risk (offer CHT to patient)
- 8-14 = Rising Risk (patient may meet criteria for CHT)
- <8 = Discuss referral with CHT before offering to patient

CHT Outcomes to Date

RTT Data Summary from 3 CHTs



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3. PCMH-Kids

- Cohort 1 bridge funding from UHC and NHP; sustainability payments to be included in Medicaid rates.
- July expansion to 17 practice sites; 64 providers; 43k lives.
- Total PCMH-Kids population = 109,818
- Represents over half of all children in the state and over 90% Medicaid children in a CTC PCMH.
- IBH learning collaborative – SBIRT screening for adolescents.

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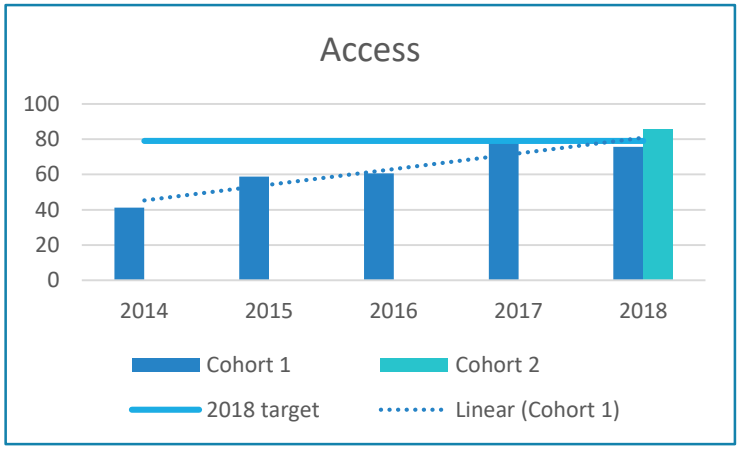
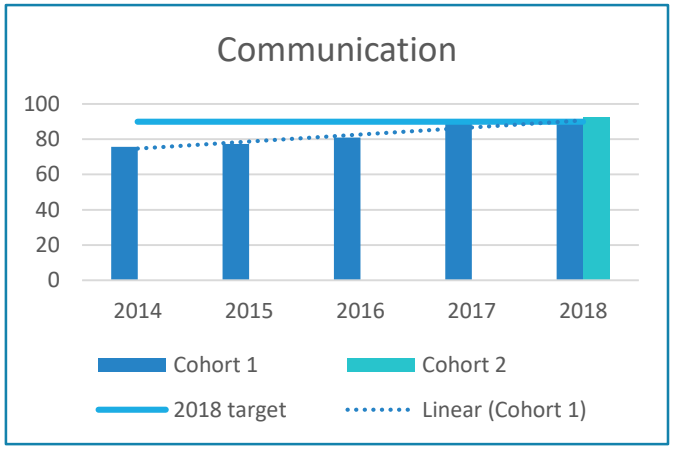
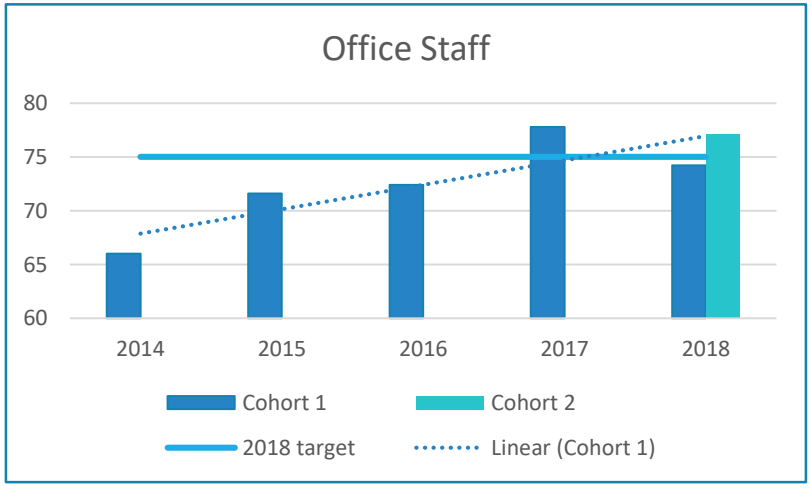
Results to Date: PCMH-Kids Improved Customer Experience

Patient Experience Survey Results PCMH-Kids Cohort 1 & 2

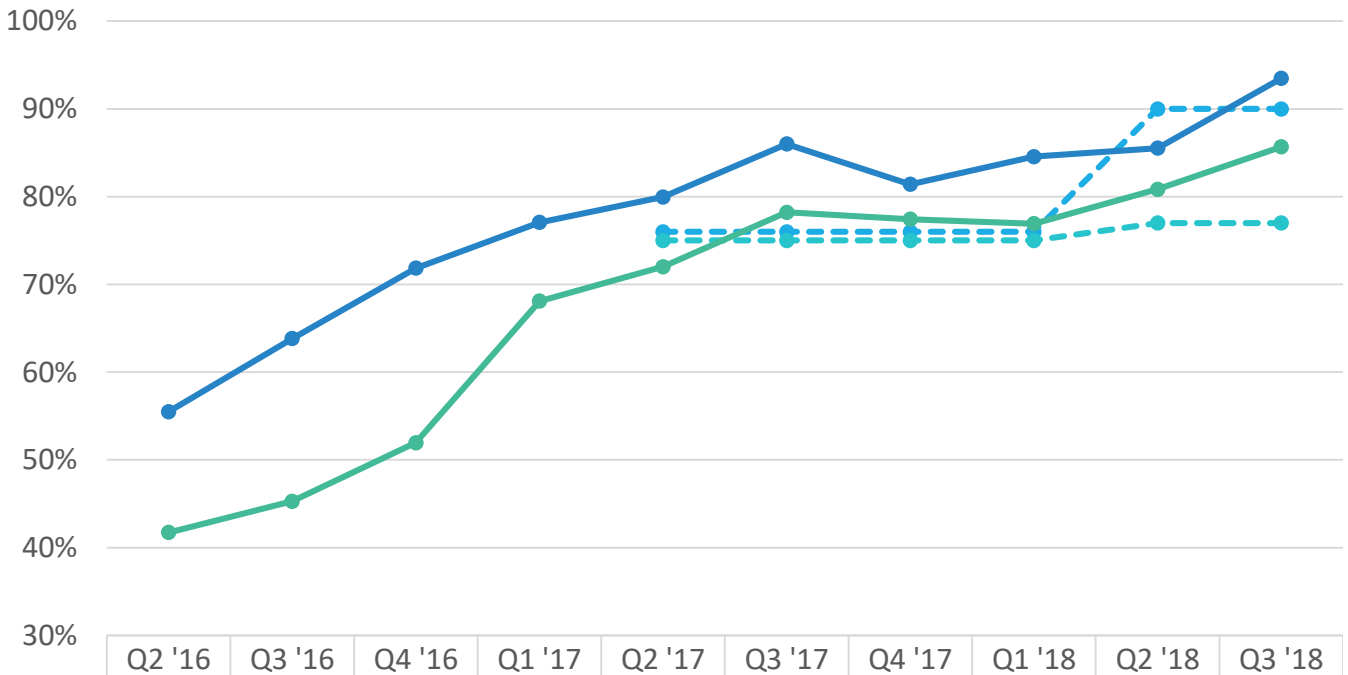






Results to Date: PCMH-Kids Improved BMI and Developmental Screening Rates

Quality Measures PCMH-Kids Cohort 1 & 2



	Q2 '16	Q3 '16	Q4 '16	Q1 '17	Q2 '17	Q3 '17	Q4 '17	Q1 '18	Q2 '18	Q3 '18
BMI Target					76%	76%	76%	76%	90%	90%
BMI	55%	64%	72%	77%	80%	86%	81%	85%	86%	93%
Developmental Screenng Target					75%	75%	75%	75%	77%	77%
Developmental Screenng	42%	45%	52%	68%	72%	78%	77%	77%	81%	86%

Results to Date: Improved ED Utilization

PCMH-Kids Cohort 1 & Kids Comparison
Rate per 1,000 Member Months (Excluding ERISA Members)

Group	July 2015 – June 2016 (A)	July 2016 – June 2017 (B)	Difference (2015 – 2017) (B-A)	% Difference (2015 – 2017)
Emergency Department Visits				
(1) Kids Cohort 1	29.2	28.6	-0.7	-2.3%
(2) Kids Comparison	29.0	29.0	0.1	0.2%
Difference (1–2)			-0.7	-2.5%
Inpatient Discharges				
(1) Kids Cohort 1	1.5	1.5	0.01	0.7%
(2) Kids Comparison	1.2	1.2	0.01	0.5%
Difference (1–2)			0.00	0.3%

Results to Date PCMH-Kids

Integrated Behavioral Health Services into Pediatric Primary Care through:

1. **Hired onsite social worker care coordinators .**
2. **Improved screening for social-emotional challenges in infants and toddlers.**
3. **Multi-practice IBH learning collaboratives participation focused on:**
   - **ADHD** screening, diagnosis and treatment plans;
   - **Maternal post-partum depression screening**:
     - Improved screenings from a baseline of 22% to 87%
     - and implemented referrals protocols for intervention.
   - **Screening, Brief Intervention, Referral, and**
     - **Treatment (SBIRT) in adolescents**: 75 providers,
     - with a total pediatric population of ~34,000,
     - enrolled in the learning collaborative;

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4. **Clinical Strategy Committee rechartered as a Board subcommittee co-chaired by Matt Collins, MD MBA and Andrew Saal, MD MPH**
   - Increased representation systems of care, Medicaid, OHIC.

   - Progress has been made in the identified 3 prioritized areas of work:
     1. Primary Care / Specialist Collaboration: ACP High-Value Care Coordination Kickoff Feb 19th for 6-month project. 23 practices (12 primary care and 11+ specialist)

     2. Low-Value Care: Project continues to gain momentum. Review of preliminary data of 10 identified measures 3/15/19.

     3. Improving Clinician Well-being (reduce administrative burden): CSC supported RIDOH effort to stop hospital waivers of Transition of Care (TOC) documentation regulations which will benefit clinicians. CSC was asked to work with RIDOH Primary Care Physician Advisory Committee to help reduce burnout. Additional potential areas of work supported by CSC to work to increase ED/PCP collaboration and PCP involvement to improve TOC with hospitals.

Goal 1: To continue to transform primary care in the context of an integrated health care system by **shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)**

5. **CDC Chronic Care Initiative focuses on best practices**
   - Hypertension and undiagnosed hypertension
   - Diabetes and Pre-diabetes
   - Cholesterol management
   - Practice facilitators working with 24 practices
   - CTC providing data management services to capture and display practice performance

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New Funding Furthering Investments in CTC Mission – Total over $1M for 2019 FYTD

UnitedHealthcare – xGLearn; IBH program 10 practices; Kids bridge

Tufts Health Plan – IBH online training module; PCMH-Kids home visiting/IBH; enhanced analytics and functionality of APCD data

Integra – IBH – 5 pediatric and 5 adult practices; and train the trainer

RIQI/SIM – 10 practices to testing Advanced Directives technology platform

RIDOH/CDC – Chronic care initiative HTN, diabetes, cholesterol management

RIDOH Project LAUNCH – IBH sustainability

NHP- PCMH-Kids bridge for Medicaid

Goal 2: Cultivate and establish relationships that enable and enhance our ability to successfully implement our programs.

1. Clinical Strategy Committee representation expanded to ACO/AE

- Leadership co-chaired by Matt Collins, MD MBA and Andrew Saal, MD MPH.
- Committee representation expanded to include Medicaid, ACO and AE representation.
- Specialist engagement via HVCC project, potentially ED/PCP communication and PCP role in TOC with hospitals.

2. CTC to work with RIDOH Primary Care Physician Advisory Committee to reduce burnout/improve provider wellness

3. SIM/CMS Site Visits to review IBH and CHTs; SIM vendor meetings

4. Collaboration with National Associations

- Milbank multi-state collaborative
- American Case Management Association: Test Transition of Care Standards with adult and pediatric primary care practices.
- Patient-Centered Primary Care Collaborative
- American College of Physicians: High-Value Care Coordination project is based on this collaboration.
- American Academy of Pediatrics – SBIRT screening adolescents

5. RI Outreach

- Children's Cabinet Policy Director: Kayla Rosen, to educate about CTC.
- BHDDH: Michelle Brophy, Director of Policy regarding IBH initiatives in primary care.
- Rhode Island Free Clinic: To participate in RIDOH CCE initiative
- Planned Parenthood: Women's health services and potential partnership for SBIRT.

Goal 3: Adjust our organization's supports and safeguards as CTC grows and changes.

- **Management Services Arrangement with HCA**
  1. Sublease agreement with Healthcentric Advisors has been renewed.
  2. Management Services Agreement – revised pricing structure.
  3. Converted IT systems (conference lines, shared files) from UMMS to CTC-RI.
  4. Information Technology (IT) - CTC IT is hosted on HCA server. CTC will be upgrading encryption and security software under HCA management contract to position CTC to host PHI if necessary in the future.
  5. Explored possibility of CTC using file server, policies and procedures for data storage security systems containing PHI. While CTC doesn't have an immediate need for this, anticipating for the future.
  6. Also discussed the possibility of additional space if we were to expand.
  7. CTC is initiating an internal planning process with respect to CHT data collection that would include PHI. This has been prompted by CTC's state contract for CHT's centralized network management. Final plan will be brought to CTC Board for discussion at a future date.

Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination.

1. All-Payer Claims Database

- Now with 5 data points, 6th to be added April 2019
- Continued enhancements allow risk-adjusted and unadjusted utilization and cost measures display as well as provider-specific and health plan-specific results.
- Supporting Brown School of Public Health / Ira Wilson efforts to identify and connect PCPs to practices and systems of care APCD.

2. Quarterly Breakfast of Champions

- September 2018 and February 2019 meetings with 65-80 attendees:
  - Presentation of CTC IBH program and results.
  - Presentation on use of scribes in RI PCP practices.
  - Breakout discussions on screening and mitigating SDOH and improving primary care / specialist.
  - EOHHS presentation “Efforts to Improve Technology and Data Flow to Impact Care”.

3. Annual Conference (Attendees 330+) with National Speakers

- NYS: 1st 1000 Days Campaign
- VT: Women’s Health and Care Coordination
- Maine: Integrated Behavioral Health
- Massachusetts: Neighborhood Risk Scores and Medical Legal Partnership
- CT: “What Patients Want”

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Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (continued)

4. Nurse Care Manager training

- Geisinger Core Curriculum Training Program: 52 NCM/CC Trained; Pediatric faculty certified as a trainer.
  - 88% improved care management skills
  - 60% improved risk stratification
  - 53% developed patient engagement expertise
  - 45% improved ability to manage behavioral health challenges
- Diabetes Train-the-Trainer Program: 50+ NCM trained
- Pediatric High-Risk Framework: PCMH-Kids practices tested and refined pediatric-sensitive high-risk framework.
- Nurse Care Manager Training in Medication Assisted Treatment
  - Colleen LaBelle, MSN, RN-BC, CARN content expert presented 2 sessions > 60 attendees
- Diabetes Train-the-Trainer Program: 50+ NCM trained
- Pediatric High-Risk Framework: PCMH-Kids practices tested and refined pediatric-sensitive high-risk framework.

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Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (continued)

5. **Data and Evaluation Committee**
   - Oversight for:
     - IBH Qualitative Analysis
     - IBH Quantitative Analysis
     - Onpoint All-Payer Claims Database Analysis
     - Alignment with OHIC

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Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

- **State/Regional/National Presentations, Publications, Awards Part 1**

  - **University of Rhode Island:** Debra Hurwitz and Dr. Nelly Burdette presented the CTC Integrated Behavioral Health Pilot, Integrated Behavioral Health Transformation in Rhode Island: How the Smallest State Plans to Make the Biggest Changes.

  - **PCMH Congress national presentation:** CTC and practices presented their work on integrated behavioral health at the September national conference " A Successful Blueprint for implementing Integrating Behavioral Health in Primary Care".

  - **PCPCC Collaborative:** Debra Hurwitz, MBA, BSN, RN and Pano Yeracaris, MD MPH participated in workshop on increasing investment in primary care. This invitation-only workshop is aiming to engage about 100 thought leaders from around the country with the goal of advancing primary care investment in states across the country.

  - **RI Foundation Community Leadership Award 2018**

  - **AAP recognition of PCMH-Kids as a national model 2018**

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Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

- **State/Regional/National Presentations, Publications, Awards Part 2**

  - **RIDOH Health Equity Summit:** Debra Hurwitz participated in a panel discussion and Linda Cabral presented a poster "Addressing Health and Social Needs with Community Teams" at the annual DOH Health Equity Summit in September.

  - **Milbank Multi-State Collaborative Steering and Convener Meeting:** Kansas City, MO Debra Hurwitz participated with Nick Minter and Rayva Virginkar of CMMI: Track 3 for CPC+ in September.

  - **Abstract Submissions:**
    - PCMH Congress "PCMH-Kids: A Patient-Centered Medical Home Program that Works for Children and Families"
    - City Match: "PCMH-Kids: A Patient-Centered Medical Home Community that Works for Children and Families"

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

- **State/Regional/National Presentations, Publications, Awards Part 3**

  - Providence Community Health Center, Andrew Saal, MD, MPH Chief Medical Officer and Nelly Burdette Psy.D Director of Integrated Behavioral Health, discussed the operational and clinical system changes required when scaling the universal screening pilot up to the whole population in their presentation, "Population Health Meets Integrated Behavioral Health within an FQHC."

  - PCMH-Kids leaders Patricia Flanagan, MD, FAAP and Elizabeth Lange, MD, FAAP, honored by American Academy of Pediatrics in November with the 2018 AAP Calvin C.J. Sia Community Pediatrics Medical Home Leadership and Advocacy Award.

  - Suzanne Herzberg PhD, MS, OTR/L, Director of Transformation at Brown Primary Care Initiative, presented at the International Conference on Practice Facilitation Tampa, FL in December.

  - PCMH-Kids: December 2018 Rhode Island Medical Journal

Goal 5: Evolve CTC Board of Directors to a Governance Board that is able to provide appropriate oversight to CTC as a 501c3 nonprofit

- **Executive Committee:** Executive Committee charter revised based on input form Board. By-laws amended by CTC attorney and voted on by Board in August. CTC held its first Executive Committee call in September.
- **Nominating Committee:** July meeting to discuss open positions with recommendations for Board of Directors approval. Orientation of Deborah Powers to Board of Directors.
- **Finance Committee:** Budget reviewed by health plans in June. Presented recommendation for establishing 403b for CTC staff.

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Next Steps - CTC Management Team

1. Launch February HVCC Pilot Program.
2. Low-value care review data in March and refine project statement/budget.
3. Kickoff IBH projects in February/March –
   UHC 9 practices / Integra 10 practices.
4. PCMH-Kids expansion - April onboard; go live July 1.
5. Deploy annual provider well-being survey in March.
6. CHT sustainability work with Medicaid - March AE meeting.
7. APCD – continue to enhance utility of APCD data.
8. Program evaluations – work with Brown and URI – CHT and IBH evaluations.
9. Participate and inform the state and national policy discussions.

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Board Discussion

1. Are these still the right goals?
2. Is the focus correct for the 2020 projects?
3. Review of CTC committee structure.
4. Are there Board development activities?
5. Other?

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CTC-RI COMMITTEES: CONTRIBUTIONS TO STRATEGIC PLANNNG GOALS (2018-2019)

Practice Reporting / Practice Transformation Committees:

Practice Reporting Chairs: Patty Kelly-Flis and Andrea Galgay
Practice Transformation Chairs: Charlotte Crist and Sarah Fessler
Combined Practice Reporting and Transformation into one Committee

Practice Reporting Charge: Review practice data quarterly, perform data validation, public reporting via CTC-RI web portal, support quarterly performance improvement and data sharing meetings with practice staff, and assist with EMR/IT issues where possible. Serve as liaison to other committees.
Practice Transformation Charge: Support practice transformation through conferences, convene best practice learning collaborative sessions, support practice-based coaching and technical assistance, and support workforce development for PCMH.

Accomplishments:
Practice Reporting:

- Clinical quality reporting using updated measurement specifications,
- training for successful submission for CAHPS survey,
- training on using APCD and Onpoint portal and
- preparation for meeting OHIC PCMH and new clinical quality measure expectations.

Best Practice Sharing:

- Customer experience,
- clinical quality measures,
- transitions in care and medication reconciliation,
- NCQA renewal process, and
- pre-visit planning.

Data and Evaluation Committee:

Chairs: Peter Hollmann and Jay Buechner

Charge: Lead performance improvement, measure selection and harmonization, develop goals and benchmarks, evaluation, research, and liaison with the APCD. Serve as liaison to other committees.

Accomplishments:

- Provided oversight for IBH qualitative analysis, IBH quantitative analysis, Onpoint All-Payer Claims Database and CAHPS,
- alignment with OHIC and eQM project, and
- approved 2018-19 Performance Standards for Adults and PCMH Kids and changes to quality measures and thresholds.

PCMH-Kids Stakeholder Committee:

Chairs: Pat Flanagan and Elizabeth Lange

Charge: To guide and drive the activities within the PCMH-Kids Initiative.

Accomplishments:

- Practices presented outcomes from implementing of PCMH-Kids high-risk framework,
- best practice sharing from implementing Service Delivery Requirements and Screening, Brief Intervention and Referral to Treatment Adolescent Initiative,
- built partnership with KIDS NET to obtain practice profile information,
- built partnership with KIDS COUNT to help launch RI 1st 1000 Days campaign,
- built partnership with Home Visiting Program to pilot increased care coordination for at-risk children and families.

Clinical Strategy Committee:

Chairs: Matthew Collins and Andrew Saal

Charge: Identify and test clinical and financial strategies to improve quality and reduce cost.

Accomplishments:

- Committee rechartered as a Board subcommittee,
- increased representation systems of care, Medicaid, and OHIC,
- progress made on 3 prioritized areas: Primary care/Specialist Collaboration, Low Value Care, and increasing clinician well-being.

Breakfast of Champions

Facilitator: Pano Yeracaris

Charge: Quarterly meeting of CTC practice clinical champions and office leaders to focus on: best practice sharing, learning to strengthen team-based care, and foster joy in work as critical components of advanced primary care/PCMH transformation.

Accomplishments:

- Best Practice Sharing: IBH, CHT, Medical Legal Partnership, Eco-system Maltreatment Findings, and Screening for Social Determinants of Health.

Nurse Care Manager/Coordinator Best Practice: Facilitators: Debra Hurwitz and Susanne Campbell Charge: Best practice sharing amongst CTC NCMs and Care Coordinators Accomplishments: • NCM/Care Coordinator Core Curriculum Training Program and report out of capstone projects, • Pediatric High-Risk Framework: testing and reporting on practice implementation, • Resource sharing: RIDOH Community Health Network, Asthma Program, HCA Diabetes Train-the-Trainer Program, CEDAR program, Family Visiting program, United Way 211 program, Kids Link, and Home Care Telemedicine Program.	**Integrated Behavioral Health Committee:** Chairs: Matthew Roman and Rena Sheehan Charge: Establish a workgroup to lead the transformation of primary care in RI in the context of an integrated health care system. Accomplishments: • Best practice sharing for Adult and Pediatric IBH programs including Performance Improvement for reducing ED, • providing group visits for patients with chronic conditions and IBH needs, billing and coding, IBH Care Collaborative opportunity, using psychiatry, adolescent SBIRT Initiative, and • updated IBH charter.
Community Health Team Best Practice: Chair: Liz Fortin Charge: Explore best practice for continued implementation and evaluation of CTC-RI Community Health Teams, geographically located across the state. CHT host agencies include South County Health, Blackstone Valley Community Health Center, Family Service of Rhode Island, Thundermist Health Center, and East Bay Community Action Program. Accomplishments: • In partnership with URI and SIM, developed standardized measurement set and implemented evaluation plan across all teams, • implemented universal screening for depression, anxiety, substance use disorders and social determinants of health, • in partnership with RIDOH and SIM, implemented pharmacy, nutrition and medical legal partnership services for patients served by the CHT, and completed Day Health Solutions Sustainability Plan.	**Finance Committee:** Treasurer and Chair: Al Charbonneau Charge: To recommend CTC financial policies, goals, and budgets as well as review CTC's financial performance against its goals and propose major transactions and programs to the Board of Directors. Accomplishments: • Budget reviewed by Health Plans, • presented recommendations for establishing 403b for CTC staff. **Contracting Committee:** Facilitators: Susanne Campbell and Pano Yeracaris Charge: Responsible for contract development, attribution, and looking at alternate payment models and PCMH as part of a delivery system. Serve as liaison to other committees. Accomplishments: • Reviewed and recommended updated Adult and PCMH Kids Service Delivery requirements • Reviewed and recommended PCMH Kids expansion together with updated common contract, service delivery requirements and rate sheet.