CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

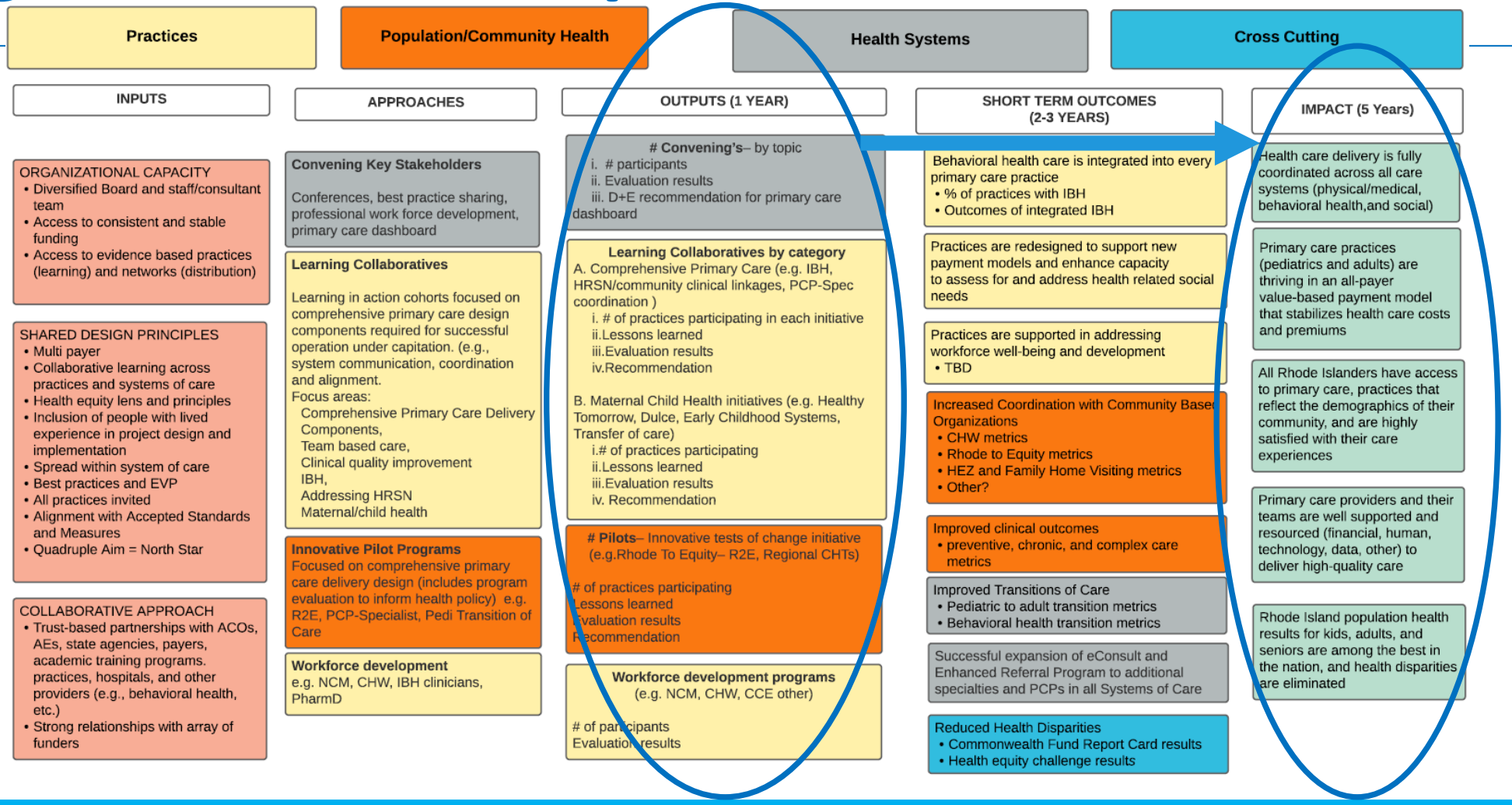
ADVANCING INTEGRATED HEALTHCARE

# CTC-RI Accomplishments Report FY23

Board of Directors | April 26, 2024

*Care Transformation Collaborative of RI*

# Logic Model for Impact – Narrative Link



# Strategic Priorities 5-Year Impact Areas (2022-2027)

Health care delivery fully coordinated across all care systems

Primary care practices thriving in an all-payer value-based payment model that stabilizes healthcare costs and premiums

All Rhode Islanders have access to primary care practices reflecting demographics of their community, and highly satisfied with care experiences

Primary care providers and their teams are well-supported and resourced to deliver high-quality care

Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

Cross-Cutting Themes: Reducing Health Disparities and Improving Health Equity

# Strategic Priorities Impact Area 1 Initiatives

Health care delivery fully coordinated across all care systems

- IBH/TEAM UP
- Asthma
- Health Transitions of Care / Care Coordination
- Healthy Tomorrows / Wellness Visits
- IBH Practice Facilitation Training Program
- NCQA Behavioral Health Distinction
- Pediatric Weight Management

# **Project Spotlight:** Increasing Pediatric IBH Capacity using CHWs

## Funding Support:

Blue Cross Blue Shield of Rhode Island

Point32Health

Harvard Pilgrim Health Care

TUFTS Health Plan

UnitedHealthcare

## Funding and Evaluation Support:

Hassenfeld CHILD HEALTH INNOVATION INSTITUTE BROWN UNIVERSITY

## Program/Training Support:

TEAM UP FOR CHILDREN

# **Project Spotlight:** Increasing Pediatric IBH Capacity Using CHWs

Project Goal: Increase the capacity of pediatric providers and IBH programs by training CHWs in behavioral health care coordination and providing support to a practice's IBH team.

## Core Team:

CHW
IBH Clinician
Provider
Champion/Practice Leader

## Participating Practices

*Coastal Bald Hill
*Coastal Waterman
*CCAP
*Hasbro Children's Hospital Pediatric Primary Care
*Family Care Center
*Wood River Health

# **Project Spotlight:** Increasing Pediatric IBH Capacity Using CHWs

## Project Accomplishments

- Kickoff and Mid-point meeting
- Monthly Practice Facilitation meetings
- 2 IBH clinician trainings days
- Monthly IBH consults
- Monthly CHW case consults
- 5 CHW in-person training days

## QI Projects Started

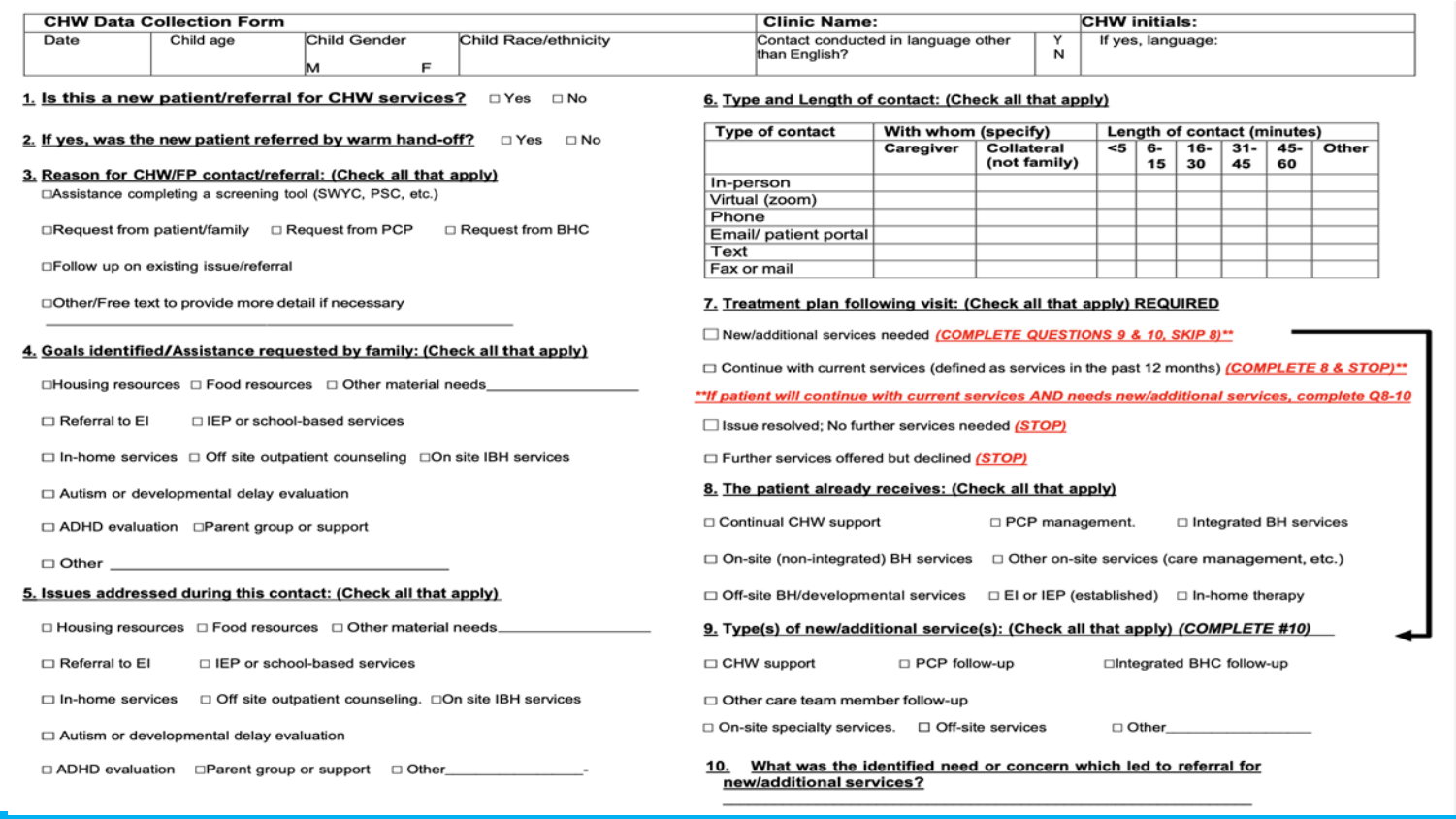
- Improving and Expanding BH Screening
- Increasing and tracking CHW referrals and assessing patient satisfaction
- Increasing IBH capacity and decreasing ED MH visits

# **Project Spotlight:** Increasing Pediatric IBH Capacity Using CHWs

## Baseline Assessments Completed

- Infancy Screening Rates 45-93%
- Adolescent Screening Rates 56-97%

## CHW Data Collection Form



**CHW Data Collection Form** | **Clinic Name:** | **CHW initials:**

| Date | Child age | Child Gender M F | Child Race/ethnicity | Contact conducted in language other than English? Y N | If yes, language: |
|---|---|---|---|---|---|
| | | | | | |

**1. Is this a new patient/referral for CHW services?** ☐ Yes ☐ No

**2. If yes, was the new patient referred by warm hand-off?** ☐ Yes ☐ No

**3. Reason for CHW/FP contact/referral: (Check all that apply)**

☐Assistance completing a screening tool (SWYC, PSC, etc.)

☐Request from patient/family ☐ Request from PCP ☐ Request from BHC

☐Follow up on existing issue/referral

☐Other/Free text to provide more detail if necessary _____

**4. Goals identified/Assistance requested by family: (Check all that apply)**

☐Housing resources ☐ Food resources ☐ Other material needs_____

☐ Referral to EI ☐ IEP or school-based services

☐ In-home services ☐ Off site outpatient counseling ☐On site IBH services

☐ Autism or developmental delay evaluation

☐ ADHD evaluation ☐Parent group or support

☐ Other _____

**5. Issues addressed during this contact: (Check all that apply)**

☐ Housing resources ☐ Food resources ☐ Other material needs_____

☐ Referral to EI ☐ IEP or school-based services

☐ In-home services ☐ Off site outpatient counseling. ☐On site IBH services

☐ Autism or developmental delay evaluation

☐ ADHD evaluation ☐Parent group or support ☐ Other_____-

**6. Type and Length of contact: (Check all that apply)**

| Type of contact | With whom (specify) | | Length of contact (minutes) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Caregiver | Collateral (not family) | <5 | 6-15 | 16-30 | 31-45 | 45-60 | Other |
| In-person | | | | | | | | |
| Virtual (zoom) | | | | | | | | |
| Phone | | | | | | | | |
| Email/ patient portal | | | | | | | | |
| Text | | | | | | | | |
| Fax or mail | | | | | | | | |

**7. Treatment plan following visit: (Check all that apply) REQUIRED**

☐ New/additional services needed *(COMPLETE QUESTIONS 9 & 10, SKIP 8)***

☐ Continue with current services (defined as services in the past 12 months) *(COMPLETE 8 & STOP)***

***If patient will continue with current services AND needs new/additional services, complete Q8-10*

☐ Issue resolved; No further services needed *(STOP)*

☐ Further services offered but declined *(STOP)*

**8. The patient already receives: (Check all that apply)**

☐ Continual CHW support ☐ PCP management. ☐ Integrated BH services

☐ On-site (non-integrated) BH services ☐ Other on-site services (care management, etc.)

☐ Off-site BH/developmental services ☐ EI or IEP (established) ☐ In-home therapy

**9. Type(s) of new/additional service(s): (Check all that apply) *(COMPLETE #10)***

☐ CHW support ☐ PCP follow-up ☐Integrated BHC follow-up

☐ Other care team member follow-up

☐ On-site specialty services. ☐ Off-site services ☐ Other_____

**10. What was the identified need or concern which led to referral for new/additional services?**

_____

# **Project Spotlight:** Increasing Pediatric IBH Capacity Using CHWs

Funding secured so that all practices have opportunity to participate in Y2

Y2 Milestones and Deliverables shared with the practices

# Strategic Priorities Impact Area 2 Initiatives

Primary care practices thriving in an all-payer value-based payment model that stabilizes healthcare costs and premiums

- PCP/Specialist Collaboration Including eConsults and Enhanced Specialist Referrals
- Annual Learning Collaborative Series / Celebration of Champions
- Alzheimer's Disease and Related Disorders (ADRD) Learning Collaborative
- Best Practices Team-Based Care
- Improving Child Health Stakeholder Meeting
- Nurse Care Managers / Care Coordinators
- RI MomsPRN

# Project Spotlight: PCP/Specialist Collaboration Including eConsults & Enhanced Referrals

## Funding Support:

Blue Cross Blue Shield of Rhode Island

Point32Health

TUFTS Health Plan

UnitedHealthcare

## Oversight Committee/ Systems of Care

- CTC-RI, AAMC
- Lifespan (co-chair), CNE/Integra
- EOHHS, OHIC
- BCBSRI (co-chair), UHC, Tufts/Point32Health
- RI Business Group on Health
- Prospect
- RI Quality Institute

Lifespan
*Delivering health with care.*

## National AAMC CORE – "Coordinating Optimal Referral Experience" Model

AAMC Association of American Medical Colleges

CORE®

integra

# Project Spotlight: PCP/Specialist Collaboration Including eConsults & Enhanced Referrals

**Goals:** Help improve timely and equitable access to specialty care, improve the quality and experience of patients, providers and specialists while reducing the cost of care

**eConsult Results thru December 31,2023:**

- Total of 641 successful eConsults have been completed (with only 28 declined and 21 converted)
- More than 95% of eConsults are completed in less than 3 days.
- Greater than 50% of eConsults would have been a referral to a specialist if service was not available.
- Both PCPS & Specialists are very satisfied with eConsults (>90% satisfaction across Lifespan & CNE/Integra)
- Both Systems see the eConsult/enhanced referral effort as a critical part of a broader strategy for specialist engagement and alignment to improve quality and cost of care.

# Project Spotlight: PCP/Specialist Collaboration Including eConsults & Enhanced Referrals

**Lifespan specialties live on eConsults:**
Cardiology, Adult GI, Pediatric GI, Psychiatry, Concussion Care, Neurology, Rheumatology, Benign Heme, OB Medicine, Physiatry, Plastics (Hand)

**CNE/Integra specialties live on eConsults:**
Cardiology, Infectious Disease, Pulmonary, Sleep Medicine, Psychiatry, Geriatrics, Orthopedics, Ob-Gyn, Endocrinology (discontinued)

**Enhanced Referral Results thru December 31,2023:**
**Lifespan**: 5,422 enhanced referrals placed
**CNE/Integra:** 4,023 enhanced referrals placed

**Next Steps:** Lifespan and CNE/Integra starting billing for eConsult services as of March 1,2024;
A subcommittee formed to help manage deployment of the HIE to allow EHR agnostic econsults; "external pivot" strategy is moving forward with technical feasibility, timeline and cost expected in June 2024.

# Strategic Priorities Impact Area 3 Initiatives

All Rhode Islanders have access to primary care practices reflecting demographics of their community, and highly satisfied with care experiences

- Developmental Understanding and Legal Collaboration for Everyone (DULCE)
- Community Health Worker (CHW) Grant (Alignment with Impact Area 5)
- Data and Evaluation Committee (Alignment with Impact Area 5)
- Increasing Pediatric IBH Capacity Using CHWs

# DULCE: Developmental Understanding and Legal Collaboration for Everyone

## Braided Funding

**Rhode Island Department of Health Early Childhood Comprehensive Systems (ECCS):** Funding covers portion of project management expense, consultation time (pediatrician and Rhode Island Association Infant Mental health and Brazelton Training).

**UnitedHealthcare:** Applied for funding and received 2-year funding for Cohort 1 practices ($263,000) which covers practice payments, practice facilitation time, Medical Legal Partnership consultation, Newborn Observation Training, Planning Committee stipends and portion of project management.

**Congressional Direct Spend:** Received 12-month funding (with 3 month no cost extension) which covers practice payments for Cohort 2 practices (2 practices), Cohort 1 practices, practice facilitation/Medical Legal Partnership, planning committee stipends, portion of project management: $273,990.98.

**Tufts Health Plan:** Applied for funding to improve communication and coordination between primary care practices and family visiting organizations. CTC-RI used some of the Tufts funding to help cover the cost of practice payment for Cohort 2: practice five.

**Home and Community Based Funding:** Provides Cohort 2 practices with full support (practice facilitation, Medical Legal Partnership) and "lighter touch" support for Cohort 1 practices together with practice facilitation support specifically for implementation of a business sustainability plan inclusive of FS/CHW billing, added consultation support from Center for the Study of Social Policy for the development of a Theory of Change to support pre-natal integration: $274,315

# DULCE: Developmental Understanding and Legal Collaboration for Everyone

**Milestones through Dec 2023:**

- **Continuation agreement signed with Cohort 1 Practices:** Care New England Family Care Center (prenatal and pediatric) and Coastal Tollgate (pediatric)
- **Enrollment of three new Cohort 2 Practices:** Hasbro (pediatric) Tri-county Community Action Agency, Inc. and Blackstone Valley Community Health Center, Inc. (prenatal and pediatric)
  - Cohort 2 practices hired new family specialists/CHWs
- **Practice Facilitation** established bi-monthly for Cohort 1 practices and monthly for Cohort 2 practices
- **Interdisciplinary Teams** established for Cohort 2 practices
- **Brazelton Training** Provided in Dec 2023 to 7 Family Specialists/CHWs
- **Newborn Observation Training:** 3 FS/CHW attended NBO training (offered on-line) to the new FS/CHW. The third new FS/CHW will attend online training in Spring 2024.
- **Kick off Meeting:** September 28, 2023
- **Second Learning Collaborative Meeting:** December 14, 2023
- **Reflective Consultation:** Family Specialists/Community Health Workers (FS/CHW): Cohort 1 (September 2023) and Cohort 2 practices (starting January 2024) meet monthly (1.5 hours) with RIAIMH consultant
- **MLPB Legal Consultation**: Cohort 1 (September 2023) and Cohort 2 practices (starting January 2024) as part of the interdisciplinary teams

**Next Steps:**

Updated agreements to include development of practice sustainability plan, additional practice facilitation and continuation of MLPB and RIAIMH support

# DULCE: Developmental Understanding and Legal Collaboration for Everyone

**Care New England FCC (enrollment began Jan 2023)**

- 40 babies enrolled overall as of March 2024
- 17 prenatal patients enrolled overall as of March 2024
- 87 Routine Healthcare Visits completed on time as of Oct 2023
- Family Specialist present for 88% of appts as of Oct 2023
- 85% of families on Medicaid as of Oct 2023
- Baseline well child visit rate increased from 67.4% to 83.75% for DULCE participants.

**Coastal Toll Gate Pediatrics (enrollment began Jan 2023)**

- 190 babies enrolled overall as of March 2024
- Year1: 102 enrolled
- Year 2: 88 enrolled
- 34% of families on Medicaid as of Oct 2023
- Family Specialist present for 81% of appts as of Oct 2023
- No show rate for practice is 3.1%; for DULCE enrolled newborns NS rate is 0.6%

**Tri-County Community Action Agency (enrollment began Jan 2024)**

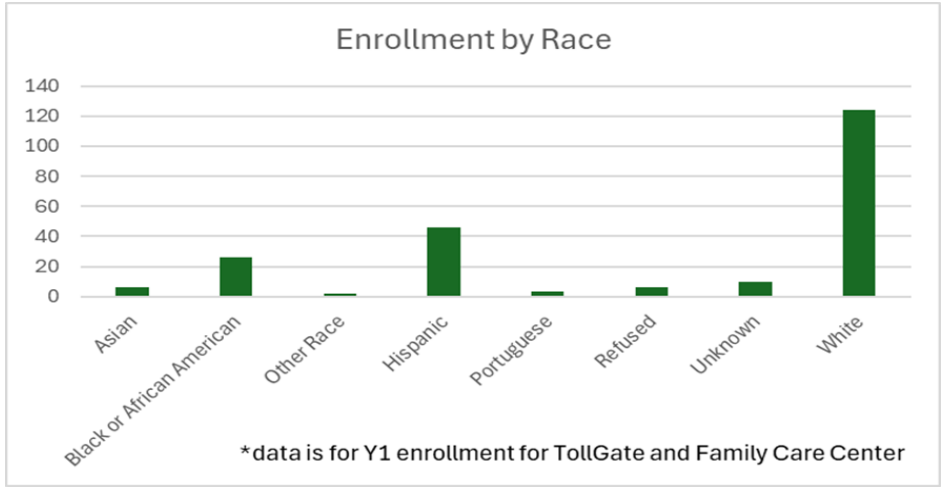
- 10 babies enrolled overall as of March 2024
- 2 prenatal patients enrolled overall as of March 2024

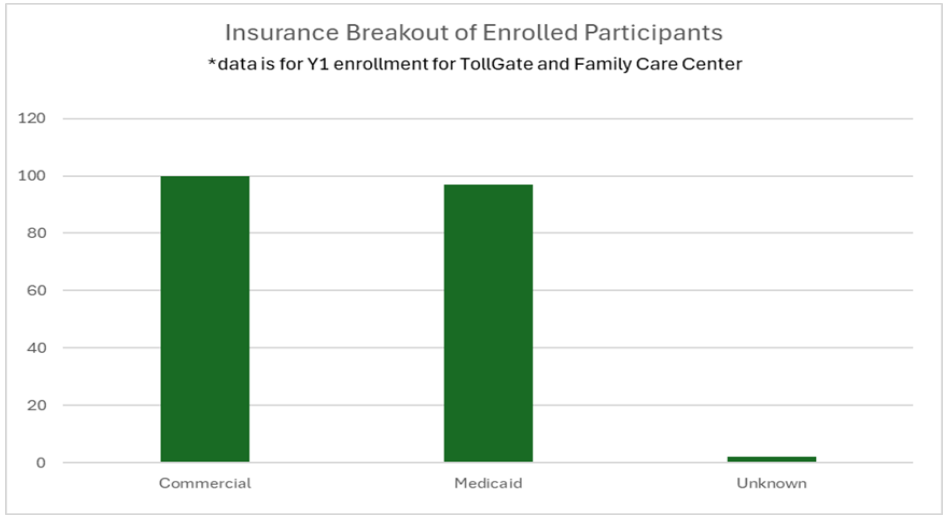
**Hasbro (enrollment began Jan 2024)**

- 14 currently engaged babies as of March 2024

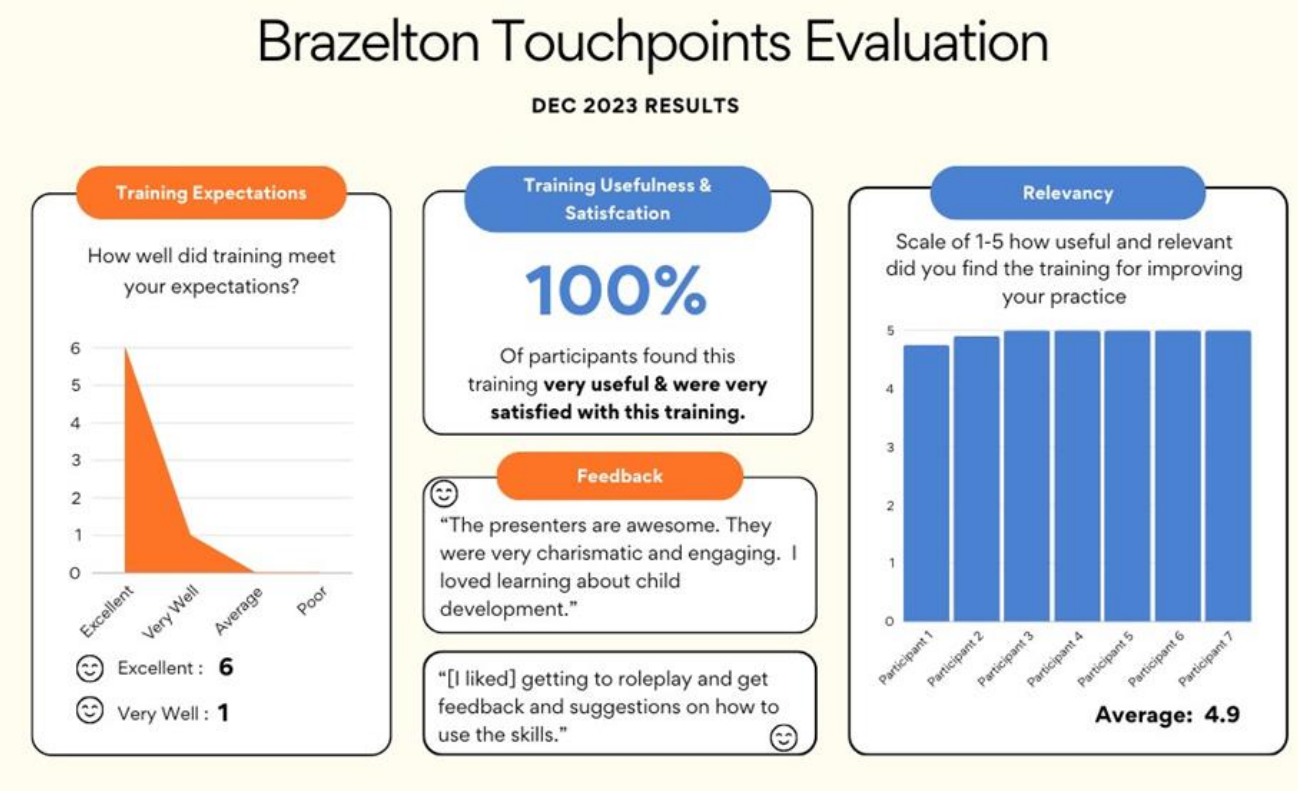
**Blackstone Valley Community Health Center (BVCHC)(enrollment began Jan 2024)**

- 10 babies enrolled overall as of March 2024
- 1 prenatal patient enrolled overall as of March 2024



# DULCE: Developmental Understanding and Legal Collaboration for Everyone




Examples of Care New England, Inc. success stories shared a quarterly learning collaborative meeting (3/14/24):

- Family originally in Arizona, baby born at 29 weeks after just crossing border/ 15 yr. old mother (in transit to RI/family)
- Enrolled in CNE DULCE
- Connected with bilingual Family Visitor (FV); coordination with Integra for insurance and follow up appointments (Cardio, neonatal clinic, ophthalmology, transportation)
- Resources explained: WIC, Family Visitor went to store to help mom shop with WIC benefit; attended cardiology appointment.
- Mom in immigration court – receiving MLPB assistance in getting attorney and hearing details; Family Visitor assistance with Dorcas / advice on staying in country / coordination.
- Wait list for early intervention; FV helping in interim.
- ED avoidance (help with language – appropriate use of clinic/ED)
- Help mom get back to school (Noelle academy)

# Strategic Priorities Impact Area 4 Initiatives

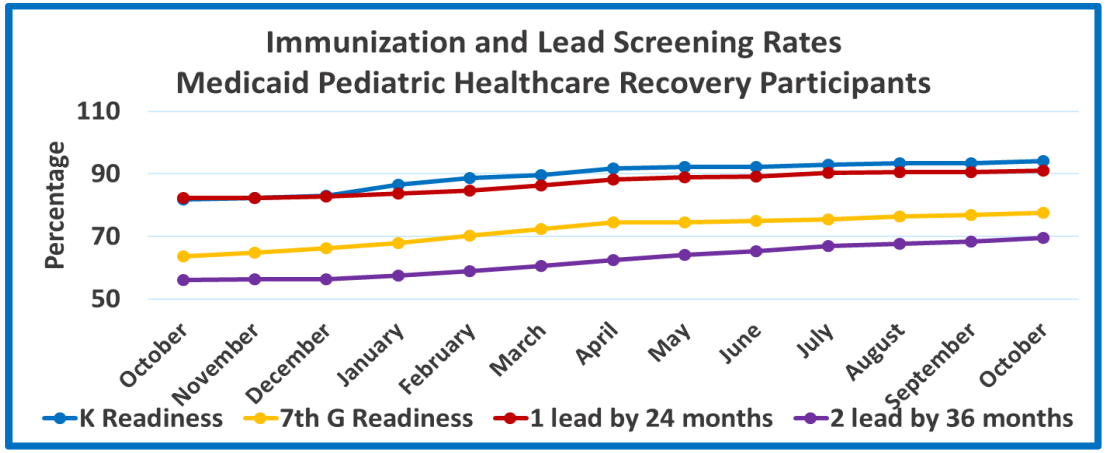
## Primary care providers and teams are well-supported and resourced to deliver high-quality care

- Pediatric Relief Program
- Asthma
- Healthy, Happy Teams
- Integrated Learning: Clinical Strategy Committee, Breakfast of Champions, Annual Conference
- Pharmacy Quality Improvement Learning Collaborative
- Prior Authorization Steering Committee
- Task Force for Primary Care Provider Workforce Development

# Medicaid Pediatric Healthcare Recovery Program

- **$7.3 million funded through the American Rescue Act, paid to 44 pediatric and family medicine applicants.**
- **Payments were contingent on practices meeting Immunization and Lead Screening targets or demonstrating prescribed improvement.**

| Payment Reporting Periods | % of practices meeting 3 out of 4 targets / improvement targets |
|---|---|
| October 2022 (Baseline) | 100% for participation |
| January 2023 | 75% |
| April 2023 | 75% |
| July 2023 | 77.5% |
| October 2023 | 80% |




- **In addition, practices were paid to participate in a six-month ECHO Behavioral Health (BH) Learning Initiative.**
- **100% of the practices met the payment requirements for BH ECHO participation.**

Suicide Risks, Prevention & Tools | Presentation | Recording
Medication Management in Pediatrics | Presentation | Recording | Quick Reference
CBT/Anxiety | Presentation | Recording
School Avoidance | Presentation | Recording
Navigating Schools to improve connections | Presentation | Recording
Difficult Conversations (with emphasis on vaccine hesitancy) | Presentation | Recording

# Strategic Priorities Impact Area 5 Initiatives

Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- Demographic Data Pilot Program
- Rhode to Equity (R2E)

# Demographic Data Collection Pilot Baseline Needs Assessment and Train-the-Trainer Webinar Series

- **Funding -** CDC / Rhode Island Department of Health / Executive Office of Health & Human Services
- **Goal** – COVID-19 revealed health disparities among high-risk and underserved populations, including racial and ethnic minorities. The Centers for Disease Control & Prevention (CDC) prioritized improving health outcomes by increasing and improving demographic data collection. Improved demographic data collection assists providers who work with priority populations.
- **Timeline** – April 2023 – May 2024

# Demographic Data Collection Pilot Baseline Needs Assessment and Train-the-Trainer Webinar Series

## Planning Committee

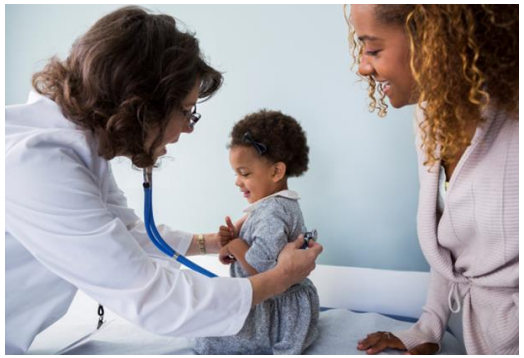
CTC-RI Project Team
Executive Office of Health & Human Services
IMAT
Lifespan Health System
Neighborhood Health Plan RI
Providence Community Health Center
Prospect Health System
RI Department Of Health
RI Health Center Association
RI Quality Institute
United Healthcare

## Participating Practices

- Concilio Pediatrics
- East Bay Community Action Program
- The Center for Primary & Specialty Care
- The Miriam Hospital Medical Clinic
- University Internal Medicine

**RIPCPC Practices**

- Atlantic Pediatrics
- Children First Pediatrics
- East Bay Pediatrics
- Family Doctors Group, PC



RIPCPC Practices

- Jamiel Ambrad, MD
- Olga Tverskaya, MD
- Richard Ohnmacht, MD
- Smithfield Pediatrics
- Snow Family Medicine
- Your Health

# Demographic Data Collection Pilot Baseline Needs Assessment and Train-the-Trainer Webinar Series

## Project Activities

- Environmental Scan Reports (Available on CTC-RI Website at links below)
  - Best Practice Summary Report & Key Informant Interviews
  - RI Demographic Data Collection Performance
  - Current & Anticipated Demographic Data Standards & Race/Ethnicity Standards Table
  - Baseline Practice Needs Assessment Summary Report
- Call for Applications Released July 2023
  - 15 practices engaged
- Baseline Needs Assessment August 15 – September 15, 2023
  - Practice Assessment
  - Patient Survey,
  - Staff Survey
  - Walk Around Tool Completed
- 6 Session Webinar Series
  - October 2023 – March 2024

# Demographic Data Pilot Added Initiatives



## NCQA Health Equity Accreditation Training

- Hosted by CTC-RI at Annual Conference October 2023

## Technical Enhancement Funding

- Application Period – **January 8 – February 2, 2024**
- Practices eligible to apply for up to **$920 per practice**
- Technical Enhancements to Support Improvements Identified in Practice Baseline Needs Assessment

## Quality Improvement Initiative

- Funded by United Healthcare and Rhode Island Foundation
- Program Period  April 2024 through December 2024
- 15 Practices Engaged - 12 New Practices and 3 Continuing Practices from Pilot
- Improve Demographic Data Completeness & One Practice Selected Measure

# Demographic Data Collection Pilot Webinar Series

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE

| DATE | TOPIC | PRESENTER |
|---|---|---|
| **October 10th, 2023** | Why Demographic Data is Important | Christin Zollicoffer (Lifespan) |
| **November 14th, 2023** | Demographic Data Standards | Jennifer Etue & Natasha Viveiros (PCHC) |
| **December 12th, 2023** | SOGIE | Quinten Foster (EBCAP) |
| **January 10th, 2024** | Patient Perspective | Farah Kader (Westchester County Dept of Health) & Lusia Cardenas (New York Academy of Medicine) |
| **February 29th, 2024** | Best Practices Improving Demographic Data Collection and Reporting | Marsha McGehee & Damaris Constantinople (Cornell Scott) & Darcey Cobb-Lomax (Yale Center for Health Equity) |
| **March 13th, 2024** | Participant Sharing | All Participating Practices |

# Year 2 Outcomes at a Glance

## Learning Collaboratives & Events

- 24 Projects & Initiatives
- 180 Learning Collaboratives & Events
- 5,798 Attendees
- CME/CEU Credits Offered

## Communities Served

- 190 Practices
- 900,000 Patients: 200k <18, 700k adults
- 18 NCMs & 7 Nursing Students Trained
- NCM CEU Credits Awarded

## Funding

- $6m Total Revenue
- $2m+ Funding to Primary Care Practices
- $7.2m American Rescue Act Practice Funds
- 7.4% Admin Expenses

## Funding Collaborators

- Govt. Agencies: RI EOHHS, RIDOH, US HHS
- Health Plans: BCBSRI, NHP, THP, UHC
- AMA, Brown Medicine, Brown University
- Deloitte, Integra, MLPB, Prospect, RIAAP

## Digital Outreach

- 1,797 Newsletter Subscribers
- 23% Newsletter Open Rate
- 5.7 Monthly Email Campaigns
- 480 LinkedIn Visits

## Academic Dissemination Activities

- 2 Published Papers
- 4 White Papers / Reports
- 4 Regional / National Presentations

# CTC-RI FY23 Journal Articles


- Borkan J, Coppa D, Flanagan P, Hurwitz D, Saal A, Bowes Y, Nicolella E, Hollmann P. Primary Care Access for All: A Roadmap for Addressing the Primary Care Crisis in Rhode Island. *Rhode Island Medical Journal.* April 2024; 107(4):40-44. PMID: 38536140.

- Szkwarko D, Cabral L, Patry G. Project ECHO in Rhode Island. *Rhode Island Medical Journal*. 2024; 107(1):51-53. PMID: 38166079.

# CTC-RI FY23 White Papers and Reports

- Sanzen K D, Kogut S, Campbell S. Pharmacy Quality Improvement Initiative: Improving Avoidable Hospitalizations and Emergency Department Visits through Team-Based Care. *White Paper, Care Transformation Collaborative of Rhode Island.* April 2024.
- Borkan J, Coppa D, Hurwitz D, Flanagan P. Primary Care Workforce Task Force Primary Care Access for All: A Strategic Road Map for Patient Access and Primary Care Workforce Capacity Building. *Strategic Roadmap, Care Transformation Collaborative of Rhode Island.* January 2024.
- Coleman M, Goldman R E. Rhode Island MomsPRN Perinatal Behavioral Health Learning Collaborative Pilot Program, Qualitative Evaluation Report. *Qualitative Evaluation Report, Care Transformation Collaborative of Rhode Island.* December 4, 2023.
- Coleman M, Goldman R E. Medicaid Billing for Community Health Worker (CHW) Services in Rhode Island, Complete Evaluation Report. *Complete Evaluation Report, Care Transformation Collaborative of Rhode Island.* July 31, 2023.

# CTC-RI FY23 Regional and National Presentations

- Burdette N. Motivational Interviewing for Cancer Navigators. Presented at the RICHA Cancer Screening Summit; April 10, 2024; Crowne Plaza, Warwick, RI.
- Cabral L, Lawrence D. Community Health Worker Strategy, Opportunities and Training. Presented at the RIHCA Cancer Screening Summit; April 10, 2024; Crowne Plaza, Warwick, RI.
- Hurwitz D, Burdette N, Cabral L, Lange E, Salazer S. Promoting Integrated Behavioral Health in Pediatrics: Rhode Island Efforts. Presented at the Camden Coalition: Putting Care in the Center; November 2, 2023; Boston, MA.
- Cabral L. Expanding the Scope of Community Health Workers. Presented at the TEAM UP for Children Annual Symposium; October 13, 2023; Waltham, MA.

# Next Steps in Strategic Priorities

- Implementing Primary Care Workforce Strategic Roadmap
- Demographic Data Collection Quality Improvement Initiative
- Integrated Care – e.g., IBH and CCBHC
- Improving Care for Older Adults
- Sexually Transmitted Infections – ECHO and Quality Improvement Learning Collaborative
- Transition of Care – Payment; National Collaborative Participation
- Early Childhood – e.g., Family Visiting, DULCE, MomsPRN, TEAM-UP, AAP Wellness, and Sleep

# Strategic Priorities 5-Year Impact Areas (2022-2027) Midpoint Review (2024)

Health care delivery fully coordinated across all care systems

Primary care practices thriving in an all-payer value-based payment model that stabilizes healthcare costs and premiums

All Rhode Islanders have access to primary care practices reflecting demographics of their community, and highly satisfied with care experiences

Primary care providers and their teams are well-supported and resourced to deliver high-quality care

Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

Cross-Cutting Themes: Reducing Health Disparities and Improving Health Equity

# CTC-RI Team

**Debra Hurwitz, MBA, BSN, RN**
Executive Director

**Pano Yeracaris, MD, MPH**
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Clinical Director and PCMH Kids Co-Chair

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Senior Program Administrator

**Linda Cabral, MM**
Senior Program Manager

**Nelly Burdette, PsyD**
Senior Integrated Behavioral Health Program Leader

**Liz Cantor, PhD**
Pediatric IBH Practice Facilitator

**Sue Dettling, BS, PCMH CCE**
Program Manager & Practice Facilitator

**Yolanda Bowes**
Project Manager

**Jennifer Capewell, BA**
Senior Manager, Administration

**Carolyn Karner, MBA**
Program Management & Evaluation

**Michelle Mooney, MPA**
Program Coordinator II

**Edyth Dwyer, MPA, MPH**
Program Coordinator

**Nijah Mangual, BA**
Program Coordinator

**Jade Arruda, BS**
MomsPRN Project Coordinator

**Diane Paravisini, MA, BS**
Administrative Assistant / Program Coordinator