CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

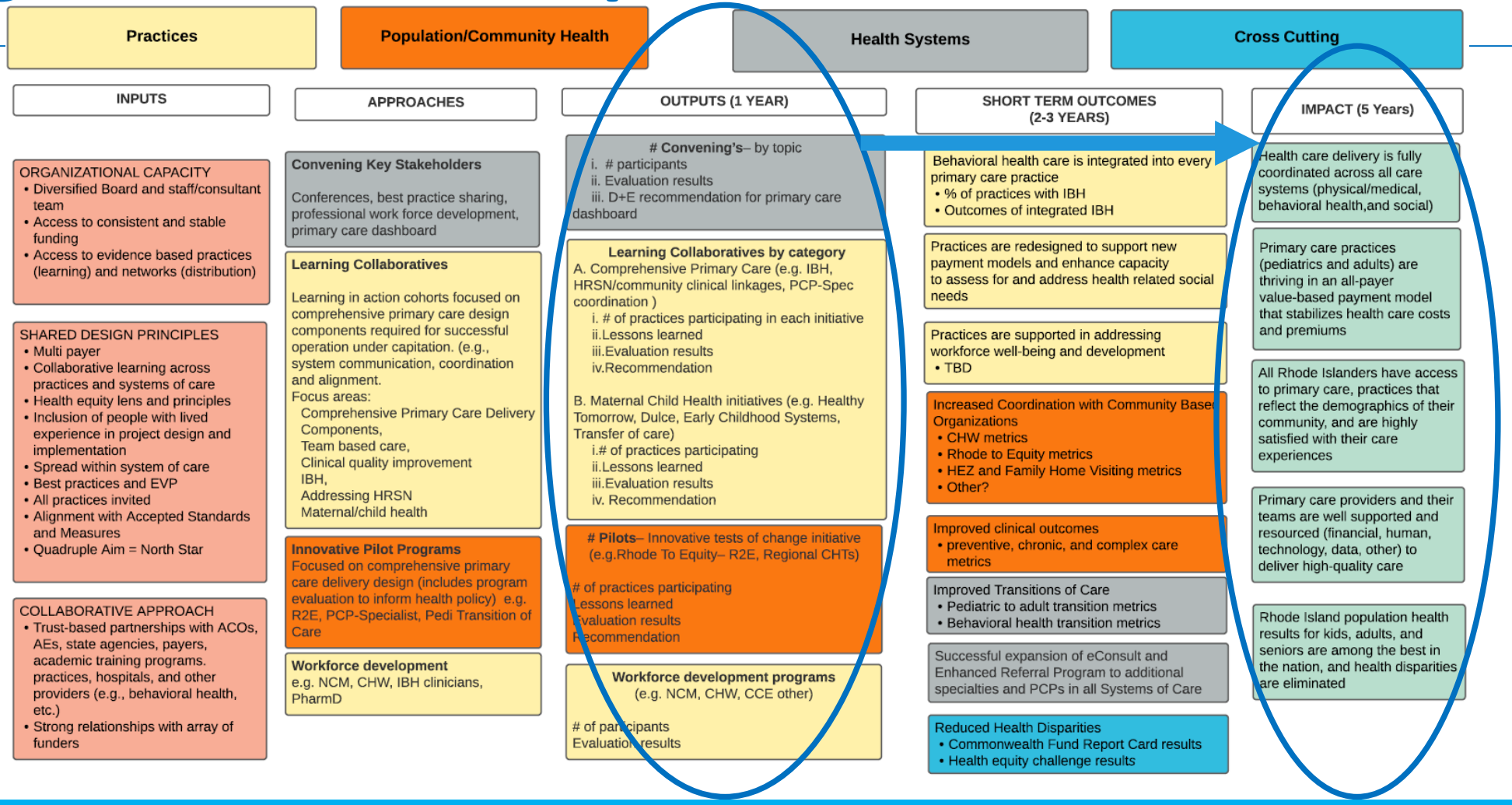
ADVANCING INTEGRATED HEALTHCARE

CTC-RI Accomplishments Report FY23

Board of Directors | March 24, 2023

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

- Health Transitions of Care for youth from pedi to adult care
- Healthy Tomorrows coordination pedi and family home visiting
- Integration of Behavioral Health in Primary - NCQA Behavioral Health Distinction
- PCP-Specialist Collaboration enhanced referral and eConsults
- Rhode to Equity – clinical community linkages

Strategic Priorities Impact Area 2 Initiatives

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

- Identify consultants to support transformation implementation to capitation
- OHIC letter on capitation readiness
- Public comments to OHIC Regulation and Affordability Standards
- SME/guest speakers on primary care capitation (adult and pedi)
- Team-based care cost calculator

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

- Alzheimer's Disease and Related Disorders (ADRD) Learning Collaborative
- Community Health Worker Training
- Developmental Understanding and Legal Collaboration for Everyone (DULCE)
- Healthy Tomorrows / Wellness Visits
- Pediatric Weight Management ECHO® series
- Strength-Based Visit Pilot
- Unconscious Bias presentations

Strategic Priorities Impact Area 4 Initiatives

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

- Annual Conference
- Best Practices in Team-Based Care
- Breakfast of Champions
- Clinical Strategy Committee
- Pediatric Relief Program: support with funding; practice facilitation; data and collaborative learning
- Pharmacy Quality Improvement Initiative
- Resiliency Trainings

Strategic Priorities Impact Area 5 Initiatives

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

- Asthma
- Demographic Data Pilot Program
- Rhode to Equity (R2E)
- RI MomsPRN

Year 1 Outcomes at a Glance

Learning Collaboratives & Events

- 38 Projects & Initiatives
- 51 Learning Collaboratives & Events
- 1850 Attendees
- 1,364 CME/CEU Credits

Communities Served

- 190 Practices
- 900,000 Patients: 200k <18, 700k adults
- 18 NCMs Trained
- 809 NCM CEU credits awarded

Funding

- $3.8m Grant Income
- $2.1m Funding to Practices and CBOs YTD
- $7m Medicaid Pedi Relief
- 6% Admin Expenses

Funding Collaborators

- State Agencies: OHIC, EOHHS, RIDOH
- Health Plans: BCBSRI, UHC, THP, NHP
- AMA, RIAAP, MLPB, Brown University
- Brown Medicine, Integra, Prospect

Digital Outreach

- 1697 Newsletter Subscribers
- 23% Newsletter Open Rate
- 5.6 Monthly Email Campaigns
- 639 LinkedIn Visits

National/Regional Dissemination

- 4 Published Papers
- 2 White Papers
- 4 Presentations
- 1 Poster

Next Steps… Work in progress

- **Task Force on Primary Care Workforce**
  - February kickoff – Primary Care Workforce Strategic Plan
- **Prior Authorization Subcommittee**
  - April kickoff
- **Demographic Data project**
  - EOHHS and RIDOH – Health Disparities/ Equity
- **Statewide Pediatric Relief Initiative effort**
  - Continues with focus on vaccination rates and lead testing
- **Integrated Behavioral Health**
  - Work in pediatrics and workforce development continues

CTC-RI Team

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Appendix

Project-Level Highlights

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

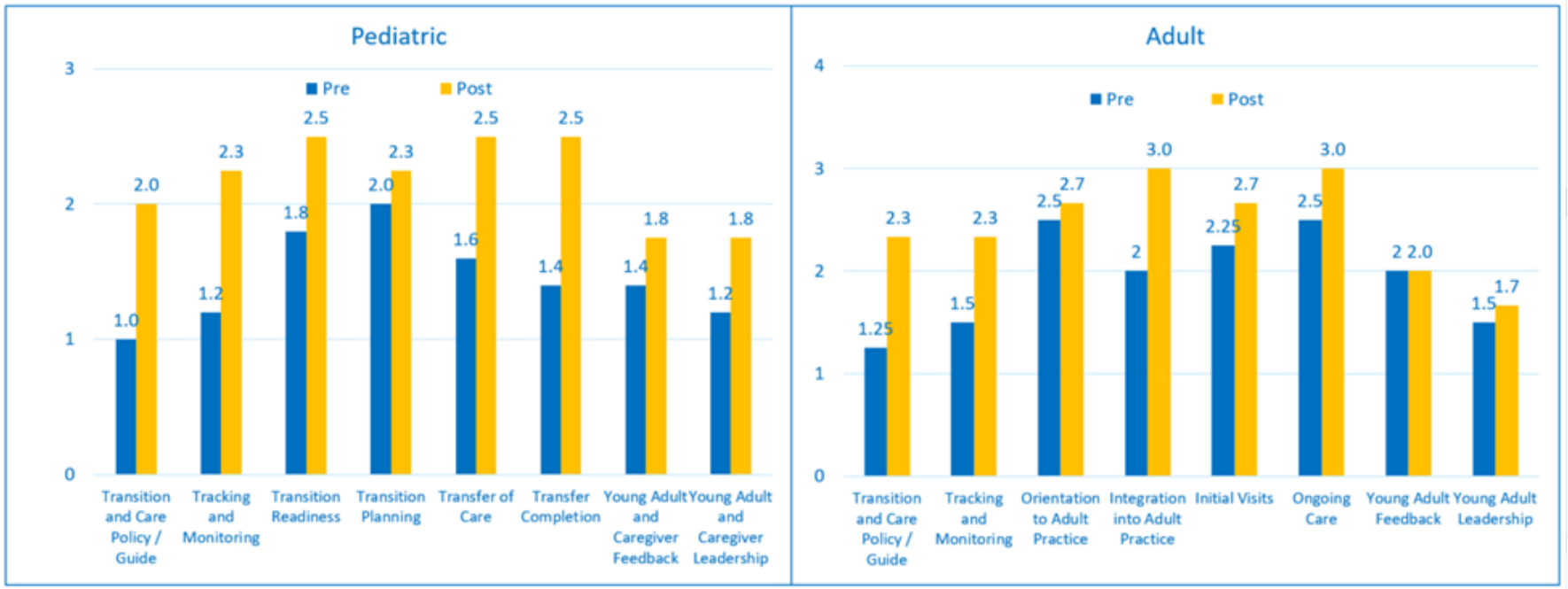
- **Health Transitions of Care (HTOC)**
  - Goal: Pediatric transitions of care to adult primary care are planned
  - # practices:
    - Cohort 1 – May 2021 – April 2022
      - 7 practice dyads (9 total practices)
    - Cohort 2 – June 2022 – May 2023
      - 3 practice dyads & 1 solo practice (7 total practices)
  - Funding to Practices:
    - Cohort 1: $5,000 per practice = Total $45k
    - Cohort 2: $5,000 per new practice & $2,500 per continuing practice =Total $17.5k

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Health Transitions of Care (HTOC) (continued)**
  - Evaluation Results:
    - Cohort 1: During the 12-month learning collaborative, 29 patients successfully transferred from pediatric to adult care. An additional 12 patients participated in the program and had appointments scheduled but had not yet seen their adult providers by the program's end.
    - At least 5 patients from all 7 dyads had either successfully transferred to an adult provider or had an appointment scheduled by the end of the learning collaborative.

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Health Transitions of Care (HTOC) (continued)**
  - Evaluation Results:
    - Practice Assessments before and after participation



IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Health Transitions of Care (HTOC) (continued)**
  - Evaluation Results:
    - Youth/Young Adult Feedback Surveys

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Explain the transition process in a way that you could understand?	100% Yes
Give you a chance to speak with them alone during visits?	100% Yes
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	100% Yes
Create and share your medical summary with you?	82.4%Yes
Help you find a new adult doctor or other health care provider to move to?	100% Yes
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Address any of your concerns about your move to a new practice/doctor?	88.24% Yes
Give you guidance about their approach to accepting & partnering with new young adults?	88.24% Yes
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	94.1% Yes

- **Overall, how ready did you feel to move to a new adult doctor? 88.24% "Very"; 11.76% "Somewhat"**

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Health Transitions of Care (HTOC) (continued)**
  - Milestones:
    - Published White Paper for Cohort 1
    - Implemented a strategy to spread HTOC through continuation opportunity: Hasbro successfully included residents in HTOC initiative; Chad Nevola (RIPCPC) developed strategy to spread HTOC system wide
    - Developed Care Coordination Training Opportunity to better support children and families with special health care needs

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health**
  - Goal: Improved Coordination with community-based organizations and strengthen team-based care; build primary care work force, wellbeing and development
  - # of Practices:
    - Summary – 18 practices/agencies
      - Healthy Tomorrows - Cohort 2 – March 2022 – Feb 2023
        - 4 pediatric practices and 4 family visiting agencies
      - Healthy Tomorrows – Cohort 3 – March 2023 – Feb 2024
        - 3 pediatric practices and 3 family visiting agencies
      - DULCE – Sep 2022 – Nov 2023
        - 2 practices
      - Strength-Based Visit Pilot – (Project timeline: August 1, 2022 – July 31, 2024)
        - Practices participating between March 2023 – April 2024
          - 2 Practices

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Money to practices
    - Healthy Tomorrows – Cohort 2 Paid, Cohort 3 to be paid
      - $2,000 per practice
      - $2,000 per family visiting agency
    - DULCE
      - $20,000 per practice (Practices have received $10,000 each to date)
    - Strength-Based Visit Pilot – No payments made yet
      - Up to $6,000 per practice for visits completed
      - $500 stipend via gift cards per practice

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Evaluation
    - Healthy Tomorrows – Cohort 2
      - Pre- and Post-Survey completed
        - The post-program survey results identified that Family Visitors felt that there were big improvements in their knowledge with working with pediatric practices, collaboration with the practice about shared families, and ability to interact with children's medical practice and the health care system. Pediatric practice staff identified big improvements in their knowledge of Family Visiting and working with Family Visiting programs, reduction of barriers to making a referral to family visiting, increased collaboration with family visiting about shared families, and improvement of health for children based on increased collaboration/utilization.

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Milestones Summary:
    - The Maternal Child Health initiatives include the use of evidence-based programs and tools that are culturally and linguistically appropriate. Each initiative has a health equity lens that strives to help build better relationships between the family and care team by focusing on family strengths. All initiatives include people with lived experience in the project design and in the implementation process.

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Milestones Healthy Tomorrows:
    - Linkage of evidence-based programs that have demonstrated improvements in a wide range of maternal and child health outcomes with pediatric practices.
    - Inclusion of family lead consultant with lived experience on planning committee and provided opportunity to present to pediatric practices during quarterly meetings.
    - Advanced health equity by supporting families to receive culturally and linguistically appropriate services and support with paired FV partner.
    - Increase use of KIDSNET report to identify shared patients.

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Milestones DULCE:
    - Engagement of Center for Study of Social Policy as subject matter experts to help plan the collaborative and provide live training and resources.
    - Inclusion of Doulas and Community Health Workers in the planning committee to assist with project design.
    - Collaborated with Meeting Street to offer Brazelton Touchpoints training to both participating practice sites and to member of the planning committee. This provided the participating practices the opportunity to meet each other and build relationships with Family Visitors that also attended the training.
    - Obtained funding from Congressional Direct Spend to support a second DULCE cohort

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Healthy Tomorrows/ DULCE / Strength-Based Visit Pilot: Improving Maternal Child Health (continued)**
  - Milestones Strength-Based Visit Pilot:
    - New contract with AAP
    - 4 focus groups held with families (in English and Spanish) and CHW/doulas to discuss visit design and family health goals.

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Integrated Behavioral Health Expansion**
  - In FY23, CTC-RI supported **17 adult and pediatric practices** as they expanded their capacity to provide IBH in their practice. They have received training and practice facilitation support to implement screenings and workflows. **10 of these practices are preparing to submit for NCQA** Distinction in Behavioral Health Integration or have already successfully done so.
  - **39 Behavioral health clinicians** have received support to increase their ability to successful work in an IBH practice, either through completing the UMass Certificate in Primary Care Behavioral Health (N=20) or participating in our monthly, informal “Meet and Eats” with our IBH practice facilitators (N=19).

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Nurse Care Manager / Care Coordinators (NCM/CC): Workforce Development**
  - Goal: To increase training for NCM/CC to work successfully in team-based care
  - # Participants 18
  - # CEUs: 809 credits awarded

  Milestone:
  - Started work to create a pipeline for future NCM by partnering with URI faculty/student

IMPACT AREA 1: Health care delivery fully coordinated across all care systems

- **Nurse Care Manager / Care Coordinators (NCM/CC): Workforce Development**
  - Evaluation results:

IMPACT AREA 3: All Rhode Islanders have access to primary care practices reflecting demographics of their community, and highly satisfied with care experiences

- **Alzheimer's Disease Initiative: Improving Population Health**
  - Goal: To help primary care practices and other organizations deliver care that is aligned with age friendly approach and 4 M framework
  - # Learners registered for ECHO: 90
  - Milestones:
    - Initiated a "brainstorming session" with URI Geriatric Education Council, RIDOH Geriatric Advisory Council and CTC primary care practices which resulted in shared resources/funding to create a Age Friendly ECHO series and QI initiative
    - **Creating a broader learning community** for the ECHO program (including primary care providers, nurse care managers, long term care, assisted living and PACE)
    - Obtained new contract with RIDOH to fund this effort (together with funding from UnitedHealthcare and URI GEC)

IMPACT AREA 3: All Rhode Islanders have access to primary care practices reflecting demographics of their community, and highly satisfied with care experiences

- **Became an ECHO Hub**

  CTC-RI underwent AAP training to become an ECHO Hub to bring together a community of learners around a particular topic to share best practices and utilize case-based learning. CTC-RI launched 2 ECHO projects in 2022:

  - **Pediatric Weight Management** - 7 pediatric practices enrolled in 1-hour sessions (September 2022-August 2023) with 29-39 attendees each session, representing providers, nurse care managers and IBH clinicians. CME credits were provided and the sessions' ability to deliver balanced and objective, evidence-based content was rated as 'very good' or 'excellent' by 91-100% of participants across all sessions.

  - **Asthma Essentials** - **60 participants registered to attend 6 1-hour sessions (October 2022 – March 2023) with average 45 attendees each session** including community health workers, school nurses, nurse care managers, providers, pharmacists and respiratory therapists. 160 certificates of attendance and CME credits were provided with 90% of participants reporting that they will be able to use the session content in their work and that the biggest changes will be in patient education and treatment plans. The sessions' ability to deliver balanced and objective, evidence-based content rated as 'very good' or 'excellent' by 97% of participants across all sessions.

IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Best Practices in Team-Based Care and offered CEU's**
  - # of participants: 605 (since July 2022)
  - # of CEUs awarded: 94
  - Topics covered:
    - It's all about the Relationship: How Connection in Primary Care Occurs Among Team Members
    - RIGEC on Older Adults at Risk for Opioid-Induced Respiratory Depression
    - Improving Care of People with Diabetes Through Team-Based Care
    - Improving Hypertension Patient Care: a Team-Based Approach
    - Best Practice Sharing: Improving Lead Screening
    - RIGEC on Incontinence in Older Adults

IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Clinical Strategy Committee (CSC) and Breakfast of Champions (BOC)**
  - Ongoing monthly CSC and quarterly BOC have continued focus on optimizing expanded care team effectiveness, promoting health equity and maternal child health, and innovation in primary care capitation. **Attendees have averaged 45 per CSC meeting and 73 per BOC.**
  - Highlights include project to improve PCP/specialist collaboration through implementation of eConsults and enhanced referrals (AAMC "CORE" program) with Integra and Lifespan. **To date, combined 90 PCPs have been engaged and 12 specialties with 156 eConsults and 3,246** enhanced referrals made. Significant progress has been made for sustainability with **BCBSRI commitment to pay for PCP and specialist completed eConsults without copay or co-insurance as of 10/1/23**, commitment of support from RI Medicaid and UHC.
  - September and December BOC focused on implicit/unconscious bias training as critical to improving health equity as well as optimizing diverse care team function.

IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pediatric Relief Program**
  - Goal: **Pediatric practices improve access to immunization and lead screening**; improve capacity of pediatric practices to respond to behavioral health needs; To improve financial stability of pediatric practices
  - # Participants: **40 Applicants, representing 62 practice sites**
  - Behavioral Health ECHO® Participation:
    - 2 out of 6 ECHO®s have been completed
    - 77 participants and 80% of participating applicants attending the 1st session on Difficult Conversations with an emphasis on immunization hesitancy
    - 60 participant and 72.5% of participating applicants attending the 2nd session on Navigating Schools.
    - CEUs awarded: 75
  - **Funding to practices: ~$2.4million has been awarded to participating practices** through EOHHS. In total, ~$7.1million is expected to be dispersed by October 2023.

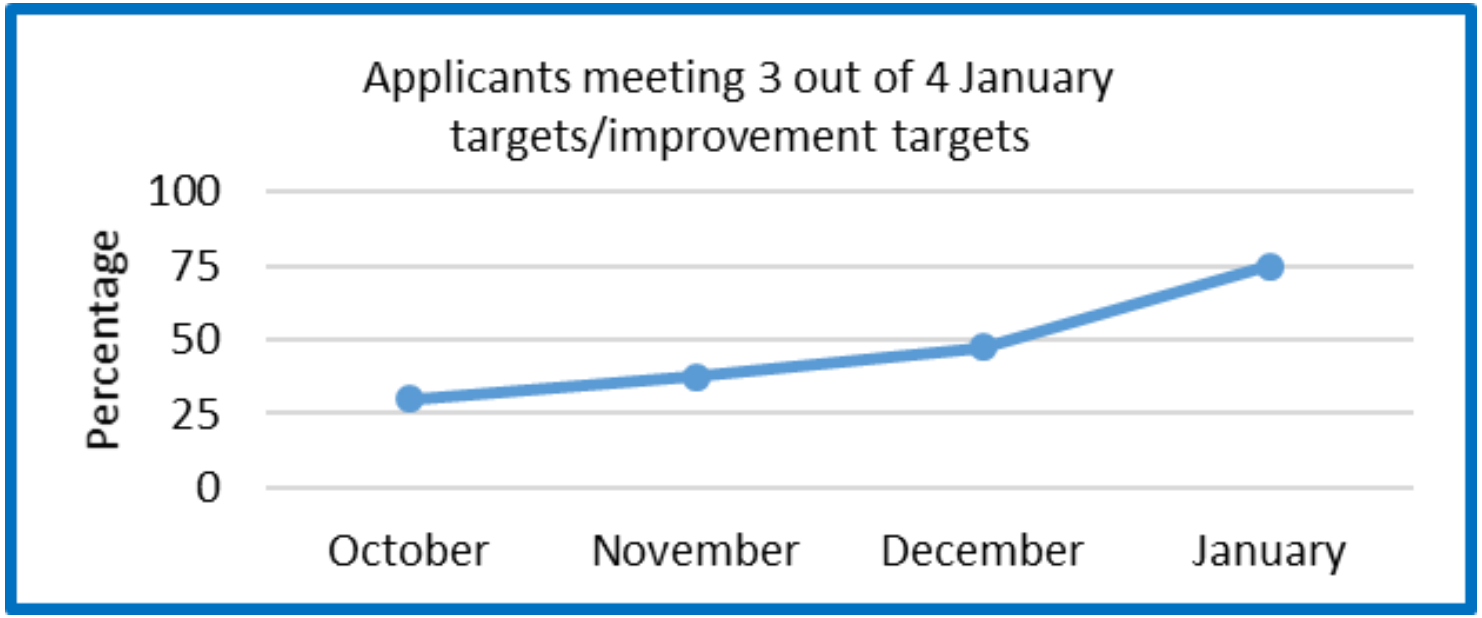
IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pediatric Relief Program (continued)**
  - Behavioral Health ECHO® Evaluation results:

Session	Overall Opinion (Excellent or Good)	Felt the content was "Just Right"
Difficult Conversations with an emphasis on immunization hesitancy	98%	98%
Navigating Schools	92%	95%

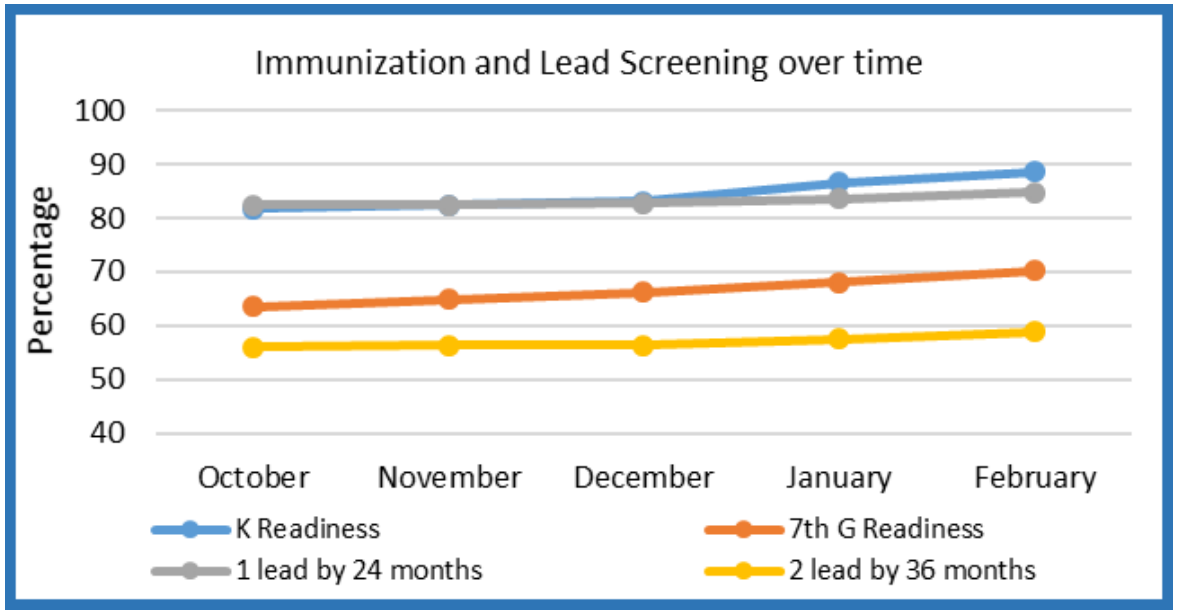
IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pediatric Relief Program (continued)**
  - Milestones:
    - 75% of applicants met the 3 out of 4 incentive target or improvement targets for January reporting.



IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pediatric Relief Program (continued)**
  - Milestones:
    - Provided monthly status reports on practice's achievement towards the 3 out of 4 immunization and lead screening targets or improvement targets.



IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pediatric Relief Program (continued)**
  - Milestones:
    - **127 practice facilitator meetings** have been conducted with 1 focused on Behavioral Health.
    - Created **a new KIDSNET Prevention report**: Provides practices with efficient way to identify children due for immunizations;
    - Behavioral Health ECHO Training Program: Increased practice engagement through case presentations; increased collaboration with community partners (PediPRN, RIPIN)
    - As part of Year 1 Medicaid Pediatric Healthcare Recovery Program Accomplishments, CTC-RI in partnership with the RI Chapter of the American Academy of Pediatrics (RIPAA), provided three virtual learning sessions addressing pediatrician burnout and resiliency. Dr. Nelly Burdette led the 3-part resiliency program (September 2022) focusing on individual, organizational, and community approaches.

IMPACT AREA 4: Primary care providers and their teams are well-supported and resourced to deliver high-quality care

- **Pharmacy Quality Improvement Initiative: Improving Population Health: Diabetes**
  - #Practices/Systems of Care: 6
  - Participation in Learning Collaborative: 100 participants
  - Funding to Practices: Year 1 $120,000.
  - Patient success story: Patient was thought to have Parkinson's. As a result of this pilot and through the use of ProCGM, Pharmacy team was able to determine the cause of tremors was due to low blood sugar. Tremors have been corrected and blood sugar is now in control.
  - Milestones:
    - Pharmacy led initiative including URI College of Pharmacy
    - All practices/SOC are asked to report on standardized measures, staff experience, patient experience
    - Addresses health inequities through offering professional use continuous glucose monitoring to people to all people based on eligibility criteria, not health insurance

IMPACT AREA 5: Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- **Asthma: Improving Population Health**
  - Goal: Focus on improving disease management of priority conditions
  - Offered six (6) 1 hour sessions (Oct 2022-March 2023)
  - CEU/certificates of attendance: 160
  - # Participants: 80 participants registered and on average 45 people attended each session including school nurses, nurse care managers, providers, pharmacists and respiratory therapists
  - Evaluation Results
    - On average, 90% of participants reported that they will be able to use the session content in their work and reported that the biggest changes will be in patient education and treatment plans
    - Sessions' ability to deliver balanced and objective, evidence-based content rated as 'very good' or 'excellent' by 97% of participants across all sessions
  - Asthma Quality Improvement Initiative: Launched "Call for Applications"
    - 2 pediatric practices registered and will receive individual practice facilitation meetings for six months
  - Milestone:
    - Created a solid Interdisciplinary Planning Committee to oversee learning transformation process
    - Created a broader ECHO learning community by inviting participation from primary care, school nurses, respiratory therapies and CHW.

IMPACT AREA 5: Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- **Enhancing Community Clinical Linkages via Rhode to Equity**
  - The Rhode to Equity project, supported by EOHHS and RIDOH, continues to pilot innovative ways for community and clinical systems to partner to address health inequities. **6 teams have been established that include partners from health equity zones, accountable entities, community health teams, primary care, community health workers and people with lived experience of inequities.** The teams have established relationships and infrastructure to continue working together into the future, including securing federal grant funding.

  - In December 2022, CTC-RI hosted an **in-person conference of 100 attendees** who gathered for subject matter expert sessions with national and local leaders on healthy housing, food justice, and housing first models. Average session rating was 4.46 out of a 5-point scale.

IMPACT AREA 5: Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- **RI MomsPRN: Improving Maternal Child Health**
  - Goal: To help prenatal care practices increase the identification, early intervention and treatment of depression, anxiety and substance use among their pregnant and postpartum patients
  - # practices: 5 continuing practices + 4 new practices
  - Participation in Learning Collaborative: 86 participants
  - # of calls to MomsPRN line: 80
  - # of CEUs awarded: 10
  - Funding to practices: Cohort 3 initial payout to practices was $16,500. In total, ~$77,000 is expected to be dispersed by October 2023.

IMPACT AREA 5: Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- **RI MomsPRN: Improving Maternal Child Health (continued)**
  - Milestones:
    - Final year of HRSA funded project (10/1/19-9/30/23): Total funding to CTC: $666,660 for 3 cohorts
    - Added qualitative evaluation: practices and community based organizations
    - Included practice specific learning programs (including CEU's)
    - Raised awareness and need to address of health disparities among prenatal population at Clinical Strategy, Breakfast of Champions, Board of Directors meeting

IMPACT AREA 5: Population health results for all Rhode Islanders are among the best in the nation with health disparities eliminated

- **RI MomsPRN: Improving Maternal Child Health (continued)**
  - Milestones:
    - Improved Depression, Anxiety and Substance Use Screenings – Cohort 3 new practices went from 0 screens to 41% for Anxiety, 73% for Depression and 27% for Substance Use. Screening rates for continuing practices went from 36% to 69% for Anxiety, 43% to 73% for Depression and 3% to 48% for Substance Use.