CTC Strategic Plan 2022- 2025

Narrative to Logic Model

OUR MISSION: The mission of CTC-RI is to support the continuing transformation of primary care in Rhode Island as the foundation of an ever-improving integrated, accessible, affordable, and equitable health care system. CTC-RI brings together critical stakeholders to implement, evaluate and spread effective multi-payer models to deliver, pay for and sustain high-quality, comprehensive, accountable primary care.

OUR VISION: Rhode Island has a thriving primary care system that ensures every person has equitable and affordable access, engages patients and families as active partners, and results in excellent health for patients, families, and communities.

OUR DESIRED IMPACT BY 2027

IMPACT AREA 1: Health care delivery **is fully coordinated** across all care systems (physical/medical, behavioral health, and social)

- **SHORT TERM OUTCOMES (by 2024-2025):**
  - Behavioral Health Care is integrated into every primary care practice and coordinated with specialty BH providers as needed
  - Pediatric transitions of care to adult primary care are planned
  - PCP – Specialist - referrals and e-consults are enhanced and standardized to reduce unnecessary referrals, and increase primary care expertise and capacity to treat certain conditions
  - Increased care coordination with community based organizations
- **KEY YEAR 1 INITIATIVES**:
  - Establish statewide IBH training capacity for BH clinicians (BH Workforce development)
  - Implement and/or enhance IBH in 10 practices (adult/pedi)
  - Support practices in obtaining NCQA Behavioral Health distinction (to meet OHIC requirement)
  - Practice facilitation to strengthen team based care
  - Implementation and evaluation of population health initiatives (e.g. R2E, CHWs and CHTs)

IMPACT AREA 2: Primary care practices (pediatrics and adults) are **thriving in an all-payer value-based payment model** that stabilizes health care costs and premiums

- **SHORT TERM OUTCOMES (by 2024-2025):**
  - Practices are redesigned to support new models and enhanced capacity to assess for and address HRSN
  - Maintain/Improved Clinical Outcomes (metrics) related to prevention, chronic and complex conditions
  - Evaluation and expansion of enhanced PCP-specialist referrals and e-consults
  - Inform State policy (e.g. affordability standards) on PCP-Specialist lessons learned
- **KEY YEAR 1 INITIATIVES**
  - Support SOC and practices in the implementation of care delivery design components needed for success under value based payment models (e.g. IBH, HRSN, remote monitoring/telehealth)
  - Focus on disease management for priority diagnoses (e.g. diabetes, COPD, HTN)
  - Develop a primary care performance dashboard (pending BOD approval)
  - Launch multi-payer PCP- Specialist enhanced referral and e-consult pilot
  - Annual training for nurse care manager's/care coordinators

IMPACT AREA 3: All Rhode Islanders **have access to primary care**, practices that reflect the demographics of their community, and are highly satisfied with their care experiences

- **SHORT TERM OUTCOMES (by 2024-2025)**
  - CTC monitors access, equity and patient experience measures via statewide Primary Care Dashboard
  - All Rhode Islanders designate and utilize a primary care provider whose practice is connected to community health workers to support HRSN

- **KEY YEAR 1 INITIATIVES**
  - Expansion of Community Health Workers integrated into of primary care, who reflect the race/ethnicity of the communities served
  - Pilot Rhode to Equity project which engages a person with "lived experience" to inform the team on ways to strengthen community – clinical linkages
  - CHWs assist in connecting patients to primary care
  - Support primary care use of Unite Us implementation via learning collaborative
  - Pediatric practices improve access to well child care, immunization and lead screening
  - Working with Data and Evaluation Committee to draft recommendations for a primary care dashboard

IMPACT AREA 4: Primary care providers and their teams are **well supported** and resourced (financial, human, technology, data, other) to deliver high-quality care

- **SHORT TERM OUTCOMES (by 2024-2025)**
  - Current Care more fully supports care management/ care coordination, transitions of care, medication management and end of life care
  - Develop and implement approaches for primary care to improve care team well-being and offer policy recommendations

- **KEY YEAR 1 INITIATIVES**
  - Collaborate with RIQI on Current Care development to enhance care management/coordination, chronic care/disease management
  - Collaborate with Unite Us on care coordination with CBOs
  - Support primary care practices in achieving NCQA BH recognition
  - Provide learning collaboratives and funding opportunities to support care team well being
  - Implement team based initiatives that include measurement of provider well-being

IMPACT AREA 5: Rhode Island population **health results** for kids, adults, and seniors are among the best in the nation, and **health disparities** are eliminated

- **SHORT TERM OUTCOMES (by 2024-2025)**
  - Reduce health disparities as measured by Commonwealth Fund Report (or other identified measures)

- **KEY YEAR 1 INITIATIVES**
  - Identify measures of health equity for primary care dashboard- establish baseline
  - Target areas of opportunity
  - Develop trainings and learning collaboratives to address disparities/inequities
  - Support multi-sector teams to advance community-clinical linkages and population health goals via Rhode to Equity
  - Advancing success in the Moms PRN, Care Community and Equity, DULCE, Healthy Tomorrows, and Obesity projects

CTC DRAFT LOGIC MODEL FOR IMPACT

Practices | **Population/Community Health** | **Health Systems** | **Cross Cutting**

INPUTS

ORGANIZATIONAL CAPACITY
- Diversified Board and staff/consultant team
- Access to consistent and stable funding
- Access to evidence based practices (learning) and networks (distribution)

SHARED DESIGN PRINCIPLES
- Multi payer
- Collaborative learning across practices and systems of care
- Health equity lens and principles
- Inclusion of people with lived experience in project design and implementation
- Spread within system of care
- Best practices and EVP
- All practices invited
- Alignment with Accepted Standards and Measures
- Quadruple Aim = North Star

COLLABORATIVE APPROACH
- Trust-based partnerships with ACOs, AEs, state agencies, payers, academic training programs. practices, hospitals, and other providers (e.g., behavioral health, etc.)
- Strong relationships with array of funders

APPROACHES

Convening Key Stakeholders

Conferences, best practice sharing, professional work force development, primary care dashboard

Learning Collaboratives

Learning in action cohorts focused on comprehensive primary care design components required for successful operation under capitation. (e.g., system communication, coordination and alignment.
Focus areas:
Comprehensive Primary Care Delivery Components,
Team based care,
Clinical quality improvement
IBH,
Addressing HRSN
Maternal/child health

Innovative Pilot Programs
Focused on comprehensive primary care delivery design (includes program evaluation to inform health policy) e.g. R2E, PCP-Specialist, Pedi Transition of Care

Workforce development
e.g. NCM, CHW, IBH clinicians, PharmD

OUTPUTS (1 YEAR)

 # Convening's– by topic
i. # participants
ii. Evaluation results
iii. D+E recommendation for primary care dashboard

Learning Collaboratives by category
A. Comprehensive Primary Care (e.g. IBH, HRSN/community clinical linkages, PCP-Spec coordination)
i. # of practices participating in each initiative
ii.Lessons learned
iii.Evaluation results
iv.Recommendation

B. Maternal Child Health initiatives (e.g. Healthy Tomorrow, Dulce, Early Childhood Systems, Transfer of care)
i.# of practices participating
ii.Lessons learned
iii.Evaluation results
iv. Recommendation

 # Pilots– Innovative tests of change initiative (e.g.Rhode To Equity– R2E, Regional CHTs)

# of practices participating
Lessons learned
Evaluation results
Recommendation

Workforce development programs
(e.g. NCM, CHW, CCE other)

# of participants
Evaluation results

SHORT TERM OUTCOMES (2-3 YEARS)

Behavioral health care is integrated into every primary care practice
- % of practices with IBH
- Outcomes of integrated IBH

Practices are redesigned to support new payment models and enhance capacity to assess for and address health related social needs

Practices are supported in addressing workforce well-being and development
- TBD

Increased Coordination with Community Based Organizations
- CHW metrics
- Rhode to Equity metrics
- HEZ and Family Home Visiting metrics
- Other?

Improved clinical outcomes
- preventive, chronic, and complex care metrics

Improved Transitions of Care
- Pediatric to adult transition metrics
- Behavioral health transition metrics

Successful expansion of eConsult and Enhanced Referral Program to additional specialties and PCPs in all Systems of Care

Reduced Health Disparities
- Commonwealth Fund Report Card results
- Health equity challenge results

IMPACT (5 Years)

Health care delivery is fully coordinated across all care systems (physical/medical, behavioral health,and social)

Primary care practices (pediatrics and adults) are thriving in an all-payer value-based payment model that stabilizes health care costs and premiums

All Rhode Islanders have access to primary care, practices that reflect the demographics of their community, and are highly satisfied with their care experiences

Primary care providers and their teams are well supported and resourced (financial, human, technology, data, other) to deliver high-quality care

Rhode Island population health results for kids, adults, and seniors are among the best in the nation, and health disparities are eliminated

SUNSETTING WORK: Cohort 3 PCMH Kids, SBIRT, Telehealth