



#### ADVANCING INTEGRATED HEALTHCARE

## Welcome

Care Transformation Collaborative of Rhode Island

Patricia Flanagan, MD, FAAP, PCMH Kids Co-chair Elizabeth Lange, MD, FAAP, PCMH Kids Co-chair

PCMH Kids Stakeholder Meeting | July 7, 2022





# **Agenda**

Topic Presenter(s)	Duration
Welcome & Opening Remarks  Pat Flanagan, MD, FAAP and Beth Lange, MD, FAAP — PCMH Kids Co-chairs	5 minutes
Reflections, Current Environment, and Strategic Direction  Pat Flanagan, MD, FAAP and Beth Lange, MD, FAAP — PCMH Kids Co-chairs	30 minutes
What's next for PCMH Kids Stakeholder group – open discussion Pat Flanagan and Beth Lange, Co-chairs to facilitate discussion	25 minutes





### **Mission**

To engage providers, payers, patients, parents, purchasers and policy makers to develop high quality, family and patient-centered, medical homes for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-drive system improvement. PCMH's for children will be cost effective and sustainably resourced.

### **Vision**

All children and youth in RI will be cared for in high quality, family and patient centered, medical homes. Rhode Island's children and youth will grow up healthy and reach their optimal potential.

Think about "What are PCMH Kids' priorities for the next 2 – 5 years?" and what can CTC-RI do?





- Convened PCMH Kids in 2013 to extend the transformation of primary care to practices that serve children across
   Rhode Island
- Established a pediatric learning network **transforming** traditional **practices** into **team-based**, **data-driven**, **high quality**, **value based family-centered medical homes**
- 3 Cohort of practices, comprised of 36 practices, engaged with health plans under common agreements to become NCQA recognized patient centered medical homes.
  - covering over 105,000 lives
  - including over 250 pediatricians and trainees
  - representing more than 80% of the state's pediatric Medicaid population
- Improved developmental screening of all children age 9-30 months from a baseline of 41% screened to 85.9% screened which is fundamental to the Governor's third grade reading readiness initiative;
- Improved BMI screening and counseling from a baseline of 55% to 85.8%;
- Improved ADHD screening, diagnosis and treatment plans;





### **More Reflections**

- **Improved maternal post-partum depression screening** from baseline of 22% to 87% and implemented referrals protocols for intervention.
- Enrolled 75 providers with a total pediatric population of ~34,000, in the **Screening, Brief Intervention, Referral, and Treatment (SBIRT) in the adolescents** learning collaborative;
- Developed and implemented a **pediatric specific high-risk framework** to identify children and families that would benefit from care coordination services:
- **Achieved national recognition from AAP** for PCMH Kids Co-Chairs (Dr. Flanagan and Dr. Lange) receiving the Calvin C.J. Sia Community Pediatrics Medical Home Leadership award at the November 2018 annual meeting.
- PCMH Kids practices that maintain RI PCMH recognition are eligible for sustainability payments (Medicaid & Commercial)
- Persevered through COVID; Established monthly "coffee breaks" to take the pulse of the pediatric community.





### **More Reflections**

- 2020 funded programs:
  - Cares Act Pediatric Relief Fund and Medicaid Access to Care
  - **\$7,229,795.79** paid to pediatric practices
  - Welcomed 34 more pediatric / family medicine practices
- Pediatric Integrated Behavioral Health initiative 8 pediatric practices improved screening children for behavioral health conditions.
- Telehealth initiative to help practices address the essential and immediate need to adopt technology with the onset of COVID-19.
- **Pharmacy** Initiative with focus on Asthma





# PCMH Kids Cohort 3 Clinical Quality Performance Final Results

#### Legend:

Met Target
Met Medicaid Target
Met Target via Improvement

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Did	Not	Meet	Target
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			Develop	omental									
	BMI		Screening		Adolescent Well Child		d 2 MMR		Lead Screening				
		4/15/22		4/15/22		4/15/22	CTC Target	1/15/22		1/15/22			
		Submissio	CTC/OHIC	Submissio	CTC/OHIC	Submissio	within 90%	Submissio	CTC/OHIC	Submissio	Meet 2	Meet 3	Meet 5
PCMH Kids Cohort 3 Practices	CTC Target r	า	Target	n	Target	n	of 12/2019	n	Target	n	out of 5	out of 5	out of 5
Children First Pediatrics	80%	97.62%	45%/55%	84.04%	65.00%	75.08%	63.09%	85.96%	73.11%	63.50%			
Adolescent Medicine, RI Hospital	80%	51.35%	45.00%	NA	44%/65%	48.68%		NA		NA		NA	NA
Atlantic Pediatrics	80%	94.02%	55.00%	94.76%	65.00%	75.90%	87.59%	93.10%	73.11%	76.47%			
North Providence Pediatrics	80%	98.14%	45%/55%	100.00%	44%/65%	78.77%	86.90%	100.00%	73.11%	53.85%			
Ocean State Pediatrics	80%	92.84%	55.00%	78.39%	65.00%	81.23%	86.78%	96.75%	73.11%	73.64%			
Partners in Pediatrics	80%	92.59%	55.00%	89.29%	65.00%	76.37%	84.57%	97.74%	73.11%	51.59%			
PCHC - Capitol Hill	80%	59.11%	45.00%	77.18%	44.00%	81.03%	75.00%	77.55%	73.11%	80.00%			
PCHC - Central	80%	33.93%	45.00%	81.05%	44.00%	73.15%	75.84%	80.95%	73.11%	86.03%			
PCHC- Chafee	80%	32.97%	45.00%	66.09%	44.00%	61.30%	72.50%	74.77%	73.11%	77.83%			
PCHC- Olneyville	80%	79.56%	45.00%	89.34%	44.00%	66.47%	72.16%	86.07%	73.11%	74.85%			
PCHC - Prairie Ave	80%	59.63%	45.00%	80.58%	44.00%	86.62%	71.76%	77.69%	73.11%	75.83%			
PCHC - Randall Square	80%	33.22%	45.00%	74.56%	44.00%	71.14%	81.00%	88.11%	73.11%	59.48%			
Santiago - North Providence	80%	99.90%	45.00%	99.33%	44.00%	76.06%	81.66%	97.02%	73.11%	96.92%			
Santiago - Pawtucket	80%	99.90%	45.00%	99.33%	44.00%	76.06%	73.93%	95.24%	73.11%	90.00%			
Tri-County - Johnston	80%	79.84%	45.00%	73.30%	44.00%	42.72%	72.00%	76.09%	73.11%	55.17%			
Tri-County - North Providence	80%	79.84%	45.00%	73.30%	44.00%	42.72%	79.09%	90.74%	73.11%	86.84%			





## **Pediatric Integrated Behavioral Health Pilot Program**

- 3-year pilot program with 2 waves of practices
- Cohort 1 practices graduated in July 2021 and still participating
- **Cohort 2 practices graduated in April 2022**
- **Key Program Components:** 
  - Support culture change, workflows, billing
  - Universal Onsite IBH Practice Facilitation: Screening 3 out of 5: Depression (adolescent), Anxiety (adolescent), Substance use (adolescent), Middle childhood, or Postpartum depression
  - Embedded IBH Clinician: warm hand offs, pre-visit planning, huddles
  - Quarterly Best Practice Sharing: data driven improvement, content experts











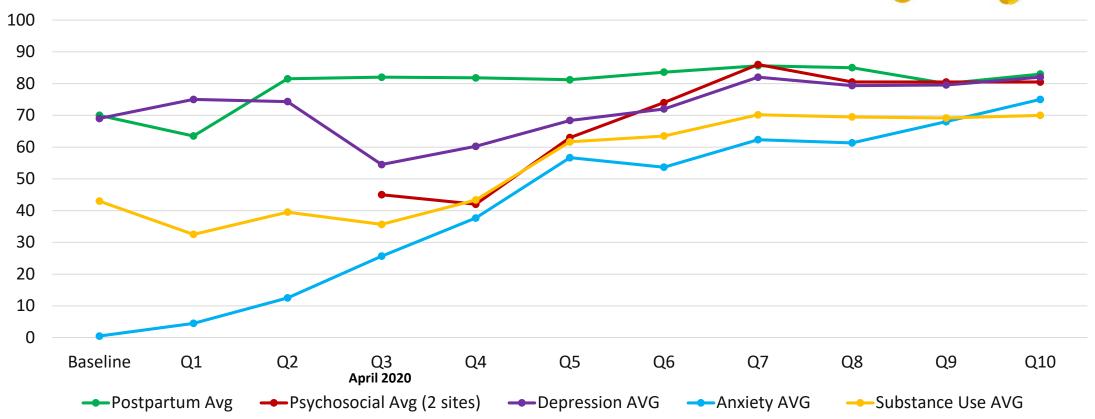
	Anchor Pediatrics
Cohort 1	Comprehensive Community Action Program (CCAP)
	Hasbro Pediatric Primary Care
Cohort 2	Coastal Medical – Bald Hill
	Coastal Medical - Waterman
	Hasbro Medicine Pediatric Primary Care
	Northern RI Pediatrics
	Tri-County Community Action Agency



# **Screening Data – despite COVID**



### **Screening Results - Combined**







"...so I think every practice should have that (onsite clinician.) Every patient and family should have access to that kind of support in the moment when we're courageous enough to say, 'we need help'....And the payoff may not be to you, insurance company, your foundations; but it's going to be a payoff to society at large, and that's really, really important."





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# **Telehealth Project - Phase 3: Year-Long Learning Collaborative**

21 practices: 11 Adult or family, 10 pediatric:

- A to Z Primary Care
- Anchor Medical Lincoln Adult
- Anchor Medical Lincoln Pediatric
- Anchor Medical Providence
- Anchor Medical Warwick
- Barrington Family Medicine
- Barrington Pediatrics
- CharterCARE Medical Associates
- Coastal Medical
- Encompass Pediatrics LLC
- Hasbro Pediatric Primary Care/RIH Medicine-Pediatrics
- Hasbro Medicine Pediatrics
- Kingstown Pediatrics
- Medical Associates of RI, Bristol
- Medical Associates of RI, East Providence
- P.R.I.M.A. Inc
- Richard Ohnmacht, MD
- Santiago Medical Associates

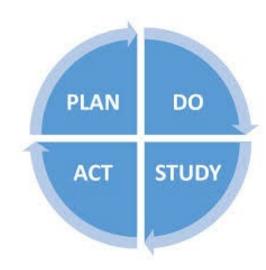


Practice Type	Chronic Conditions of Focus
Adult	Heart Failure Diabetes Hypertension COPD
Family Medicine	Heart Failure Hypertension Obesity Asthma
Pediatrics	Mental Health (Depression, Anxiety, ADHD) Social Determinants of Health Asthma Diabetes Hypertension Liver Enzymes Obesity





- 2022 Medicaid Pediatric Healthcare Recovery Program
- MomsPRN
- Healthy Tomorrows
- Transitions from Pediatrics to Adult Healthcare







## Medicaid Pediatric Healthcare Recovery Program



#### **Behavioral Health TA Sessions**

- Attendance: 77 at the 1<sup>st</sup> session on April 7<sup>th</sup> with topic on Brief Intervention Training for Pediatric Staff
- Attendance: 85 at the 2<sup>nd</sup> session on April 19<sup>th</sup> with topic on Impact of COVID on children's social-emotional development
- Attendance: 55 at the 3<sup>rd</sup> session on May 12<sup>th</sup> with topic on Behavioral Plan Basics
- Looking at the evaluation results (as of 5/7/2022)
  - 100% said that the materials presented met the stated objective
  - 97.5% overall opinion of the sessions was good (16.8%) to excellent (80.7%).
  - 95.9% thought the content was just right (other choices were too advanced or too basic).
  - "I will be able to use the content of this session in my practice" 51.3% strongly agree; 41.2% agree with that statement
  - 45.4% (54 individuals) suggested that they are interested in customized Psychosocial / Behavioral Health technical assistance. Which Liz Cantor is trying to wrap her brain around this. J
  - 73.1% are interested in CME credit for the session





# Medicaid Pediatric Healthcare Recovery Program



### **Well Child Visits – April Summary**

							Composite
	3 – 11 year olds			12	Score		
	Num	Den	Rate	Num	Den	Rate	Rate
March submission - Baseline							
(1/1/21-12/31/21)	22485	28803	78.1%	13878	18493	75.0%	76.9%
April submission (4/1/2021-							
3/31/2022)	23349	29785	78.4%	14712	19353	76.0%	77.5%

- 38,061 Medicaid children out of 49,138 received their well child visits from 4/1/2021 3/31/2021 (77.5%).
- The composite score improved slightly despite practices having a little over a month (from the time they submitted their applications on March 9th to April 15th) to improve well child visits.
- Some practices actually went down in their April submission due to the rolling 12 months now including January and February of 2022, impacted by another COVID surge.
- 100% practices hit the HEDIS or their improvement target







- Behavioral health conditions are often underrecognized, underdiagnosed, and undertreated during pregnancy and/or the postpartum period.
- Statewide program launched in 2019, modeled after <u>PediPRN</u>, that is funded by a HRSA grant award that is implemented by the RIDOH, the Center for Women's Behavioral Health at Women & Infants Hospital (WIH), and CTC-RI.
- Program seeks to help providers universally screen for behavioral health among their pregnant and postpartum patients and respond with appropriate treatment/referral through availability of
  - 1. Real-time psychiatric telephone consultation and resource/referral services;
  - 2. Virtual practice advisement and quality improvement support services

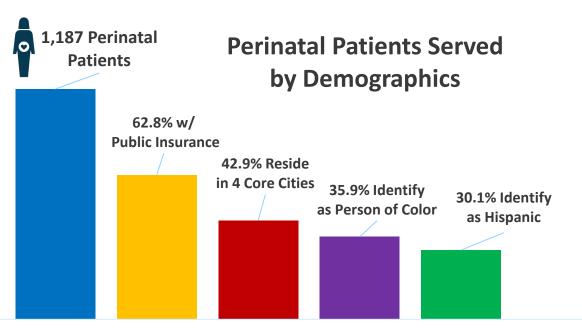




# **RI MomsPRN Teleconsultation Impacts**

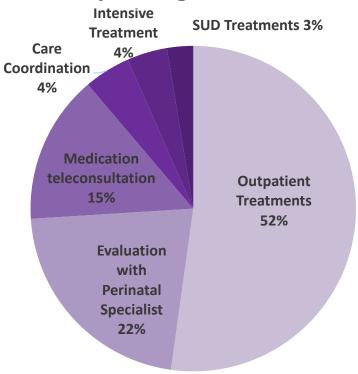


Source: RI MomsPRN Program as of May 2022 since September 20019 launch



Source: RI MomsPRN Program as of May 2022; Percentages exclude unknowns

# Referrals/Services Requested by Calling Providers



Source: RI MomsPRN Program as of May 2022









# **Healthy Tomorrows Initiative**

Funded by Health Resources and Services Administration (HRSA) and Tufts Health Plan 5 year Program

#### Goals

- PCMH-Kids practices and FHV programs have the tools, data and work flows needed to integrate care coordination
- PCMH-Kids practices and FHV programs acquire knowledge, skills and relationships for integrating care coordination through participation in a year-long Learning Collaborative
- PCMH-Kids practices and FHV programs develop and implement strategies to support family engagement in primary care and FHV programs
- Integrated Care Coordination activities will continue after the period of federal funding ends.

Year 1 (Mar 2020 – Feb 2021) – Planning Year

Year 2 (Mar 2021 – Feb 2022) – Pilot with Meeting Street & Blackstone Valley Community Action Program + Hasbro Pediatric Primary Care & Providence Community Health Center – Central

Year 3 (Mar 2022 – Feb 2023) – Expanded to 2 more practices + 2 Family Visiting programs + PAT





### Healthcare Transitions from Adolescent to Adult Care

### Funded by RI Department of Health and Tufts Health Plan

### Goals

- Create standardized process for transfer from pediatric to adult care with youth, with and without special needs, and families
- Use nationally recognized HCT approach and quality improvement methods to implement practice improvements in both pediatric and adult care
- Strengthen engagement with youth and collaboration between pediatric and adult primary care sites
- Measure HCT practice improvements and consumer experience with HCT process
- Encourage sustainable HCT process through improvements in payment and infrastructure support









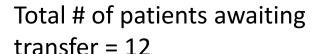


# **Data Summary**

### **Learning Collaborative May 2021 – April 2022**

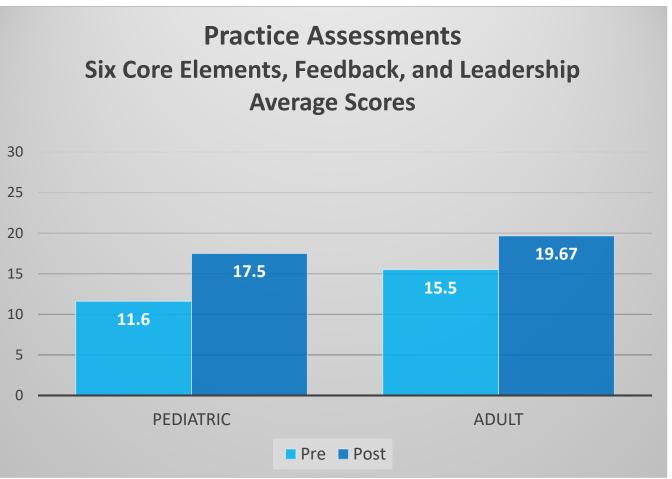


Total # of patients transferred = 29





Total # of youth surveys received = 17







# Results from Youth Surveys: 17 received



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"







with focus on Tele-IBH and NCQA BH Distinction NEED TO UPDATE

- 11 practices across 2 cohorts
- Adult/Pedi IBH
- 12-month initiative
- 2 IBH practice facilitators meet monthly with each practice
- 1 PDSA focused on either obtaining NCQA Designation in IBH or Tele-IBH
- 3 Learning Collaborative meetings



### **Practices**

Associates In Primary Care Medicine

Brown Medicine - Internal Medicine

Anchor Medical - Lincoln Adult Medicine

Anchor Medical - Providence

Anchor Medical - Warwick

**Anchor Pediatrics** 

**CNEMG Family Care Center** 

**Providence Community Health Centers - Capitol** 

**Providence Community Health Centers - Central** 

**Providence Community Health Centers - Olneyville** 

**Providence Community Health Centers - Prairie** 





- Year 2 Medicaid Pediatric Healthcare Recovery Program under development
- Pediatric Neighborhoods: Adopting DULCE (Developmental Understanding and Legal Collaboration for Everyone) to Better Serve Families and their Infants
- Rhode to Equity Team (02907) with a focus on asthma healthcare conditions
- Asthma Learning Collaborative using ECHO Learning Approach
- Pediatric Weight Management Initiative using ECHO Learning Approach
- Workforce Development training opportunity for BH clinicians (UMass training)
- Nurse Care Manager / Care Coordinator GLearn Training Program



# RI State Budget FY23 (7/1/22-6/30/23)

So great for RI's Children!!

- 1. Extension of Medicaid Benefits 12 month postpartum
- 2. Re-instatement of Medicaid eligibility for all kids, regardless of immigration status
- 3. Increased Rates for El providers, Child Care workers
- 4. Funding for Another Pediatric Medicaid Relief Project

AND.... Medicare Rate Parity for Pediatric Primary Care Medicaid Codes

### **CTC Five Year Strategic Plan**





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#### CTC DRAFT LOGIC MODEL FOR IMPACT

**Practices** 

#### Population/Community Health

#### Health Systems

#### **Cross Cutting**

INPUTS

APPROACHES

OUTPUTS (1 YEAR)

#### ORGANIZATIONAL CAPACITY

- Diversified Board and staff/consultant
- 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,
- Strong relationships with array of funders

#### 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

Addressing HRSN Maternal/child health

#### **Innovative Pilot Programs**

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

#### Workforce development

e.g. NCM, CHW, IBH clinicians,

#### # 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)
- f of practices participating
- essons 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

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

#### 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





# "What are PCMH Kids' priorities for the next 2 - 5 years?"

PCMH Kids Stakeholder → Improving Child Health in RI

**OPEN DISCUSSION** 





### Thank You to our funders













Lead, Transform, Inspire













# Thank You, Pat & Beth











### Thank You to our founders

### Think Tank that wrote the original White Paper – **June 2012**

David Keller

Bill Hollinshead

Peter Hollmann

Elizabeth Burke Bryant

**David Bourassa** 

Ailis Clyne

Michael Fine

Pat Flanagan

**Deidre Gifford** 

#### Conveners -

Secretary Steven Costantino

**Director Deidre Gifford** 

### **Administrative Support –**

Hannah Oakley Hakim

Melody Lawrence

Stacey Aguiar

### Planning Committee -

Blythe Berger

Tina Spears

Jason Lyon

**Deidre Gifford** 

Bill Hollinshead

Pat Flanagan

Beth Lange







# Thank You, Practice Facilitators













# Thank you from CTC-RI Team





Debra Hurwitz, MBA, BSN, RN Executive Director



Pano Yeracaris, MD, MPH Chief Clinical Strategist



Patricia Flanagan, MD PCMH Kids Co-Chair



Nelly Burdette, PsyD Senior Integrated Behavioral Health Program Leader



Linda Cabral, MM Program Manager



Susanne Campbell, RN, MS, PCMH CCE Senior Program Director



Liz Cantor, PhD Pediatric IBH Practice Facilitator



Sue Dettling, BS Program Manager & Practice Facilitator



Jennifer Capewell, BA Manager, Administration



Carolyn Karner, MBA Program Management & Evaluation



Michelle Mooney, MPA Program Coordinator



Anh Kim Nguyen-Leite, MHA Program Coordinator II



Sarah Summers, BA Program Coordinator II



Jade Arruda, BS Telehealth and MomsPRN Project Coordinator





# Friendly Reminders of Upcoming Meetings...

Date	Meeting
July 19th	Best Practices in Team Based Care, 8:00-9:00AM, <a href="https://ctc-ri.zoom.us/j/93572867243?pwd=L1h2dDkvc2VMeklRRW1iRlZ2NnJTQT09">https://ctc-ri.zoom.us/j/93572867243?pwd=L1h2dDkvc2VMeklRRW1iRlZ2NnJTQT09</a> Meeting ID: 935 7286 7243; Passcode: 646876; One tap mobile: 6468769923,,93572867243#,,,,,0#,,646876#  CME credits pending approval
Aug 4th	Virtual Coffee Break with Pat & Beth, 7:30-8:00AM <a href="https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09">https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09</a> Meeting ID: 959 6302 4930; Passcode: 646876; One tap mobile: 6468769923,,95963024930#,,,,,0#,,646876#
Sept 9th	Breakfast of Champions, 7:30-9:00AM <a href="https://ctc-ri.zoom.us/j/85259643839?pwd=Z3VDLzF1RGhFdTg4dHhXdEluczRNZz09">https://ctc-ri.zoom.us/j/85259643839?pwd=Z3VDLzF1RGhFdTg4dHhXdEluczRNZz09</a> Meeting ID: 852 5964 3839; Passcode: 646876; One tap mobile: 6468769923,,85259643839#,,,,,0#,,646876#  CME credits available





#### ADVANCING INTEGRATED HEALTHCARE

# Thank you Stay Healthy and Safe

Virtual Coffee Breaks: August 4, 2022 & September 1, 2022

Next "Improving Child Health in RI" (Stakeholder) Meeting: October 6, 2022