Building Capacity for Comprehensive Primary Care

CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND
DEBRA HURWITZ, MBA, BSN, RN - EXECUTIVE DIRECTOR CTC-RI
NOVEMBER 1, 2018
CTC-RI Overview

- **Vision**: Rhode Islanders enjoy excellent health and quality of life.

- **Mission**: To lead the transformation of primary care in Rhode Island in the context of an integrated healthcare system; and to improve the quality of life, the patient experience of care, the affordability of care, and the health of populations we serve.

- **Approach**: CTC-RI brings together key stakeholders to implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.
- Increase Capacity and Access to Patient-Centered Medical Homes (PCMH)
- Improve Quality and Patient Experience
- Reduce Cost of Care
- Improve Population Health
- Improve Provider Satisfaction (“Fostering joy in work”)
Expanding PCMH

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

- **106 primary practices**, including internal medicine, family medicine, and pediatric practices.
- Approximately **650,000 Rhode Islanders** receive their care from one of our practices.
- **750 providers** across our adult and pediatric practices.
- Investment from every health insurance plan in Rhode Island, including private and public plans.
- **All Federally Qualified Health Centers** in Rhode Island participate in our Collaborative
- Saving more than $217 million in total cost of care dollars in 2016 (compared to non-patient centered medical homes in Rhode Island), according to data from the state’s All-Payer Claims Database.
Expanding Care in the Neighborhoods

CHT and SBIRT locations:
- Woonsocket
- Blackstone Valley
- Providence
- West Warwick
- Newport
- South County

New • Existing ▲

SBIRT locations:
- Several sites including:
  - Dept of Corrections
  - Kent Hospital
  - Butler Hospital
  - CCAP
  - RIPIN
  - The Providence Center
“I mean, when I say how much I love having integrated behavioral health, is that I can't imagine primary care without it. It just makes so much sense to me to have those resources all in the same place because it's so important. So I love it. I can't speak highly enough of it.”

(Medical Provider)
Better Care - Lower Costs Adults

Total Medical & Pharmacy Costs (with Exclusions) risk adjusted (Cost per Member-Month)

- IBH Cohort 2
- IBH Cohort 1
- CTC - non IBH
- Adult Comparison

Data Source: Rhode Island All Payer Claims Database
Better Care Through Workforce Development: IBH

3 Practice Facilitators specifically trained within IBH in Primary Care
• 6 months Didactic and Experiential training
• Backgrounds include psychology, social work and marriage & family therapy
• 3 PCMH sites are receiving practice facilitation services over 1 year period

Represents the first training of its’ kind in the country

This program was made possible through the support of the RI Foundation and RI College.
Better Care - Lower Costs
PCMH Kids Cohort 1 & Kids Comparison

Rate per 1,000 Member Months (Excluding ERISA Members)

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<tbody>
<tr>
<td></td>
<td>(A)</td>
<td>(B)</td>
<td>(B-A)</td>
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<tr>
<td><strong>Emergency Department Visits</strong></td>
<td></td>
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<tr>
<td>(1) Kids Cohort 1</td>
<td>29.2</td>
<td>28.6</td>
<td>-0.7</td>
<td>-2.3%</td>
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<td>(2) Kids Comparison</td>
<td>29.0</td>
<td>29.0</td>
<td>0.1</td>
<td>0.2%</td>
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<td>Difference (1–2)</td>
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<td>-0.7</td>
<td><strong>-2.5%</strong></td>
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Data Source: Rhode Island All Payer Claims Database?
Better Care Through Partnerships

- Thank you to our Sponsors
- Rhode Island Department of Health: Chronic Care and Community Equity
- Patient Engagement: SIM and RIQI
- Nurse Care Manager/Care Coordinator Training: UnitedHealth Plan
- Integrated Behavioral Health Initiatives: Rhode Island Foundation/Tufts/SIM
Better Care Through Partnerships

Thank you for your advocacy!
Thank you to our health plans

- Blue Cross and Blue Shield of RI
- Neighborhood Health Plan of RI
- Tufts Health Plan
- UnitedHealthcare
## CTC Strategic Priorities 2018-19

### Primary Care Practice Transformation
- Provide support to CTC practices
- Implement nurse care manager training for practices providing MAT
- Expand our pediatric practice participation through a call for applications

### Integrated Behavioral Health (IBH) in primary care
- Conclude 3 year pilot program
- Finalize qualitative analysis
- Conduct a robust quantitative analysis with Brown University
- Offer IBH technical assistance and services for practices and systems of care interested in implementing IBH
- Establish Dr. Nelly Burdette as CTC’s Senior IBH leader

### Community Health Teams
- Test and evaluate outcomes of 6 geographic CHTS that function as an extension of primary care
- Provide assessments for depression, anxiety, SUD and social determinants of health and work with patients to improve health outcomes and service utilization
- Expand community health team to include nutrition and pharmacy services
- Work with Day Health Strategies to develop a sustainability plan for the CHTs

### Innovation and Incubation
- Identify innovative models of care that support value based care through the Re-chartered CTC Clinical Strategy Committee
- Areas of focus: low value care & improved coordination with specialists

### Public Education
- Focus attention on the value of advanced primary care

### Improve CTC Data Analytic Capability
- Leverage APCD and data management systems
- Develop and market product lines.
  - IBH Practice Facilitation Services
  - Practice Facilitation Services for PCMH
  - CHT Services
  - Data Management Services
  - Project Management Services

### Areas of focus:
- Low value care & improved coordination with specialists
National Recognition for Better Pediatric Care

American Academy for Pediatrics’ Calvin C.J. Sia Community Pediatrics Medical Home Leadership Award

PCMH Kids Co-Chairs:
Dr. Pat Flanagan
Dr. Beth Lange

Thank You!