CTC-RI Strategic Plan
Review of Accomplishments
2018 FYTD

CTC-RI BOARD OF DIRECTORS
MARCH 22, 2019
Strategic Plan
Accomplishments 2018 FYTD

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Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim.

Overview

1. Integrated Behavioral Health in Primary Care
2. Statewide CHT network - 6 geographic regions - extension of primary care.
3. PCMH-Kids sustainability and expansion
4. Clinical Strategy Committee
5. CDC initiative on hypertension, pre-/diabetes, and cholesterol management
Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

1. Integrated Behavioral Health in Primary Care
   - Successfully concluded 3-year IBH pilot project that tested universal screening for depression, anxiety and substance use disorder.
   - This intervention demonstrated an average $45 PMPM lower total cost of care than our CTC practices and $63 PMPM lower cost of care than the non-PCMH comparison group.

   - **SBIRT** Exceeded Year 1 SBIRT screening targets by 52%
     - 7858 screens completed across 20+ sites
     - Follow-up screens 74% (target 75%)
IBH Pilot Results: Universal Screening Cohort 1 & 2
IBH Pilot Results:
Better Care - Lower Costs

Total Medical & Pharmacy Costs (with Exclusions) Risk-Adjusted
(Cost per Member-Month)

Data Source: Rhode Island All Payer Claims Database
CELEBRATING 1 YEAR OF RI-SBIRT!
September 2017 - September 2018

7,858 Screens Completed
1,460 interventions
9 out of 10 people at risk received an intervention.

1 of every 2 (53%) clients who reported illegal drug use at intake reported no use 6 months later.

Of those selected for follow-up, only 15% of clients who reported opiate use at intake reported use at follow-up.

20 clients at intake
3 clients at follow-up

Clients who reported marijuana use at intake reported significantly fewer marijuana use days at follow-up.

2 out of 5 (40%) clients who reported binge drinking in the month before intake reported no binge drinking at follow-up.

- 18% of clients were Hispanic
- 55% of clients were female
- Average age = 47

Percent of clients who reported risky use of alcohol and/or drugs
- No risk: 76%
- Alcohol only: 5%
- Drug only: 13%
- Alcohol & drug: 6%

20% of clients received an intervention

Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

2. Statewide CHT network established covering 6 geographic regions working as an extension of primary care.
   - Teams have significantly reduced patients “the high-risk driver scores by 42% from intake to discharge.
   - Depression and anxiety scores significantly reduced from intake to discharge.
   - Total cost of care analysis for South County Hospital shows early data - small N - not statistically significant, but directionally correct. Adding Thundermist data to increase sample size for analysis.
   - URI conducting quality of life and patient satisfaction evaluation for Q3/4 2019
   - Sustainability planning continues:
     ◦ Completed sustainability plan with Day Health Solutions,
     ◦ In discussions with Medicaid,
     ◦ Working with Medicaid to convene a meeting with AE’s.
## CHT Results to Date: Clients Served and SDOHs

### Demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>63% Female</td>
</tr>
<tr>
<td>Age</td>
<td>Mean = 54</td>
</tr>
<tr>
<td>English Speaking</td>
<td>35% Non-English Speaking</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22%</td>
</tr>
<tr>
<td>Non-white</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Social Determinants of Health Present at Intake

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>44%</td>
</tr>
<tr>
<td>Finance</td>
<td>44%</td>
</tr>
<tr>
<td>Transportation</td>
<td>38%</td>
</tr>
<tr>
<td>Food</td>
<td>29%</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>20%</td>
</tr>
<tr>
<td>Interpersonal Violence</td>
<td>18%</td>
</tr>
</tbody>
</table>

*N = 202 CHT Intakes 10/01/18 - 12/31/18*
CHT Referral Triage Tool

Mechanism by which PCPs Identify High-Risk Referrals to CHTs

<table>
<thead>
<tr>
<th>Higher Risk Drivers (3 Points Each)</th>
</tr>
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<tbody>
<tr>
<td>Utilization (medical or psych):</td>
</tr>
<tr>
<td>□ IP admit in past 30 days OR</td>
</tr>
<tr>
<td>□ 30-day Readmission in past year OR</td>
</tr>
<tr>
<td>□ 2+ IP admits in past 6 months OR</td>
</tr>
<tr>
<td>□ 2+ ED visits in past 6 months</td>
</tr>
<tr>
<td>□ Health Plan High Risk Report – impactable costs actual or predictive &gt; $25,000</td>
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<table>
<thead>
<tr>
<th>Moderate Risk Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorly Controlled High Risk Chronic Disease (2 Points Total)</td>
</tr>
<tr>
<td>□ CAD □ CHF □ Diabetes</td>
</tr>
<tr>
<td>□ COPD □ Chronic Pain □ End stage disease: □</td>
</tr>
<tr>
<td>□ RX Meds: 8+ active prescriptions OR recent change in high risk meds (2 Points Total)</td>
</tr>
<tr>
<td>□ Inadequate follow-up with PCP, or</td>
</tr>
<tr>
<td>□ Not following care plan, or</td>
</tr>
<tr>
<td>□ Specialty care without coordination</td>
</tr>
<tr>
<td>□ Disability: significant Physical/ Mental/ Learning disability impacting reasons for referral (2 Points Total)</td>
</tr>
<tr>
<td>□ Insufficient income</td>
</tr>
<tr>
<td>□ Insufficient housing</td>
</tr>
<tr>
<td>□ Insufficient education</td>
</tr>
<tr>
<td>□ Insufficient Social support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fundamental Risk Drivers (1 Point Each)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Substance Abuse: Actively using, newly sober, motivated to change (2 Points Total)</td>
</tr>
<tr>
<td>□ Alcohol □ Opioid □ Benzodiazepine □ Other</td>
</tr>
<tr>
<td>□ Mental Health DX that is severe, persistent, and uncontrolled (2 Points Total)</td>
</tr>
<tr>
<td>□ Schizophrenia □ Major Depression □ Bipolar □ Debilitating Anxiety □ Other</td>
</tr>
<tr>
<td>□ Chronic Disease/ Co-morbidities – not well controlled/ not noted above (1 Point)</td>
</tr>
<tr>
<td>□ Functional Impairments – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point)</td>
</tr>
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Eligibility Determination for CHT

- **>15 = High-Risk (offer CHT to patient)**
- **8-14 = Rising Risk (patient may meet criteria for CHT)**
- **<8 = Discuss referral with CHT before offering to patient**
CHT Outcomes to Date

RTT Data Summary from 3 CHTs

CHT Referral Triage Tool Scores (N=66)

\[ t(65) = 11.84, \ p < .0001, \ 215 \text{ Days in CHT Care} \]

43% decrease in RTT score, intake to discharge
Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

3. PCMH-Kids

- Cohort 1 bridge funding from UHC and NHP; sustainability payments to be included in Medicaid rates.
- July expansion to 17 practice sites; 64 providers; 43k lives.
- Total PCMH-Kids population = 109,818
- Represents over half of all children in the state and over 90% Medicaid children in a CTC PCMH.
- IBH learning collaborative – SBIRT screening for adolescents.
Results to Date: PCMH-Kids Improved Customer Experience

Patient Experience Survey Results PCMH-Kids Cohort 1 & 2

Access

Communication

Office Staff

Cohort 1  Cohort 2  2018 target  Linear (Cohort 1)

Cohort 1  Cohort 2  2018 target  Linear (Cohort 1)

Cohort 1  Cohort 2  2018 target  Linear (Cohort 1)
Results to Date: PCMH-Kids Improved BMI and Developmental Screening Rates

Quality Measures PCMH-Kids Cohort 1 & 2

Q2 '16 | Q3 '16 | Q4 '16 | Q1 '17 | Q2 '17 | Q3 '17 | Q4 '17 | Q1 '18 | Q2 '18 | Q3 '18
--- | --- | --- | --- | --- | --- | --- | --- | --- | ---
BMI Target | 76% | 76% | 76% | 76% | 90% | 90% |
BMI | 55% | 64% | 72% | 77% | 80% | 86% | 81% | 85% | 86% | 93% |
Developmental Screening Target | 75% | 75% | 75% | 75% | 77% | 77% | 77% | 77% | 77% |
Developmental Screening | 42% | 45% | 52% | 68% | 72% | 78% | 77% | 77% | 81% | 86% |
Results to Date: Improved ED Utilization

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>
<td></td>
</tr>
<tr>
<td><strong>Emergency Department Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Kids Cohort 1</td>
<td>29.2</td>
<td>28.6</td>
<td>-0.7</td>
<td>-2.3%</td>
</tr>
<tr>
<td>(2) Kids Comparison</td>
<td>29.0</td>
<td>29.0</td>
<td>0.1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Difference (1–2)</td>
<td></td>
<td></td>
<td>-0.7</td>
<td>-2.5%</td>
</tr>
<tr>
<td><strong>Inpatient Discharges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Kids Cohort 1</td>
<td>1.5</td>
<td>1.5</td>
<td>0.01</td>
<td>0.7%</td>
</tr>
<tr>
<td>(2) Kids Comparison</td>
<td>1.2</td>
<td>1.2</td>
<td>0.01</td>
<td>0.5%</td>
</tr>
<tr>
<td>Difference (1–2)</td>
<td></td>
<td></td>
<td>0.00</td>
<td>0.3%</td>
</tr>
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</table>
Results to Date PCMH-Kids

Integrated Behavioral Health Services into Pediatric Primary Care through:

2. Improved screening for social-emotional challenges in infants and toddlers.
3. Multi-practice IBH learning collaboratives participation focused on:
   • ADHD screening, diagnosis and treatment plans;
   • Maternal post-partum depression screening:
     o Improved screenings from a baseline of 22% to 87%
     o and implemented referrals protocols for intervention.
   • Screening, Brief Intervention, Referral, and Treatment (SBIRT) in adolescents:
     o with a total pediatric population of ~34,000,
     o enrolled in the learning collaborative;
Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

4. Clinical Strategy Committee rechartered as a Board subcommittee co chaired by Matt Collins, MD MBA and Andrew Saal, MD MPH
   • Increased representation systems of care, Medicaid, OHIC.
   • Progress has been made in the identified 3 prioritized areas of work:
     1. Primary Care / Specialist Collaboration: ACP High-Value Care Coordination Kickoff Feb 19th for 6-month project. 23 practices (12 primary care and 11+ specialist)
     2. Low-Value Care: Project continues to gain momentum. Review of preliminary data of 10 identified measures 3/15/19.
     3. Improving Clinician Well-being (reduce administrative burden): CSC supported RIDOH effort to stop hospital waivers of Transition of Care (TOC) documentation regulations which will benefit clinicians. CSC was asked to work with RIDOH Primary Care Physician Advisory Committee to help reduce burnout. Additional potential areas of work supported by CSC to work to increase ED/PCP collaboration and PCP involvement to improve TOC with hospitals.
Goal 1: To continue to transform primary care in the context of an integrated health care system by shifting CTC program focus to include shared innovation and incubation and public education efforts that advance the quadruple aim. (continued)

5. CDC Chronic Care Initiative focuses on best practices
   • Hypertension and undiagnosed hypertension
   • Diabetes and Pre-diabetes
   • Cholesterol management
   • Practice facilitators working with 24 practices
   • CTC providing data management services to capture and display practice performance
New Funding Furthering Investments in CTC Mission –
Total over $1M for 2019 FYTD

<table>
<thead>
<tr>
<th>Company</th>
<th>Initiative</th>
</tr>
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<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>xGLearn; IBH program 10 practices; Kids bridge</td>
</tr>
<tr>
<td>Tufts Health Plan</td>
<td>IBH online training module; PCMH-Kids home visiting/IBH; enhanced analytics and functionality of APCD data</td>
</tr>
<tr>
<td>Integra</td>
<td>IBH – 5 pediatric and 5 adult practices; and train the trainer</td>
</tr>
<tr>
<td>RIQI/SIM</td>
<td>10 practices to testing Advanced Directives technology platform</td>
</tr>
<tr>
<td>RIDOH/CDC</td>
<td>Chronic care initiative HTN, diabetes, cholesterol management</td>
</tr>
<tr>
<td>RIDOH Project LAUNCH</td>
<td>IBH sustainability</td>
</tr>
<tr>
<td>NHP</td>
<td>PCMH-Kids bridge for Medicaid</td>
</tr>
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</table>
Goal 2: Cultivate and establish relationships that enable and enhance our ability to successfully implement our programs.

1. **Clinical Strategy Committee representation expanded to ACO/AE**
   * Leadership co-chaired by Matt Collins, MD MBA and Andrew Saal, MD MPH.
   * Committee representation expanded to include Medicaid, ACO and AE representation.
   * Specialist engagement via HVCC project, potentially ED/PCP communication and PCP role in TOC with hospitals.

2. **CTC to work with RIDOH Primary Care Physician Advisory Committee to reduce burnout/improve provider wellness**

3. **SIM/CMS Site Visits to review IBH and CHTs; SIM vendor meetings**

4. **Collaboration with National Associations**
   * Milbank multi-state collaborative
   * American Case Management Association: Test Transition of Care Standards with adult and pediatric primary care practices.
   * Patient-Centered Primary Care Collaborative
   * American College of Physicians: High-Value Care Coordination project is based on this collaboration.
   * American Academy of Pediatrics – SBIRT screening adolescents

5. **RI Outreach**
   * Children’s Cabinet Policy Director: Kayla Rosen, to educate about CTC.
   * BHDDH: Michelle Brophy, Director of Policy regarding IBH initiatives in primary care.
   * Rhode Island Free Clinic: To participate in RIDOH CCE initiative
   * Planned Parenthood: Women’s health services and potential partnership for SBIRT.
Goal 3: Adjust our organization’s supports and safeguards as CTC grows and changes.

• Management Services Arrangement with HCA
  1. Sublease agreement with Healthcentric Advisors has been renewed.
  3. Converted IT systems (conference lines, shared files) from UMMS to CTC-RI.
  4. Information Technology (IT) - CTC IT is hosted on HCA server. CTC will be upgrading encryption and security software under HCA management contract to position CTC to host PHI if necessary in the future.
  5. Explored possibility of CTC using file server, policies and procedures for data storage security systems containing PHI. While CTC doesn’t have an immediate need for this, anticipating for the future.
  6. Also discussed the possibility of additional space if we were to expand.
  7. CTC is initiating an internal planning process with respect to CHT data collection that would include PHI. This has been prompted by CTC’s state contract for CHT’s centralized network management. Final plan will be brought to CTC Board for discussion at a future date.
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination.

1. **All-Payer Claims Database**
   • Now with 5 data points, 6\textsuperscript{th} to be added April 2019
   • Continued enhancements allow risk-adjusted and unadjusted utilization and cost measures display as well as provider-specific and health plan-specific results.
   • Supporting Brown School of Public Health / Ira Wilson efforts to identify and connect PCPs to practices and systems of care APCD.

2. **Quarterly Breakfast of Champions**
   • September 2018 and February 2019 meetings with 65-80 attendees:
     • Presentation of CTC IBH program and results.
     • Presentation on use of scribes in RI PCP practices.
     • Breakout discussions on screening and mitigating SDOH and improving primary care / specialist.
     • EOHHS presentation “Efforts to Improve Technology and Data Flow to Impact Care”.

3. **Annual Conference (Attendees 330+) with National Speakers**
   • NYS: 1\textsuperscript{st} 1000 Days Campaign
   • VT: Women’s Health and Care Coordination
   • Maine: Integrated Behavioral Health
   • Massachusetts: Neighborhood Risk Scores and Medical Legal Partnership
   • CT: “What Patients Want”
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (continued)

4. Nurse Care Manager training
   • Geisinger Core Curriculum Training Program: 52 NCM/CC Trained; Pediatric faculty certified as a trainer.
     • 88% improved care management skills
     • 60% improved risk stratification
     • 53% developed patient engagement expertise
     • 45% improved ability to manage behavioral health challenges
   • Diabetes Train-the-Trainer Program: 50+ NCM trained
   • Pediatric High-Risk Framework: PCMH-Kids practices tested and refined pediatric-sensitive high-risk framework.
   • Nurse Care Manager Training in Medication Assisted Treatment
     • Colleen LaBelle, MSN, RN-BC, CARN content expert presented 2 sessions > 60 attendees
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (continued)

5. Data and Evaluation Committee
   • Oversight for:
     • IBH Qualitative Analysis
     • IBH Quantitative Analysis
     • Onpoint All-Payer Claims Database Analysis
     • Alignment with OHIC
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

• State/Regional/National Presentations, Publications, Awards Part 1

**University of Rhode Island:** Debra Hurwitz and Dr. Nelly Burdette presented the CTC Integrated Behavioral Health Pilot, *Integrated Behavioral Health Transformation in Rhode Island: How the Smallest State Plans to Make the Biggest Changes.*

**PCMH Congress national presentation:** CTC and practices presented their work on integrated behavioral health at the September national conference “A Successful Blueprint for implementing Integrating Behavioral Health in Primary Care”.

**PCPCC Collaborative:** Debra Hurwitz, MBA, BSN, RN and Pano Yeracaris, MD MPH participated in workshop on increasing investment in primary care. This invitation-only workshop is aiming to engage about 100 thought leaders from around the country with the goal of advancing primary care investment in states across the country.

• RI Foundation Community Leadership Award 2018

• AAP recognition of PCMH-Kids as a national model 2018
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

• State/Regional/National Presentations, Publications, Awards Part 2

  • **RIDOH Health Equity Summit**: Debra Hurwitz participated in a panel discussion and Linda Cabral presented a poster “Addressing Health and Social Needs with Community Teams” at the annual DOH Health Equity Summit in September.

  • **Milbank Multi-State Collaborative Steering and Convener Meeting**: Kansas City, MO Debra Hurwitz participated with Nick Minter and Rayva Virginkar of CMMI: Track 3 for CPC+ in September.

  • **Abstract Submissions**:
    • PCMH Congress “PCMH-Kids: A Patient-Centered Medical Home Program that Works for Children and Families”
    • City Match: “PCMH-Kids: A Patient-Centered Medical Home Community that Works for Children and Families”
Goal 4: Continue to enhance internal capacity for learning, quality improvement, and information dissemination. (Continued)

• State/Regional/National Presentations, Publications, Awards Part 3

  • Providence Community Health Center, Andrew Saal, MD, MPH Chief Medical Officer and Nelly Burdette Psy.D Director of Integrated Behavioral Health, discussed the operational and clinical system changes required when scaling the universal screening pilot up to the whole population in their presentation, "Population Health Meets Integrated Behavioral Health within an FQHC."

  • PCMH-Kids leaders Patricia Flanagan, MD, FAAP and Elizabeth Lange, MD, FAAP, honored by American Academy of Pediatrics in November with the 2018 AAP Calvin C.J. Sia Community Pediatrics Medical Home Leadership and Advocacy Award.

  • Suzanne Herzberg PhD, MS, OTR/L, Director of Transformation at Brown Primary Care Initiative, presented at the International Conference on Practice Facilitation Tampa, FL in December.

  • PCMH-Kids: December 2018 Rhode Island Medical Journal
Goal 5: Evolve CTC Board of Directors to a Governance Board that is able to provide appropriate oversight to CTC as a 501c3 nonprofit

- **Executive Committee:** Executive Committee charter revised based on input form Board. By-laws amended by CTC attorney and voted on by Board in August. CTC held its first monthly Executive Committee call in September.

- **Nominating Committee:** New committee format for attendees, officers and committee chairs and had formal charter developed.

- **Finance Committee:**
  - Meets 5 times a year with a formal charter.
  - Approves quarterly financials.
  - Oversees KLR annual audit.
  - Recommended 403b plan for CTC staff.
  - Annual budget development.

- **Clinical Strategy Committee:** New committee format for attendees, officers and committee chairs and had formal charter developed.
Next Steps - CTC Management Team

1. Launch February HVCC Pilot Program.
2. Low-value care review data in March and refine project statement/budget.
3. Kickoff IBH projects in February/March –
   UHC 9 practices / Integra 10 practices.
4. PCMH-Kids expansion - April onboard; go live July 1.
5. Deploy annual provider well-being survey in March.
6. CHT sustainability work with Medicaid - March AE meeting.
7. APCD – continue to enhance utility of APCD data.
9. Participate and inform the state and national policy discussions.
Board Discussion

1. Are these still the right goals?

2. Is the focus correct for the 2020 projects?

3. Review of CTC committee structure.

4. Are there Board development activities?

5. Other?