CTC-RI Strategic Plan
Review of Accomplishments
March 2019 - March 2020

CTC-RI BOARD OF DIRECTORS
MAY 22, 2020
# Strategic Plan Accomplishments 2019 FYTD

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<th>Page</th>
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Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

Overview

• PCMH Kids Sustainability and Expansion
• Continued Support for Adult Cohort 5 Practices
• Integrated Behavioral Health in Primary Care
• Statewide Multi-Payer CHT Network
• New Initiatives—e.g. UnitedHealthcare SEE Prescribing project, RIDOH MomsPRN program, RIDOH Health Equity Challenge and RIDOH CHT Expansion
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

PCMH Kids 2019 Improved Clinical Quality

BMI and Follow up by Cohort

Developmental Screening by Cohort

2020 results not available yet
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

PCMH Kids Cohort 2 2020 Improved Customer Experience

![Communication: 50% +Medicaid vs Non Medicaid](chart1)

- Non Medicaid
- 50%+ Medicaid
- Average
- Non Medicaid Target
- 50%+ Medicaid Target

![Office Staff: 50% +Medicaid vs Non Medicaid](chart2)

- Non Medicaid
- 50%+ Medicaid
- Average
- Non Medicaid Target
- 50%+ Medicaid Target
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

Adult Cohort 5 2020 Improved Customer Experience

Access: 50% Medicaid vs Non Medicaid

Communication: 50% Medicaid vs Non Medicaid

Office Staff: 50% Medicaid vs Non Medicaid
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

Adult Cohort 5 Improved Total Cost of Care

Adult Cohort 5 TCOC (with *Exclusions)
(Ages 18+, Cost per Member-Month) – Risk Adjusted

Data Source: All-Payers Claims Database

*Exclusions - Does not include costs associated with mental health, chemical dependency, maternity, acupuncture, vision services, or dental services

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<table>
<thead>
<tr>
<th>Period</th>
<th>Adult Cohort 5 TCOC</th>
<th>Adult Comparison TCOC</th>
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<tbody>
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<td>$138</td>
</tr>
<tr>
<td>Apr 2016 - Oct 2016</td>
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</tr>
<tr>
<td>Jan - Dec 2017</td>
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</tr>
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<td>Apr 2017 - Oct 2017</td>
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<td>Jan - Dec 2018</td>
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<tr>
<td>Apr 2018 - Mar 2019</td>
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*Exclusions - Does not include costs associated with mental health, chemical dependency, maternity, acupuncture, vision services, or dental services.
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

2019 Newly Onboarded

<table>
<thead>
<tr>
<th>PCMH Kids Cohort 3</th>
<th>PCMH Kids IBH</th>
<th>Adult IBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children First Pediatrics</td>
<td><strong>Cohort 1</strong></td>
<td>• Blackstone Valley Community Health Care</td>
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<tr>
<td>• Hasbro Adolescent Medicine</td>
<td>• Anchor Pediatrics</td>
<td>• Brown Medicine Primary Care – Warwick</td>
</tr>
<tr>
<td>• Drs Concannon &amp; Vitale LLC</td>
<td>• Comprehensive Community Action Program (CCAP)</td>
<td>• Providence Community Health Center – Central</td>
</tr>
<tr>
<td>• North Providence Pediatrics</td>
<td>• Hasbro Pediatric Primary Care</td>
<td>• Providence Community Health Center – Crossroads</td>
</tr>
<tr>
<td>• Ocean State Pediatrics</td>
<td><strong>Cohort 2</strong></td>
<td>• Providence Community Health Center – Randall Square</td>
</tr>
<tr>
<td>• Partners in Pediatrics</td>
<td>• Coastal Medical – Bald Hill</td>
<td>• Tri-County Community Action Agency – North Providence</td>
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<td>• PCHC- Capitol Hill</td>
<td>• Coastal Medical - Waterman</td>
<td>• Women’s Medicine Collaborative Primary Care</td>
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<td>• Hasbro Medicine Pediatric Primary Care</td>
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<td>• Northern RI Pediatrics</td>
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<td>• PCHC- Olneyville</td>
<td>• Tri-County Community Action Agency</td>
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<td>• PCHC- Prairie Ave</td>
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<td>• PCHC- Randall Sq</td>
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<td>• Riverside Pediatrics</td>
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<td>• Santiago Medical Group - North Providence</td>
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<td>• Santiago Medical Group - Pawtucket</td>
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<td>• Tri-County Community Action Agency - Johnston</td>
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<tr>
<td>• Tri-County Community Action Agency - North Providence</td>
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Approximately 695,000 Rhode Islanders receive their care from CTC-RI and PCMH-Kids practices. PCMH Kids now represents more than 50% of Rhode Island children (110,000 patients), and more than 80% of the State’s total pediatric Medicaid population.
**Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation**

## 2020 Graduation

<table>
<thead>
<tr>
<th>PCMH Kids Cohort 2</th>
<th>Adult Cohort 5</th>
<th>IBH Adult Cohort 3</th>
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<tbody>
<tr>
<td><strong>All NCQA-recognized</strong></td>
<td><strong>All NCQA-recognized</strong></td>
<td><strong>NCQA-recognition in-process</strong></td>
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<td>Aquidneck Pediatrics</td>
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<td>Blackstone Valley Community Health Care</td>
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<td>EBCAP - Barrington</td>
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<td>Lincoln Primary Care</td>
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<td>Kingstown Pediatrics</td>
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<td>Northern RI Pediatrics</td>
<td>Ocean State – Westerly</td>
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<td>PCHC – Randall Square</td>
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<td>Prospect Charter Care</td>
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<td>Richard VanNieuwenhuize</td>
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<tr>
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<td>Robert Carrellas</td>
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<td></td>
<td>Wayland Medical Associates</td>
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</table>
IBH in Primary Care: New Pediatric IBH Pilot

• 3-year pilot program with 2 waves of 4 practices
  • Impacting ~40,000 patients
• July 2019 Kickoff
• Key Program Components:
  ▪ Support culture change, workflows, billing
  ▪ Monthly Onsite IBH Practice Facilitation
  ▪ Universal Screening 3 of 5: Depression (adolescent), Anxiety (adolescent), Substance Use (adolescent), Middle Childhood, or Postpartum Depression
  ▪ Embedded IBH Clinician
  ▪ Quarterly Best Practice Sharing: data-driven improvement, content experts
SBIRT in Primary Care: Screening, Brief Intervention, Referral, and Treatment for Adolescents

• Wrapped up another Successful Pediatric Behavioral Health Learning Collaborative
  • 11 Practices enrolled in the learning collaborative
  • Consisting of 75 Providers
  • Total pediatric population of ~34,000
  • Over 60 in attendance at final meeting where Adolescent Substance Use and Confidentiality were the topics of focus
# IBH in Primary Care: Adult Cohort 3

## Improved Screenings Rates

**IBH Cohort 3 Screening Results**

- **Depression**
- **Anxiety**
- **Substance Use**

- Baseline
- Mid-Point
- Final

### Areas most improved:
- Q6: Communication with patients about integrated care
- Q1: Colocation of treatment for primary care and mental/behavioral health care
- Q11: Patient care team for implementing integrated care
- Q3: Treatment plan(s) for primary care and behavioral/mental health care
- Q13: Continuity of care between primary care and behavioral/mental health care

- 7 practices graduated
- Impacting ~68,000 patient population
- Kickoff February 2019
- Completed February 2020

## Improved levels of Integration

(using MeHAF self-assessment tool)

All graduated practices met screening target thresholds
IBH New Online IBH Practice Facilitation Training Program

• 4 students enrolled in first Spring 2020 session (2 out-of-state & 2 RI)
  • 4 distance learning modules for self-study with reading and homework assignments between modules
  • Reference manual with course readings and monthly calls with Dr. Burdette
  • Post-tests for each module, course evaluation survey & course completion certificates
  • NASW approved 6.5 Continuing Education Credits
• Cost of the Online Program is $750 for CTC members; $1000 for out of state
• Optional Advanced Onsite IBH Shadowing available at additional cost of $750.
• Next session offered in Fall 2020
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

In its 5th year of supporting CHTs, CTC-RI has braided funding from Medicaid (HSTP), SAMHSA-funded SBIRT and SOR initiatives, and CTC-RI multi-payer contributions to:

- Expand to 7 geographic, place-based teams in 5 partner sites serving over 3000 patients/year through a referral process with statewide primary care providers.
- Add a Peer Recovery Specialist position to each team to better serve the needs of substance-exposed individuals and families.
- Add a Family Care Liaison at Rhode Island Parent Information Network (RIPIN) to expand capacity to meet family needs of CHT patients.
- Launch a multidisciplinary team pilot to coordinate care for families affected by SUD/OUD.
- Partner with Medical Legal Partnership Boston (MLPB) to provide legal consultation.
- Provide a centralized network to include a best practice series and data management system.
Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

URI SIM-Funded Evaluation

SUMMARY: Clinically & Statistically Significant Client Changes after 4.7 months of CHT Care

- 33% Reductions Health Risk, Depression, Anxiety
- 30-40% Reduced Substance Use
- 45-70% Improvements in all SDOH categories
- 20% Improvements in Number of Unhealthy Days/Quality of Life & Wellbeing categories
- Improvements in Health Knowledge & Information, Support, Health Confidence, Adherence, Current & Future Life Evaluation
- Excellent Patient Satisfaction & Experience with CHT Care (4.5/5 Avg Satisfaction Rating)

Goal 1: Continue to Transform Primary Care Focusing on Innovation and Incubation

Celebrating 2 years of SBIRT 9/2017 - 9/2019

Partnering with BHDDH and 8 implementation sites, CTC-RI is supporting important population health screening for substance use disorders.
Goal 2: Cultivate Strategic Relationships

Participation in Relevant State Agency Workgroups and Committees
Clinical Strategy Committee

- **Representation expanded to include Medicaid, ACO and AE.**
- **Priorities:**
  - **Primary Care/Specialist Collaboration** – lessons from ACP pilot highlight need for multi-payer specialist incentives to engage in statewide effort.
  - **Low-Value Care** – requesting endorsement from Cost Trend Committee for ongoing data needs.
  - **Provider Well-Being** – active participation in RIDOH Transition of Care work group; collaboration with RIMS and OHIC on proposal for statewide multi-stakeholder Prior Authorization QI efforts.
  - **Best Practice Sharing** among Systems of Care – Coastal Medical, PCHC, Integra CHF, BCBSRI, Brown Medicine Patient and Family Advisory Council (PFAC), RIH, Care New England Frail Elderly Program, UnitedHealthcare Optum Whole Person Care Program, Oak Street Health, RIQI, EOHHS, Briljent, and Innovaccer.
  - **COVID-19 Responses at Practices/SOC and Health Plans**

Goal 2: Cultivate Strategic Relationships
### Goal 2: Cultivate Strategic Relationships

**Contracts and Grants Funding**

<table>
<thead>
<tr>
<th>Award Name</th>
<th>Organization Name</th>
<th>Start Date</th>
<th>End Date</th>
<th>Amount</th>
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<tbody>
<tr>
<td>EOHHS/BHDDH</td>
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<td>Healthcare Transition Improvement Initiative</td>
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<td>PCMH-Kids IBH</td>
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<td>4/30/2022</td>
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<td>Pediatric IBH Pilot</td>
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<td>UnitedHealthcare</td>
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<td>IBH and MAT Plan</td>
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<td>5/1/2019</td>
<td>4/30/2020</td>
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<td>Payer Partner Engagement and Alignment for CPC+</td>
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<td>Enhanced care coordination for Family Care Unit</td>
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<td><strong>TOTAL</strong></td>
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<td><strong>$7,098,940</strong></td>
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</table>
Goal 3: Infrastructure Resourcing Plan

- Adapted to COVID 19 work from home requirements
- SBA PPP loan obtained
- Renewed sublease agreement with Healthcentric Advisors revised pricing structure on Management Services Agreement.
- CTC IT is hosted on Healthcentric Advisors server. CTC has upgraded encryption and security software to position CTC to host PHI if necessary.
- Completed internal CHT data collection assessment to include PHI prompted by state contract for CHT’s centralized network management (No PHI currently collected.)
- Completed business assessment to evaluate insurance coverage.
- Revised CTC fiscal policy manual approved by KLR and Finance Committee.
- Enhanced contract/grant management reporting and tracking.
- Worked with health plans to shift budget allocation vs attribution
Goal 4: Learning, Quality Improvement, and Information Dissemination

Learning Events

• Annual Conference
  o "Advancing Integrated Primary Care: Innovations at Work."
  o 363 primary care practice leaders, care team members, and stakeholders.

• Quarterly Breakfast of Champions
  o 50-75 attend quarterly; statewide hands-on clinician learning and sharing

• Integrating Medication-Assisted Treatment and Primary Care Summit
  o Co-hosted with PCHC, 60 Attendees

• Special Topic/Specific Learning Collaborative
  o NCM role in MAT; Primary Care First – Nicholas Minter

• gLearn for Nurse Care Managers and Care Coordinators
  o 42 attendees; 5 faculty; funded by UnitedHealthcare
Goal 4: Learning, Quality Improvement, and Information Dissemination

All-Payer Claims Database

• Successfully applied to APCD for custom report that has been used for Pharmacy Quality Improvement Initiative

CTC Data Management System for Practice Transformation Support

• Add services tailored for RIDOH and CHT reporting to capture patient evaluation information.
• CTC staff trained as Salesforce administrator.
• Custom forms created to support quarterly data reporting and integration with the Salesforce CRM platform.

State/Regional/National Presentations and Publications

• 5 Publications and
• 6 National and 4 Regional presentations
Goal 5: Board Development

Executive Committee
• Meeting monthly; Provides oversight and direction for management

Nominating Committee
• Meeting Ad Hoc to identify candidates for Board of Directors approval and for succession planning for officer positions currently in progress.

Finance Committee
• Meets 5 times a year with a formal charter.
• Approves quarterly financials; Oversees KLR annual audit; Reviews annual budget development.

Clinical Strategy Committee
• Meets monthly, charter updated, membership expanded, priorities identified. Serves as multi-payer collaborative for innovation and best practice sharing.

CHT Oversight Committee
• Meeting monthly with a formal charter.
• Oversees the CHT long-term sustainability planning.
Next Steps - CTC Management Team

• Post COVID 19
  • Accelerate primary care capitation
  • Support Governor’s Task Force – Issue Brief and proposed recommendations

• CHT Sustainability Plan – working with CHT Oversight Committee.

• Health Equity Challenge – Pathways 2 Population Health

• Plans for 2020 PCMH Kids
  • Vaccination quality improvement initiative
  • Healthy Tomorrow Grant: Connecting home visiting with PCMH Kids practices learning collaborative (HRSA-funded)
  • Transition of Care from Pediatrics to Adult: Primary care learning collaborative (RIDOH Title V-funded)

• Pharmacy Quality Improvement SEE evaluation

• Prior Authorization project scope.

• Disseminate annual Clinician Well-being Survey and PCC/Green Center survey results.

• Participate and inform the state and national policy discussions.
Board Discussion

1. Is there work we are not doing that we should add especially in light of COVID-19?
2. How do we better align with the RI Healthy Vision?
3. What can CTC do to facilitate transformation to primary care capitation?
4. Other?