

Shaping Rhode Island's primary care landscape

Who We Are

The Care Transformation Collaborative of Rhode Island is working with all major health care stakeholders to transform primary care in our state. Initially convened by the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, we promote the patient-centered medical home, a model of primary care that provides patients and families with care that is accessible, focused on their needs, supported by a primary care team and is coordinated with the medical neighborhood.

What We Do

We provide technical assistance and training to promote integrated, patient- and family-centered care, data driven quality improvement, and prepare practices to perform successfully under Alternative Payment Models. As a statewide learning collaborative, we facilitate the sharing of best practices in primary care and integration with specialists/health systems and provide a platform for testing and evaluating new models that improve population health. We strive to align our primary care program with State, Federal and public/private initiatives and inform health care system transformation.

Our Vision

Rhode Islanders enjoy excellent health and quality of life. They are engaged in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care.

Our Mission

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

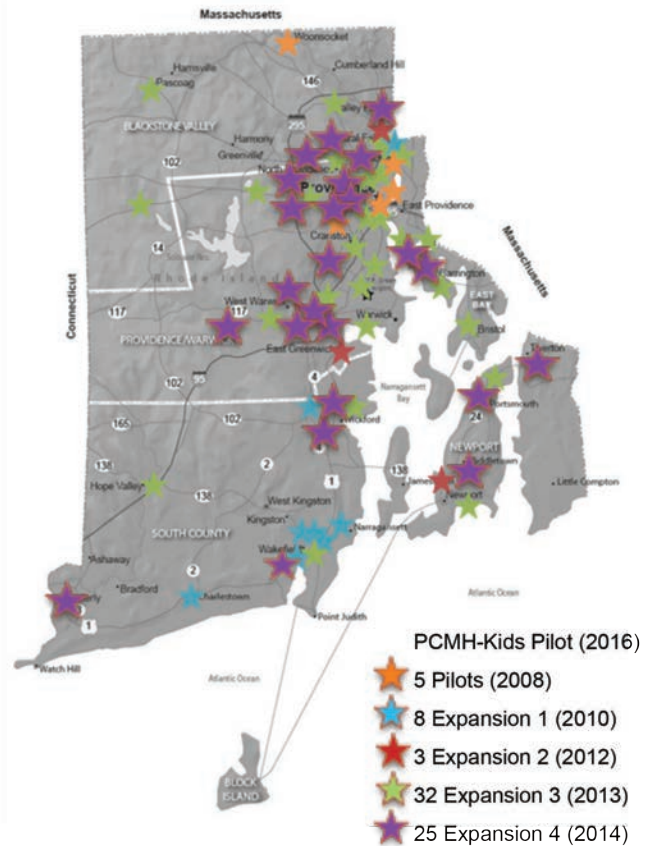
2015 Priorities

- **Improving the cost of care and efficiency** – through new programs like our Advanced Collaborative, practices developed and implemented projects focused on improving quality and reducing costs of care.
- **Evaluating, refining and scaling our Community Health Teams** – we evaluated the progress of these pilot programs and look forward to building off their successes and lessons learned.
- **Expanding to include additional practices** – we have proudly expanded our Collaborative to include pediatric practices, with an increased focus on the needs of children and families.
- **Integrating behavioral health care** – we took big steps forward to improve access to behavioral health services within primary care.
- **Expanding our learning curriculum** – through ongoing best practice sharing, learning sessions and workshops, we continue to advance our Collaborative through shared learning, leadership development, collaboration, and growth.
- **Improving data analytic capability** – we began working toward transitioning to an all-payer claims database to evaluate our practices and programs, increasing actionable reports to practices to support continued progress.

Growing access to patient-centered medical homes across Rhode Island

In 2015, our Collaborative supported the delivery of high-quality patient-centered care across more communities in Rhode Island.

- ✓ 73 adult primary care practice sites
- ✓ 9 pediatric pilot practices
- ✓ 522 providers across our adult and pediatric practices
- ✓ Supporting patient-centered medical homes in 26 cities and town
- ✓ More than 300,000 adult patients
- ✓ 30,000 pediatric patients
- ✓ Includes all R.I. Federally Qualified Health Centers



- Affinity Brookside Family Medicine
- Affinity Primary Medical Group
- Affinity-Family Medicine at Women's Care
- Anchor Medical Associates (Lincoln, Providence, Warwick)
- Anchor Medical Associates Pediatrics
- Arcand Family Medicine
- Associates in Primary Care Medicine
- Barrington Family Medicine
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- Charter Care Medical Associates
- Coastal Medical (East Providence, Narragansett, Pawtucket (Hillside), Providence, and Wakefield)
- Coastal Narragansett Bay Pediatrics
- Coastal Waterman Pediatrics
- Comprehensive Community Action Program (Cranston, Coventry, Warwick)
- Coventry Primary Care Associates
- East Bay Community Action Program (East Providence, Newport)
- East Greenwich Pediatrics
- Family Health and Sports Medicine

- Hasbro Pediatric Primary Care
- Hasbro Medicine-Pediatric Primary Care Clinic
- Internal Medicine Partners
- John Chaffey, DO, Ltd.
- Kristine Cuniff, MD
- Medical Associates of Rhode Island (Barrington and Bristol)
- Memorial Hospital Family Care Center
- Memorial Hospital Internal Medicine Center
- Nardone Medical Associates
- North Kingstown Family Practice
- Ocean State Medical
- Pediatric Associates
- Primary Care of Barrington
- Providence Community Health Centers (Capitol Hill, Central, Chad Brown, Chafee, Crossroads, North Main St., Olneyville, and Prairie Ave.)
- Richard Del Sesto, MS, MD, Ltd.
- Solmaz Behdash, DO
- SouthCoast Health System Linden Tree Health Center
- SouthCoast Health System Tiverton Family Practice
- SouthCoast Health System Family Medical Middletown
- SouthCoast Health System Family Medical Center

- South County Hospital Family Medicine
- South County Hospital Primary Care and Internal Medicine (Wakefield and Westerly)
- South County Internal Medicine
- South County Walk-In and Primary Care
- Stuart Demirs, MD
- Thundermist Health Center (Wakefield, West Warwick, Woonsocket)
- Tri-Town Community Action Program
- University Family Medicine
- University Internal Medicine
- University Medicine (Pawtucket, Governor St., North Main St., East Ave., East Providence, Plain St., Warwick)
- University Medicine-Aquidneck Medical Associates (Newport and Portsmouth)
- WellOne Primary Medical and Dental Care (Foster, North Kingstown, and Pascoag)
- Wickford Family Medicine
- Women's Primary Care, Women's Medicine Collaborative
- Wood River Health Services

Expanding in pediatrics



PCMH-Kids Pilot Practices Selected

In April 2015, nine primary care practices joined the pilot cohort of PCMH-Kids to spread the CTC collaborative model of transformation to practices serving children.

A sub-group of the PCMH-Kids Stakeholder Committee, including physicians, payers, community organizations, state agencies, and consumer representatives, reviewed applications and selected the diverse pilot cohort. The practices represent a mix of Federally Qualified Health Centers, hospital-based clinics, and small and large physician practices throughout the state. Totalling 70 providers serving approximately 30,000 children, the practices support a significant proportion of the Medicaid population (approximately 14,000 children) and children with special health care needs.

Establishing a Pediatric Common Contract

The most significant accomplishment of 2015 was the establishment of a pediatric 'Common Contract.' The pilot cohort came together with the health plans to negotiate payment for and expectations of transformation. PCMH-Kids used the construct and experience of the CTC Developmental Contract as a base, while making adjustments to best reflect pediatric care. For example, the greater needs of children are often less dependent on a medical diagnosis and more about the social and behavioral needs of the family unit. Therefore, PCMH-Kids established expectations of care coordination that may be filled by a variety of roles, like a licensed social worker or peer navigator.

The PCMH-Kids Common Contract will be effective January 1, 2016 – December 31, 2018. Through payment incentives, practices are expected to hire or designate staff to coordinate care; achieve National Committee of Quality Assurance (NCQA) PCMH recognition; engage in learning and training; report on two clinical quality measures from the electronic health record; and improve on measures of clinical quality, patient experience, and utilization.

Supporting Transformation

In fall 2015, the pilot practices began to engage in practice facilitation with Healthcentric Advisors coaches. Among many on-site support services, coaches help practices achieve NCQA PCMH recognition, produce clinical quality reports, and integrate a care coordinator, to name a few.

Practice facilitation services will continue throughout each practice's term in the Common Contract, depending on their transformation needs. In 2016, practices will join existing CTC collaborative learning opportunities, such as best practice sharing meetings and annual learning collaboratives. Practices will also begin to report and target quality improvement efforts on clinical measures regarding childhood obesity and early developmental screening.

Addressing the Community Health Needs of Children

To improve care coordination for the neediest children and their families, PCMH-Kids worked with the state Medicaid Office to improve the relationships between the pediatric offices and the Cedar Family Centers. As the state-designated health homes, Cedars are multi-disciplinary teams that can serve as an extension of the primary care office (also termed a "community health team") to coordinate care for children and youth with special health care needs and their families. Practices and Cedars are developing collaborative and co-located relationships to co-manage shared patients.

Empowering patients at the Women's Medicine Collaborative

At the Women's Medicine Collaborative, a large multi-disciplinary practice in Providence that has entered the first phase of the pilot program, primary care patients obtain universal behavioral health screening and are connected with Ph.D.-level behavioral health clinicians. The program also has an active residency program with The Warren Alpert Medical School of Brown University.

"I have worked with numerous patients in the primary care office who were experiencing depression triggered by work difficulties," said Margaret Bublitz, Ph.D., a psychologist in Women's Behavioral Medicine at the Women's Medicine Collaborative. "Patients were either in very stressful jobs or struggling to find a job. Their depressive symptoms made it very difficult for them to make a change because they had difficulty concentrating, were excessively fatigued, and felt hopelessness. In primary care, patients are receiving behavioral health interventions that enabled them to reduce stress, improve sleep, and decrease their depressive symptoms to an extent that they felt capable of finding new jobs."

"What is really exciting about this initiative is our ability to work as a team to improve patients' overall wellbeing in a primary care setting," said Joanna MacLean, M.D., a psychiatrist in Women's Behavioral Medicine at the Women's Medicine Collaborative. "We're offering patient-centered behavioral health treatment in collaboration with primary care to help patients achieve their individual goals. As a result, we're able to provide both physical and mental health care in a setting that's comfortable for patients and increases engagement and improves outcomes."



Margaret Bublitz, right, a behavioral-medicine psychologist at the Women's Medicine Collaborative, speaks with a care team member. Photo by Michael Salerno.

Expanding integration at Associates in Primary Care Medicine

At Associates in Primary Care Medicine in Warwick, before entering the first phase of the pilot program, the mid-sized private practice recognized a need for some patients to receive on-site behavioral health services. They welcomed a psychologist to their office for a half-day every couple of weeks to do intake referrals, and patients would then follow-up off-site. Now, through CTC's pilot program, a psychologist is at Associates in Primary Care Medicine three half-days each week. As a member of the care team, the psychologist sees about eight patients daily, makes notes directly into patient electronic medical records, and even offers same-day visits.

"The integrated behavioral health program has greatly improved the care we are providing to our patients. Our patients are more comfortable with a mental health referral after meeting the specialist and being introduced by their primary care provider," said Martin Kerzer, D.O. at Associates in Primary Care Medicine. "Being able to stay in their medical home has greatly improved access, and we are now able to address barriers in our patients' physical health through the integrated behavioral program."

Teaching self-management to reduce ED usage

A middle-aged, commercially insured patient (“Tim”) living alone, has been unemployed in recent years due to a back injury. Tim has a wide-range of health challenges related to uncontrolled diabetes, alcohol addiction, and pancreatitis. In just two years, Tim visited the emergency department 25 times and had 17 inpatient hospitalizations related to problems regulating his diabetes and alcohol abuse, complicated by chronic pain. He was not adhering to self-care steps, and had poor follow-through with needed at-home skilled nursing support. This led to a severe injury and partial foot amputation.

A community health team (CHT) engaged Tim and coordinated with his primary care team, a pharmacy team, and diabetes clinic. Support for Tim was shifted to

prioritize self-care, diet, nutrition, disability application support, overall treatment adherence, and support for addiction. The CHT began organizing frequent meetings with nearby family members to help support Tim at home. This led to him becoming more cooperative with home care, leading to more consistency with in-home skilled nursing, wound care, and physical therapy, which helped with gastrointestinal issues and wound healing.

Less than a year later, Tim was abstinent from alcohol, and had monthly CHT visits to help learn better self-management strategies. He became more compliant with an insulin regime, leading to fewer episodes of hypo/hyperglycemia. The following year, Tim had just three ED visits and no inpatient hospital admissions.

Helping an elderly woman regain her independence

An elderly woman (“Nancy”) with a complex medical history was referred to a Community Health Team (CHT) for support.

Once an independent business woman who served in the military, as she aged, Nancy moved into subsidized elderly housing. She suffered from coronary artery disease, high blood pressure, neuropathy, alcohol abuse, and chronic back pain. Caring for herself and managing her pain proved challenging.

As she struggled with her health conditions, Nancy also had difficulty completing applications, which jeopardized her Medicaid eligibility. She was also at risk of losing her vehicle registration because she could no longer afford automobile insurance.

A CHT stepped in, and helped Nancy apply for transportation assistance and services through the Veterans Administration and Meals on Wheels. Nancy now receives home-based medical support, personal care, and housekeeping help.

After screening positive for depression, Nancy was offered health coaching through Pro-Change, a program that allows phone-based counselors to easily provide behavior change guidance.

Nancy is now on track to better manage her health. From a new pill box to assist with medication compliance to a swimming routine (with transportation provided by her CNA), Nancy has already begun losing weight and enjoying a more active lifestyle.

**Names in stories have been changed to protect the identity of individuals.*

After 18 months, the Community Health Teams have estimated nearly \$379,000 in cost avoidance.

Moving forward, to build on and expand CHTs in Rhode Island, we will focus on:

- Introducing centralized program management to provide consistent oversight and create capacity for expansion

- Standardize policies and procedures for CHTs to better support consistency and evaluation
- Launch a centralized data infrastructure to enhance and maintain CHT service documentation and data analysis

Community Health Teams Cost Avoidance (Over 18 Months)

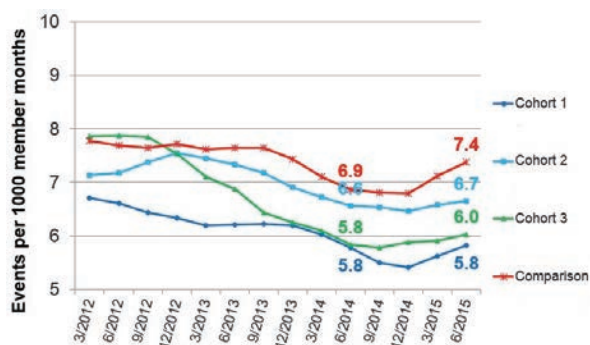
Community Health Teams	Crisis Interventions	ED Diversions	Average Cost Per Inpatient Admission	Average Cost Per ED Visit	Inpatient Cost Avoidance	ED Cost Avoidance	Total Cost Avoidance
Total Cost Avoidance	30	27	\$12,000	\$700	\$360,000	\$18,900	\$378,900

2015 Highlights by the numbers

The Rhode Island Quality Institute works with our Collaborative to implement a dedicated measurement and reporting infrastructure for our practices, which supports practice efforts to meet performance benchmarks and collaborate around best practices. Below are some 2015 CTC data highlights.

Reduced Inpatient Hospital Admissions

Since 2012, we have tracked the number of inpatient hospitalizations attributed to our practices, organized in three cohorts. Compared to non-CTC practices, all three cohorts March 2012-June 2015 have greater reduction rates of patient hospital admissions (from all causes) than the comparison group.



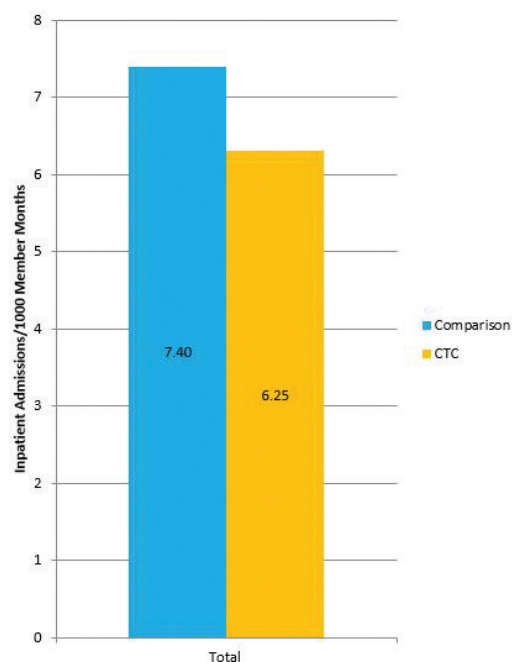
*Includes Blue Cross and Blue Shield of Rhode Island, UnitedHealthcare, and Neighborhood Health Plan of Rhode Island data. Does not include Medicaid or Medicare FFS data or RHO Dual Eligible NHP members.

“Transitions of Care” program reducing hospital re-admissions

At Coastal Medical, which has four practices in CTC, they realized how much time nurse care managers were spending managing transitions of care for patients who frequented the hospital. Coastal developed a new Transitions of Care (TOC) program that utilizes a multi-disciplinary team of nurse care managers, clinical pharmacists, nurses, and medical assistants to coordinate the care of patients discharged from hospitals and skilled nursing facilities. The TOC team enhances communication between clinicians, which in turn reduces care fragmentation and improves a patient’s care experience. Leading goals of the program are effective and timely follow-up with patients after hospitalizations, coordination of follow-up office visits, and medication reconciliation. Through these efforts, Coastal hopes to demonstrate a 10% decrease in hospital readmissions. The TOC program also allows the office-based nurse care managers to focus more exclusively on management of their care of high risk patients.

Inpatient Hospital Cost Savings

CTC practices also demonstrated inpatient savings for Fiscal Year 2015. Practices have shown less inpatient hospitalizations than the comparison group, translating to significant cost savings shown below.



Difference in Admissions/1000 MM	1.15
Total CTC Member Months	1,538,538
Difference in number of Admissions (1.15 x 1,538,538 MM/1000)	1769
Average Cost per Admission*	\$12,000
CTC Savings	\$21,231,824
Total Program costs (2015-2016)**	\$15,754,793
Net Savings	\$5,477,031

*Cost per Admission = 60th percentile; vs mean=\$14k; Median=\$10k
**Total Program Cost include CTC Admin, CHTs and Practice Payments paid by health plans

Developing best practices through shared learning and collaboration

Annual Learning Collaborative brings together local and national experts

In November 2015, we hosted our annual Learning Collaborative, which brought together national and local health care experts focused on patient engagement and empowerment, identification of patients with complex care needs, and shared decision making. As an integral component of our primary care practices, a patient-focused approach to care can increase the likelihood patients will stick to treatment recommendations, and improve health outcomes.

Among the many insightful presentations and workshops, speakers focused on best-practice sharing, and included experts from Mayo Clinic, Cambridge Health Alliance on building a complex care management program, and Boston Children's Hospital on engaging children and families in care plan development.

As our practices provide care for Rhode Islanders throughout the state, and are increasing our focus on children and families, learning from regional experts provided care teams with valuable insight and tools to that could be integrated into their individual practices.



CTC practice care team members shown above at the November 12, 2015 Learning Collaborative

Leading the state in collaborative learning to advance primary care

Collaboration and best practice sharing play an integral role in our Collaborative, providing opportunities to help advance our work and discover new approaches to complex care system challenges.

In 2015, the "Advanced Collaborative" was formed with representatives from the initial 15 CTC practices. These practices meet monthly at the Clinical Strategy Committee to focus on sharing of best practices and improve their performance in contracts with responsibility for total cost of care and population health. These Advanced practices, in partnership with the health plans, will help chart the course for greater payment reform and clinical care improvements.

The Clinical Strategy Committee also guides the agenda for the "Breakfast of Champions" where clinical and office management leadership from our practices meet quarterly to learn about ways to apply the latest knowledge in advanced primary care, and stay informed on the state and federal regulatory environment.

In addition to this learning opportunity, in 2015, we committed to supporting nurse care managers (NCMs) by expanding opportunities for collaboration. During Nurse Recognition Week in May, in partnership with Blue Cross and Blue Shield of Rhode Island, CTC hosted a conference to support new and experienced NCMs in their evolving roles. NCMs also meet monthly to discuss new strategies and ways to tackle complex challenge experienced in many practices.

2015 Board of Directors

Our board of directors is responsible for setting the strategic direction and providing overall governance of our Collaborative.



Members of the CTC Board of Directors meet in 2015

Conveners/Co-Chairs

Tom Bledsoe, MD, University Medicine (president)
Anya Rader Wallack, Ph.D., Executive Office of Health and Human Services (co-chair)
Kathleen C. Hittner, MD, Office of the Health Insurance Commissioner (co-chair)

Health Plan Representatives

David Brumley, MD, Tufts Health Plan
Neal Galinko, MD, UnitedHealthcare
Gus Manocchia, MD, Blue Cross and Blue Shield of R.I.
Tracey Cohen, MD, Neighborhood Health Plan of R.I.

Hospital Representatives

Lou Giancola, South County Hospital

Provider Representatives

David Bourassa, MD
Maureen Claflin, MSN, RN (secretary)
Patricia Flanagan, MD
Elizabeth Lange, MD
Al Puerini, MD
Ken Sperber, MD
Puneet Sud, MD

Employer Representatives

Al Charbonneau, Rhode Island Business Group on Health (treasurer)
Howard Dulude, Lifespan

At Large Representatives

Jeffrey Borkan, MD, PhD, Alpert Medical School, Brown University
Al Kurose, MD, Coastal Medical

2015 Staff

Responsible for the day to day management of our Collaborative.

Debra Hurwitz, MBA, BSN, RN Co-Director
Pano Yeracaris, MD, MPH Co-Director
Susanne Campbell, RN, MS, Senior Project Director
Hannah Hakim, Senior Project Manager, PCMH-Kids

Michael Mobilio, BS, Project Coordinator
Michele Brown, MPA, Project Coordinator
Candice Brown, BS, Project Coordinator

Looking Ahead

2015 was an incredible year of innovation and impact for our Collaborative. As we look ahead to 2016, our work will be driven by five goals:

1. Assist Rhode Island's health plans in increasing the number of primary care practices that meet state PCMH Standards.

The PCMH Standards by the Office of the Health Insurance Commissioner require insurers to increase their primary care network functioning as patient-centered medical homes by 5% for 2016, and a target of 80% of primary care clinicians in the state utilizing this model by 2019. To help meet this goal, our Collaborative will aim to support 38 practices to complete our CTC Common Contract and meet the state's PCMH standards by December 2016. We will also work to recruit 30 new adult and pediatric primary care practices in 2016 for the following year.

2. Participate in workforce development to increase the number of individuals qualified to become PCMH care team members.

To meet this goal, we will develop a robust curriculum for our physician champions, enhance a new curriculum for nurse care managers and care coordinators to support patients with complex care needs, and collaborate with outside organizations, like colleges and agencies, to develop new training and certification programs for members of patient-centered medical home care teams (i.e. physicians, nurse practitioners, medical assistants, nurse care managers, physician assistants, and community health workers).

3. Maintain an effective multi-payer program that benefits all key stakeholders.

We will seek approval from the Centers for Medicare and Medicaid Services for ongoing Medicare participation in multi-payer PCMH, to include all practices under our CTC Common Contract or who meet the state's definition of PCMH and accept Medicare FFS. Further, we will expand our Advanced Collaborative to include practices that meet the state's definition of PCMH.

4. Expand services in primary care to enhance the delivery of high-quality care that addresses physical, behavioral, and social determinants of health.

We will pilot an integrated behavioral health business model that includes universal screening for depression, anxiety, and substance use disorders, and improves access to behavioral health. This effort will work to reduce ED visits and help discover ways to sustainably fund on-site integrated behavioral health services. We will also strengthen and expand our existing Community Health Teams program.

5. Increase patient experience ratings in our practices.

Through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, our patients evaluate their health care experiences, covering topics like provider communication skills or ease of access to services. We will aim to meet or exceed 75% of the regional benchmark.

Committees and Workgroups

Our committees and workgroups are an integral part of our Collaborative. They provide opportunities to collaborative, innovate, share best practices and discover new ways to improve primary care in Rhode Island.

Community Health Team Planning Committee

Plan the implementation and evaluation of Community Health Teams in Pawtucket and South County.

Contracting Committee

Responsible for contract development, attribution, and looking at alternate payment models and PCMH as part of a delivery system.

Data and Evaluation Committee

Lead performance improvement; measure selection and harmonization; develop goals and benchmarks, evaluation, and research.

Integrated Behavioral Health Workgroup

Lead the transformation of primary care in the context of an integrated health care system.

Nurse Care Manager and Care Coordinator Best Practice Sharing Workgroup

Support best practice sharing, workforce development and role of care manager in improving population health and care coordination.

Practice Reporting Committee

Review, validate and report practice data quarterly; support quarterly performance improvement and data sharing meetings.

Practice Transformation Committee

Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice-based coaching and technical assistance; and support workforce development for PCMH.

Steering Committee

Provide guidance and insight for strategic direction and long-term strategies; monitor and review performance of the Collaborative; and provide a learning forum for all members.

Thank you to our partners who helped make 2015 a year of incredible progress.

- Blue Cross and Blue Shield of Rhode Island
- Brown University
- Care New England
- Executive Office of Health and Human Services
- Healthcentric Advisors
- Lifespan Corporation
- Medicaid and Medicare
- Neighborhood Health Plan of Rhode Island
- The New England States Consortium Systems Organization
- Office of the Health Insurance Commissioner
- Rhode Island Business Group on Health
- Rhode Island Department of Health
- Rhode Island Foundation
- Rhode Island Quality Institute
- RIGHA Foundation Fund
- State Employees Health Benefits Program
- Tufts Health Plan
- UnitedHealthcare