Expanding the Reach of Practice Facilitation

Lessons learned from inter-organizational collaboration

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Brown Primary Care Transformation Initiative (BPCTI)

- Began in 2010 as part of a 5-year federally-funded grant to facilitate primary care transformation
- Originally worked with 5 practices
- Contracted with CTC-RI in 2014 to provide facilitation services to primary care
- In 2017, through a contract with CTC, began providing facilitation services to DOH practices
- Currently work with about 40 practices/year

Care Transformation Collaborative of RI

- Convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS)
- Multi-payer initiative: BCBS, NHP, Tufts and United
- 3-year common contract - All practices have the same deliverables and payment structure (PMPM/incentives)
- Includes adults, pediatrics and IBH
- 650,000 Rhode Islanders receive their care from CTC-RI practices

Support from CTC-RI

CTC provides support with group meetings and on-site facilitation around:

- Understanding and managing data
- Clinical quality
- Work flows and efficiency
- Access to care
- Coordination of care
- Provider and patient experience
- NCQA recognition

Rhode Island Chronic Care Collaborative

- RIDOH has made investments in primary care QI since 1998 through the Rhode Island Chronic Care Collaborative (RICCC)

- Managed and primarily funded by RIDOH's Diabetes, Heart Disease and Stroke Program, but often integrated to include other programs

- In 2013, due to changes in CDC funding, a new RFP was released to recruit health centers and other primary care practices that would work on
    - QI
    - Team-based care
    - Clinical-community linkages (referrals to evidence-based lifestyle change programs)

Rhode Island Chronic Care Collaborative, cont.

- April 2014, 14 practices were awarded funding through RICCC
  - 12 FQHCs, 1 hospital-based health clinic, and 1 free clinic
  - Captured 6 measures
    1. Diabetes in Poor Control
    2. HTN in Control
    3. Self-management Goals for HTN patients
    4. Tobacco Screening and Cessation
    5. Adult BMI Screening and Intervention
    6. Referrals to Chronic Disease Self-management of Lifestyle Change Programs

- May 2015, RICCC-Enhanced was established to capture a new subset of measures
  - Prediabetes, undiagnosed HTN, and SMBP

Care + Community + Equity

- May 2017, 8 practices were awarded funding through CCE
  - Captured the some of the same measures as RICCC
    1. Diabetes in Poor Control
    2. HTN in Control
    3. Prediabetes,
    4. Undiagnosed HTN
    5. SMBP
    6. Referrals to Chronic Disease Self-management of Lifestyle Change Programs

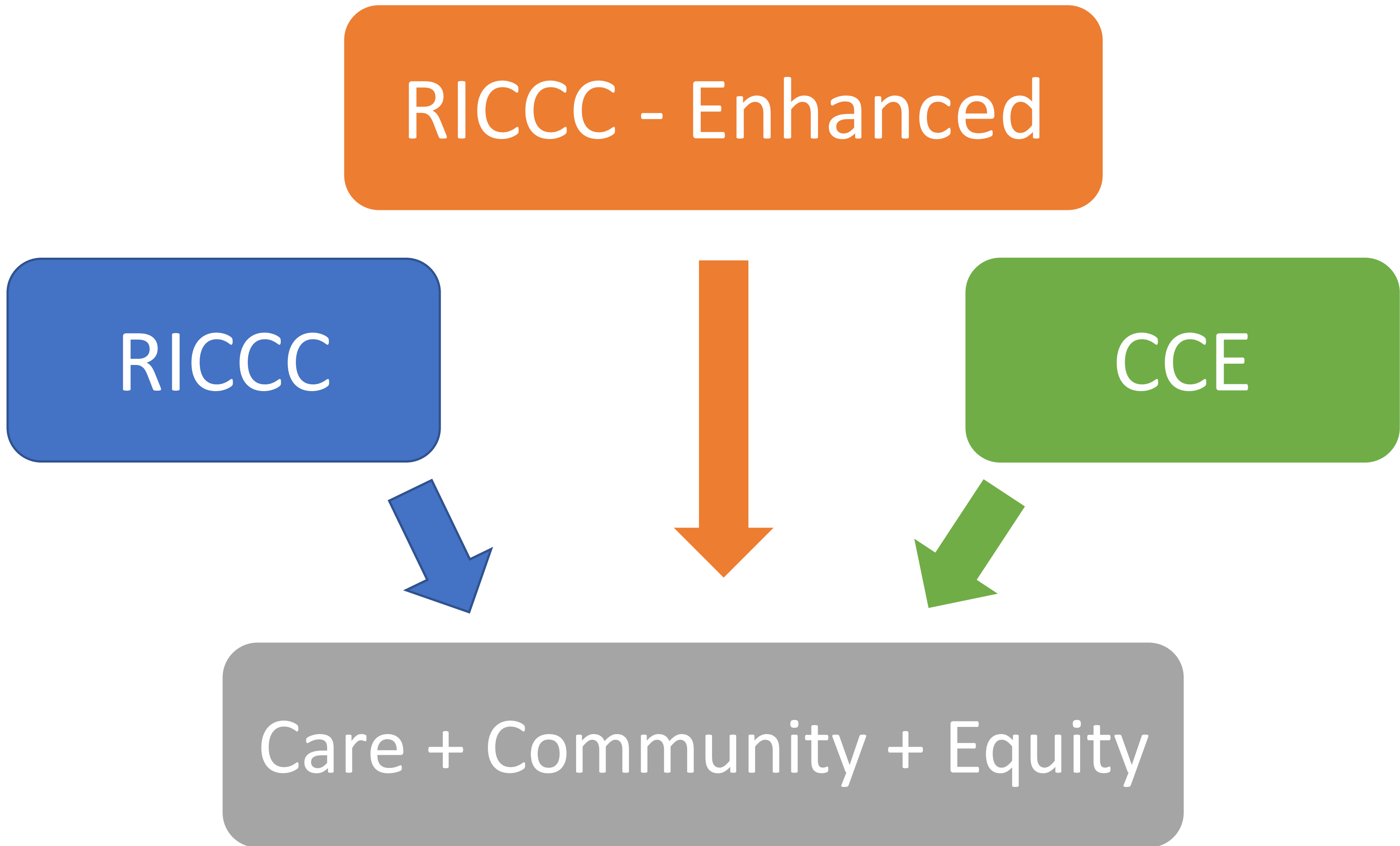
- Focus on connection to RI's Health Equity Zone (HEZ) communities to eliminate health disparities

- For more information, visit www.health.ri. gov

Seeking Assistance

- Originally contacted BPCTI in Fall 2017 to discuss facilitation role
- Familiar with their role through CTC involvement and mutual partnerships with community health centers
- Became clear that facilitation work would be enhanced through a partnership with both BPCTI and CTC-RI

Program Redesign



Impetus for Change

RHODE ISLAND DEPARTMENT OF HEALTH

Partnering with the Care Transformation Collaborative of Rhode Island for Data Management Services

- Evolution: The original Basecamp Communication Software and numerous Excel spreadsheets had exhausted their usefulness for managing their programs

- CTC-RI successfully implemented our own existing:
  - Centralized Data Management Platform: Salesforce
  - Direct Data Capture Functionality: Form Assembly
  - Secured Portal for Data Submission: Glad Works
  - Custom Visualization: Interactive Business Intelligence Tool, called “Shiny”

CTC-RI's Secured Portal Platform

ADVANCING INTEGRATED HEALTHCARE

DATA INPUT | DATA DISPLAY | DATASTAT PORTAL (CAHPS)

Welcome

View | Edit | Delete | Configure block

Welcome to the RI CTC and PCMH-Kids Portal!

The CTC Provider Portal contains a variety of information derived from the CTC Measures Database. We hope to provide a convenient and efficient means to distribuite and discuss CTC Community aggregate data, comparative data across all CTC sites, and site-level data from individual practices. The site employs role-based, restricted access to relevant Community data and pracitce-specific data only to those individuals that have been authorized by CTC practices.

If a practice or community member requires access to the CTC Provider Portal, please contact us with the name, affiliation, and email address of the person who needs access.

Data Input | Data Display | Practice Reporting Resource Documents

Data Submission (all CTC programs)

Data Collection - Kids

Data Collection - Adults

Leveraging the Format for RIDOH

DATA INPUT | DATA DISPLAY | Resources | RIPIN Calendar

Welcome

Welcome to the RIDOH Portal!

The RIDOH Provider Portal contains a variety of information derived from the RIDOH Measures Database. We hope to provide a convenient and efficient means to distribute and discuss RIDOH Care + Community + Equity (CCE) aggregate data, comparative data across all RIDOH sites, and site-level data from individual practices. The site employs role-based, restricted access to relevant CCE data and practice-specific data only to those individuals that have been authorized by RIDOH practices.

If a practice or community member requires access to the RIDOH Provider Portal, please contact us with the name, affiliation, and email address of the person who needs access.

Data Input | Data Display | Resource Documents

Measures developed for each Care+Community+Equity (CCE) Scope of Work correspond to the strategies and outcomes described in non-competitive and competitive grants from the Centers for Disease Control and Prevention (CDC-RFA-DP18-1815 and CDC-RFA-DP18-1817). RIDOH's Diabetes, Heart Disease and Stroke Prevention Program is mindful that other initiatives demand demonstration of a practice's ability to maximize the use of their Electronic Health Record (EHR) to collect, validate, and use clinical and operational data. Examples of these initiatives include Meaningful Use, Uniform Data System (UDS), CMS, MIPS, CPC+ and specific RI reporting requirements. In an effort to lessen the reporting burden of participating CCE practices, the number of required measures were reduced and many CCE measures align with UDS measures. A few measures were designed to meet the objectives of the above-mentioned grants. Please feel free to contact us with any questions or concerns.

- Data Collection for Cardiovascular Disease Management and Prevention
- Data Collection for Diabetes Control and Prevention (Prediabetes)
- Data Collection for Self Measurement of Blood Pressure

Our Collaboration Goals

- Wrap all three of the organizations around the site
- Bridge paths and align the three organizations
- Communication, documents and materials to appear seamless
- To be clear and concise
- Decrease administrative burden

This is what Practice Facilitators do!!

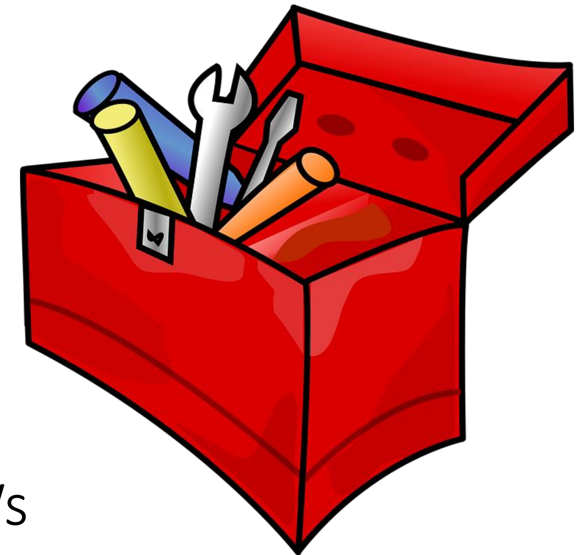
- Reviewed the previous RIDOH grant documents
- Familiar with the FQHC sites in RI and other RI initiatives
- Our skills were valued; invited to create/integrate documents
- Invited and attended the RIDOH “kickoff” meeting
- Contract stream increasing opportunities for work

Challenges with Previous RIDOH Program

- Length and frequency of PF on-site meetings and cohort meetings
- Not enough materials other than contract
- Data specifications did not adhere to UDS/HEDIS measures and was hard to read
- Data entry software was difficult to use

What we changed…

- Created a binder with the same look and feel as other familiar initiatives
  - Measure Specifications
  - Milestone document
  - NCQA policies examples
  - Addendum sheets that clarified SOWs
    - Also serves as a check list
  - Used a familiar data management portal (CTC Portal)
  - Provided patient and site-specific resources



Feedback

"Thank you for making this so clear"

"Easy to understand when items are due, check list form"

"Milestone document and addendum are written for a busy practice to develop good work flows from"

"This looks like NCQA and CTC, initiatives we are already familiar with"

"You provide us with great templates"

What questions do you have for us?

The program is supported by the Innovative state and local public health strategies to revent and manage diabetes, heart disease, and stroke 5-year cooperative agreement.