CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Improving Child Health in RI

PCMH-Kids
October 6, 2022

Care Transformation Collaborative of RI

Agenda

Topic *Presenter(s)*	Duration
Welcome *Pat Flanagan, MD, FAAP, PCMH Kids Co-chair* *Susanne Campbell, Senior Program Administer, CTC-RI*	7:30-7:35 AM
Year 2 Medicaid Pediatric Healthcare Recovery Program *Pat Flanagan, MD, FAAP, PCMH Kids Co-chair* *Beth Lange, MD, FAAP, PCMH Kids Co-chair*	7:35-7:45 AM
PCMH Kids Strategic Plan *Pat Flanagan, MD, FAAP, PCMH Kids Co-chair* *Beth Lange, MD, FAAP, PCMH Kids Co-chair* *Susanne Campbell, Senior Program Administer, CTC-RI* *Liz Cantor, Pediatric IBH Practice Facilitator* *Kim Nguyen-Leite, Program Coordinator II*	7:45-8:30 AM

PCMH-Kids

Mission

To engage providers, payers, patients, parents, purchasers and policy makers to develop high quality, family and patient-centered, medical homes for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-drive system improvement. PCMH's for children will be cost effective and sustainably resourced.

Vision

All children and youth in RI will be cared for in high quality, family and patient centered, medical homes. Rhode Island's children and youth will grow up healthy and reach their optimal potential.

Medicaid Pediatric Healthcare Recovery Program

Medicaid Pediatric Healthcare Recovery Program

Funding opportunity contingent upon submitting application and:

Payment Target Date	Target/Action Item	Payment Basis
10/31/2022	Following receipt of Application and Performance Improvement Plan	Pay for Participation
2/6/2023	Based on January 15, 2023 KIDSNET Report on practices' performance for meeting 3 out of 4 Immunization and Lead targets or improvement targets.	Pay for Performance or Improvement
5/8/2023	Based on April 15, 2023 KIDSNET Report on practices' performance for meeting 3 out of 4 Immunization and Lead targets or improvement targets.	Pay for Performance or Improvement
8/7/2023	Based on July 15, 2023 KIDSNET Report on practices' performance for meeting 3 out of 4 Immunization and Lead targets or improvement targets.	Pay for Performance or Improvement
11/6/2023	Based on October 15, 2023 KIDSNET Report on practices' performance for meeting 3 out of 4 Immunization and Lead targets or improvement targets.	Pay for Performance or Improvement
7/14/2023	Attendance at 4 out of 6 (or more) Psychosocial & Behavioral Health ECHO® session.	Pay for BH ECHO® participation

Practice Assistance

- Monthly **KIDSNET Immunization/Lead Screening information** with determination of practice eligibility for payment based on achievement of targets or improvement method and calculation of estimated patients to goal / improvement targets.
- Practice specific **Practice Facilitation** monthly virtual meetings to review immunization and lead screening data and discuss quality improvement action plans.
- **Best Practice Sharing** Learning Sessions:

Topic	Content	Date
Lead Screening	Review of new guidelines; KIDSNET Lead Reports; Best practice sharing	November 15, 2022
Understanding what matters to families	Listening to families on what matters to them regarding vaccines.	TBD
Immunization	Review of new KIDSNET school readiness reports	TBD

- **ECHO® Learning Sessions and/or Behavioral Health Technical Assistance**: learning opportunities to assist with psychosocial and behavioral health assessment/intervention. Completion of an evaluation after each session is required for participation credit and eligibility to receive CEU's.

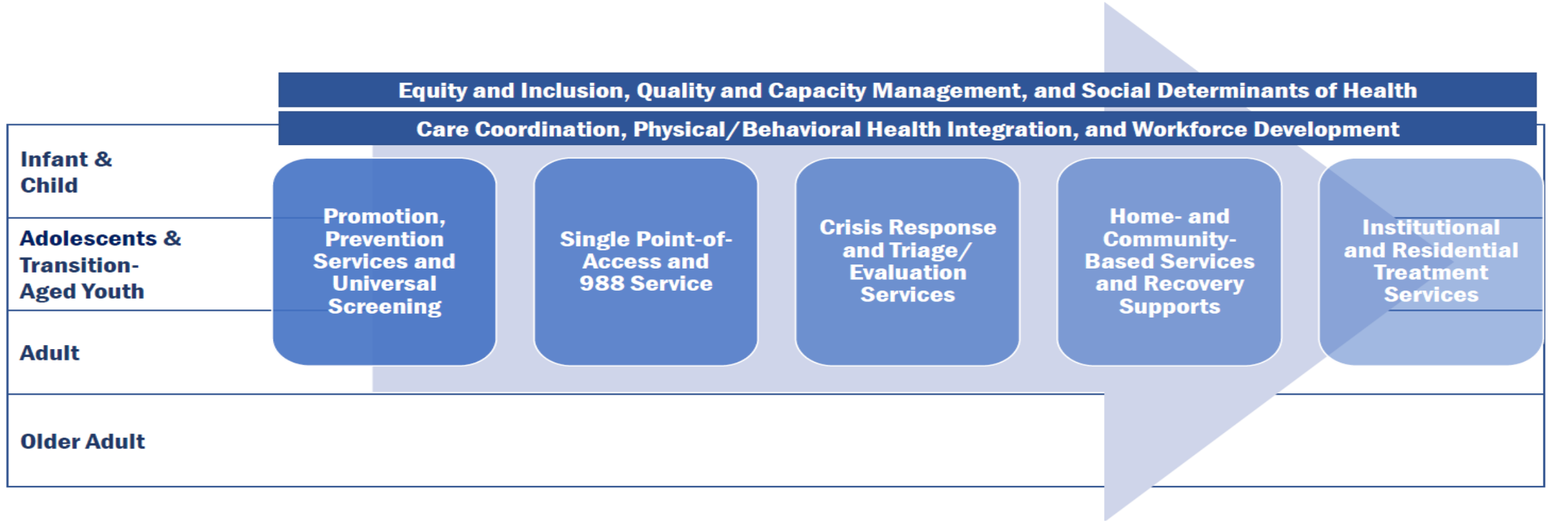
Practices must attend at least 4 out of 6 ECHO® Learning Sessions for psychosocial and behavioral health assessment/intervention

Date/Time	Topic
Thursday: January 26, 2023, 7:30-8:30AM	Difficult conversations
Wednesday: February 22, 2023, 7:30-8:30AM	Navigating schools to improve connections
Thursday: March 23, 2023, 7:30-8:30AM	School Avoidance
Wednesday: April 26, 2023, 7:30-8:30AM	CBT / Anxiety
Wednesday: May 24, 2023, 7:30-8:30AM	Medication Management in pediatrics
Thursday: June 22, 2023, 7:30-8:30AM	Suicide risk/prevention/tools
Join Zoom Meeting: https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09 Meeting ID: 959 6302 4930; Passcode: 646876; One tap mobile: +16468769923,,95963024930#,,,,*646876#	

Health of Children in RI

Health of Children in RI - BH

Rhode Island Vision of a Behavioral Health Continuum of Care



Because the behavioral health challenges for our Rhode Island youth are so dire, EOHHS and our partners at DCYF, BHDDH, RIDOH, and RIDE are prioritizing the following components of the plan for FY23:

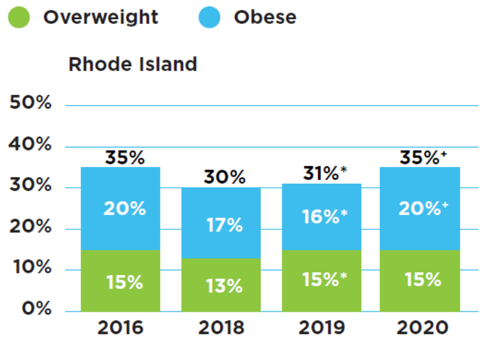
1) Single Point of Access – aligned with 988
2) Mobile Response & Stabilization Services
3) Expanding the Service Array
4) Care Management
5) Prevention

Health of Children in RI – COVID

Childhood Overweight and Obesity

The COVID-19 pandemic has impacted childhood overweight and obesity, with one study reporting that the prevalence of overweight and obesity for children ages 5 to 11 in the U.S. increased from 36% to 46% during the pandemic.[1]

The COVID-19 pandemic limited children's access to nutritious food and physical activity. Early data shows that the rate of BMI increase for children ages two to 19 nearly doubled during the pandemic.[1]



*Statistically significant trend (2016-2019), p<.05
+Statistically significant trend (2019-2020), p<.05

Immunizations

In 2020, 14% fewer doses of vaccine were administered and 24% fewer children were lead screened compared to comparable pre-COVID-19 time periods.[2]

Health of Children in RI – Pediatric Infrastructure Support/Workforce

Pre-K

The FY 2023 budget calls for a plan to reach 5,000 pre-kindergarten seats over the next five years

Early Learning & Development

Early Educator Investment: Legislation passed requiring a state plan to prepare, recruit, and retain a highly qualified early childhood workforce, including adequate wages for early childhood educators regardless of setting.

Early Intervention (EI): The FY 2023 budget provides a permanent 45% Medicaid rate increase for Early Intervention

First Connections Family Home Visiting: The FY 2023 budget provides a temporary Medicaid rate increase for the First Connections Home Visiting Program to help the program raise wages to recruit and retain staff.

Loan Reimbursement

Wavemaker Fellowship*:* The FY 2023 budget includes $3.2 million to support the Wavemaker Fellowship, a competitive student loan reimbursement program for college and university graduates working in science, technology, engineering, and medicine and expanded the fellowship to include health care professionals.

Improving Child Health in RI Strategic Plan

CTC-RI Logic Model

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Practices | **Population/Community Health** | **Health Systems** | **Cross Cutting**

INPUTS

ORGANIZATIONAL CAPACITY
- Diversified Board and staff/consultant team
- Access to consistent and stable funding
- Access to evidence based practices (learning) and networks (distribution)

SHARED DESIGN PRINCIPLES
- Multi payer
- Collaborative learning across practices and systems of care
- Health equity lens and principles
- Inclusion of people with lived experience in project design and implementation
- Spread within system of care
- Best practices and EVP
- All practices invited
- Alignment with Accepted Standards and Measures
- Quadruple Aim = North Star

COLLABORATIVE APPROACH
- Trust-based partnerships with ACOs, AEs, state agencies, payers, academic training programs. practices, hospitals, and other providers (e.g., behavioral health, etc.)
- Strong relationships with array of funders

APPROACHES

Convening Key Stakeholders

Conferences, best practice sharing, professional work force development, primary care dashboard

Learning Collaboratives

Learning in action cohorts focused on comprehensive primary care design components required for successful operation under capitation. (e.g., system communication, coordination and alignment.
Focus areas:
- Comprehensive Primary Care Delivery Components,
- Team based care,
- Clinical quality improvement
- IBH,
- Addressing HRSN
- Maternal/child health

Innovative Pilot Programs
Focused on comprehensive primary care delivery design (includes program evaluation to inform health policy) e.g. R2E, PCP-Specialist, Pedi Transition of Care

Workforce development
e.g. NCM, CHW, IBH clinicians, PharmD

OUTPUTS (1 YEAR)

 # Convening's– by topic
- i. # participants
- ii. Evaluation results
- iii. D+E recommendation for primary care dashboard

Learning Collaboratives by category
A. Comprehensive Primary Care (e.g. IBH, HRSN/community clinical linkages, PCP-Spec coordination)
- i. # of practices participating in each initiative
- ii.Lessons learned
- iii.Evaluation results
- iv.Recommendation

B. Maternal Child Health initiatives (e.g. Healthy Tomorrow, Dulce, Early Childhood Systems, Transfer of care)
- i.# of practices participating
- ii.Lessons learned
- iii.Evaluation results
- iv. Recommendation

 # Pilots– Innovative tests of change initiative (e.g.Rhode To Equity– R2E, Regional CHTs)

# of practices participating
Lessons learned
Evaluation results
Recommendation

Workforce development programs
(e.g. NCM, CHW, CCE other)

# of participants
Evaluation results

SHORT TERM OUTCOMES (2-3 YEARS)

Behavioral health care is integrated into every primary care practice
- % of practices with IBH
- Outcomes of integrated IBH

Practices are redesigned to support new payment models and enhance capacity to assess for and address health related social needs

Practices are supported in addressing workforce well-being and development
- TBD

Increased Coordination with Community Based Organizations
- CHW metrics
- Rhode to Equity metrics
- HEZ and Family Home Visiting metrics
- Other?

Improved clinical outcomes
- preventive, chronic, and complex care metrics

Improved Transitions of Care
- Pediatric to adult transition metrics
- Behavioral health transition metrics

Successful expansion of eConsult and Enhanced Referral Program to additional specialties and PCPs in all Systems of Care

Reduced Health Disparities
- Commonwealth Fund Report Card results
- Health equity challenge results

IMPACT (5 Years)

Health care delivery is fully coordinated across all care systems (physical/medical, behavioral health,and social)

Primary care practices (pediatrics and adults) are thriving in an all-payer value-based payment model that stabilizes health care costs and premiums

All Rhode Islanders have access to primary care, practices that reflect the demographics of their community, and are highly satisfied with their care experiences

Primary care providers and their teams are well supported and resourced (financial, human, technology, data, other) to deliver high-quality care

Rhode Island population health results for kids, adults, and seniors are among the best in the nation, and health disparities are eliminated

Feedback and Input

- How can PCMH Kids support primary care/pediatric practices improve child health in RI?
- How can we build off current programs and activities?
- What are the gaps, challenges, or barriers that we should focus on in the next 12 months?
- What state-wide initiatives or opportunities that we can build on?

CTC-RI 2022-2023
Improving Child Health Strategic Work plan

Goal 1: Improved Clinical Outcomes (preventive, chronic, complex care)

- Medicaid Pediatric Relief Fund
- Asthma ECHO Initiative
- Pediatric Weight Management ECHO
- RI Moms PRN

Goal 2: Improved Transitions of Care and care coordination for children and youth with special health care needs

- Health Transfer of Care
- Care Coordination

Goal 3: Improved Coordination with community based organizations

- Healthy Tomorrows
- DULCE Learning Initiative
- Rhode to Equity

Goal 4: Strengthen team based care; Build primary care work force, wellbeing and development

- Resiliency Learning Series
- Nurse Care Manager Core Curriculum Training Program
- Pediatric Community Health Worker training program
- Wellness Visit
- Medicaid Pediatric Relief Fund Behavioral Health Initiative
- NCQA BH Distinction

Medicaid Pediatric Relief Fund

Objective

Return immunization and lead screening rates to pre-pandemic levels

Immunization and Lead Data

Number of Childhood Vaccines Administered, Rhode Island, 2019-2020

	March			April			May			Total		
	2019	2020	% change	2019	2020	% change	2019	2020	% change	2019	2020	% change
Vaccine Doses Administered	30203	23294	-22.9%	28663	16019	-44.1%	28106	18803	-33.1%	86972	58116	-33.2%

Source: RIDOH, Center for Health Data and Analysis, KIDSNET

last updated 6/18/2020

Number of Lead Screening Tests, Rhode Island, 2019-2020

	March			April			May			Total		
	2019	2020	% change	2019	2020	% change	2019	2020	% change	2019	2020	% change
Number of Children Tested	2263	1209	-46.6%	2415	508	-79.0%	2573	1011	-60.7%	4678	2728	-41.7%
Number of Tests	2272	1223	-46.2%	2424	516	-78.7%	2591	1021	-60.6%	4696	2760	-41.2%

Source: RIDOH, Center for Health Data and Analysis, KIDSNET

last updated 6/19/2020

https://health.ri.gov/publications/periodicals/kidsnetupdate/202005-06.pdf

Medicaid Pediatric Relief Fund

Elevated Lead Data

Elevated Lead and Screening, 2016 - 2020

Year	Total Number of children screened	Incidence, elevated lead**	Total Number 1st time >=5 mcg/dL
2016	26,972	3.57%	834
2017	26,654	2.9%	676
2018	25,605	1.8%	406
2019	25,911	1.7%	388
2020*	20,922	2.5%	472

*2020 data are preliminary and subject to change.
Data Source: RIDOH

**Elevated Blood Lead Levels among children <= 72 months old, 2016-2020

Activities

- Infrastructure and Incentive Payments
- Practice specific performance data with improved KIDS NET data reports
- Practice improvement plan with customized practice facilitation services

https://health.ri.gov/publications/periodicals/kidsnetupdate/202103-04.pdf

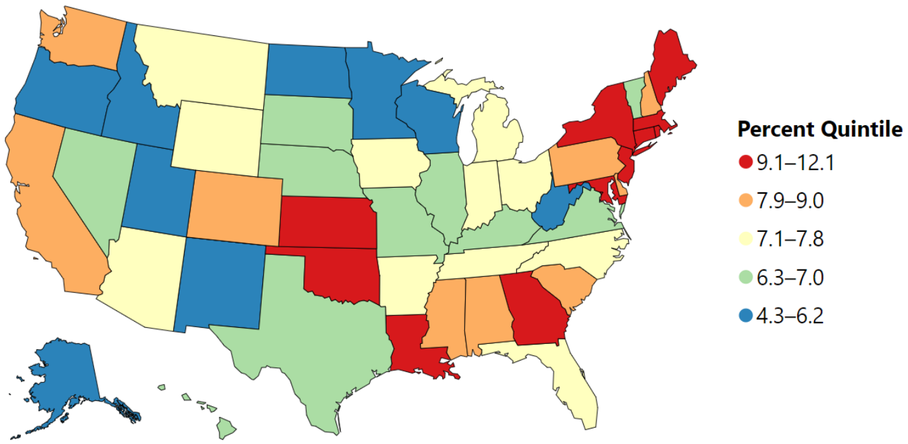
Asthma ECHO

Objective

Design and implement an asthma learning initiative to improve care for people living with asthma

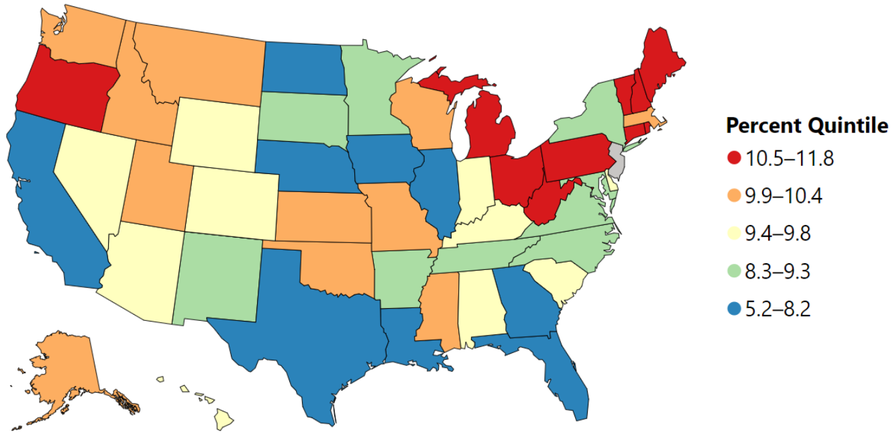
Data – Child

Current Asthma Prevalence by State or Territory (2019)



Data – Adult

Current Asthma Prevalence by State or Territory (2019)



Activity

Learners (including primary care practices, school nurses, respiratory therapists, CHW) will actively participate in ECHO learning sessions.

Up to 6 practices will improve performance in implementing evidence based practice guidelines

https://www.cdc.gov/asthma/data-visualizations/default.htm

Pediatric Weight Management - ECHO

Objectives

- To improve care in pediatric practices for children who are overweight/obese through practice participation in a data driven quality improvement learning collaborative that incorporates a BH approach
- Increase providers' clinical competence and confidence, and implement new internal protocols for managing children with weight control problems.

Data

- In 2019, 26% of RI children ages 2-4, and 38% of children between ages five and 17 were either overweight or obese. In addition, rates of being overweight or obese are higher in Black and Hispanic children. Compared to children with commercial insurance, children with public insurance have higher rates of being overweight as well (RI KIDS COUNT Childhood Overweight and Obesity: Trends in RI June 2021)

Activities

- Infrastructure payment for practices; provider and practice pre and post confidence surveys; monthly ECHO and practice facilitation meetings; access to PediPRN weight management experts; quality improvement activity

RI MomsPRN

Objective

Improve screenings for depression, anxiety and substance use disorders in prenatal practices

Data

Up to one in five women in Rhode Island suffer from a mood or anxiety disorder during their pregnancy or postpartum, making it the most common medical complication of childbirth.

MomsPRN program Cohort 2

15.5% of anxiety screens were positive; 9.7% of depression screens were positive; 21.8% of substance use screens were positive.

Activities

Infrastructure and incentive payment for practices; provider and practice pre and post confidence surveys; data display, customized clinical education and practice facilitation services; access to MomsPRN Teleconsultation services

Discussion

What other areas of focus should we consider to improve clinical outcomes?

(Preventive, Chronic, or complex care)

Health Transfer of Care & Care Coordination

Objective

Through the Health Transfer of Care Learning Collaborative for new and continuation practices youth will successfully transition from Pediatric to adult care and indicate positive patient experience with the transition process.

Data

CYSHCN: National Survey (2021)

80% of RI CYSHCN and 84% of non-CYSHCN do not receive transition preparation (compared with 76% and 82% in US); less than 2/3 had adequate insurance to cover needed services (62.5%); less than half (42.2% received care in the medial home and less than a quarter ages 12-17 years received adult health care transition planning

Activities

Pediatric and adult practices within same system of care apply as a team to transition youth with and without special healthcare needs from pediatric to adult care. New practices will identify 5 youth ready for transition (with 2 out of 5 YSHCN); Continuation practices will work to increase the spread of transition knowledge and activities within systems of care or increase resident participation in transition processes.

Discussion

What other areas of focus should we consider to improve transitions of Care or Care Coordination for children and youth?

Healthy Tomorrows

Objective

To improve communication and coordination services with improved well child outcomes and increased referrals to family visiting programs

Data

Family Visiting Enrollment

2018 KIDSNET data: There were 17,642 children with a PCMH Kids site as their identified primary pediatric provider; of these 5% (851) were or had been enrolled in FV and an additional 4% had been referred but had not gone on to enroll.

Family Visiting Eligibility

An additional 43% (7624) of children at PCMH Kids sites were identified at birth as having risk factors for poor outcomes and referred for a First Connection visit, many of whom would have been eligible to participate in FV program.

Activities

Pediatric practices are "paired" with a Family Visiting Program and develop a Care Coordination Agreement, identify a practice and FV "point of contact", regularly meet for case conferencing, and standardize care coordination process

Rhode to Equity

Objective

Provide 6 cross-sector teams, with a Health Equity Zone (HEZ) as the project lead, the opportunity to test and evaluate strategies that will build leadership and operational capacity for clinical-community linkages, and enhance place-based initiative's ability to improve both health and social outcomes.

Data

RI ranks 19 in Air and water quality
RI ranks 49 in housing with lead risk.
RI ranks 38 in income inequity,
RI ranks 39 in severe housing problems
RI ranks 43 in volunteerism

Activities

Six teams consisting of HEZ, Accountable Entity, Clinical Team and CHW, will obtain customized technical assistance from national health equity content experts and be supported in applying well designed, evidence-based population health tools. They will also have the opportunity to engage with peers in learning sessions to explore "cross pollination" of ideas and understanding.

(American's Health Rankings; United Health Foundation 2021).

DULCE Learning Initiative

Objective

Proactively addresses social determinants of health, promotes the healthy development of infants, and provides support to their parents, all during the precious and critical first six months of life by introducing a Family Specialist trained in child development, relational practice, and concrete support problem solving into the pediatric care team.

Data

Of the 9,892 babies born in RI in 2021
41% had a mother with documented history of treatment for mental health conditions,
8% had a mother with a documented history of SUD
3% had a mother with documented involvement in the child welfare system (either as a child or as an adult)

Activities

Families will engage with family specialist/CHW who is trained in early relational health who will screen for health related social needs and connect them with community resources. Teams will meet weekly, together with Medical Legal Partnership and Infant Mental Health Specialists and work together to support families using a strength based approach.

Discussion

What else can be done to improve coordination with community based organizations?

What other work is being done in this area that we may want to consider?

Strengthen team based care; Build primary care work force, wellbeing and development

Resiliency Learning Series

Objective

Virtual sessions addressing pediatrician burnout and resiliency, focused on individual, organizational, and community approaches. Sessions include:
Individual Approaches to Identifying Burnout and Building Resilience
Organizational Approaches to Impact Changing Systems Around Burnout and Resilience
Community Approaches to Bridge the Impact of Burnout and Grow Resiliency

Data

Pediatrician burnout rates are increasing at a faster rate than other specialties; Pediatricians are especially vulnerable given that many traits that are highly valued and socially expected of them (e.g. compassion and altruism) are risk factors for burnout.

New physician burnout research builds on landmark studies conducted at regular intervals between 2011 and 2021 by researchers from the American Medical Association, Mayo Clinic and Stanford Medicine. Together, these studies found the overall prevalence of burnout among U.S. physicians was 62.8% in 2021 compared with 38.2% in 2020, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011.

ADVANCING INTEGRATED HEALTHCARE

Strengthen team based care; Build primary care work force, wellbeing and development

Nurse Care Manager Core Curriculum Training Program

Objective

Provide Nurse Care Managers and Care Coordinators with a standardized, evidence-based training program in which they will learn to apply key care management concepts within primary care practice settings and organizations.

Data

According to an article in the Nursing Times, The US Bureau of Labor Statistics projects that more than 275,000 additional nurses are needed from 2020 to 2030.

Currently, the national average for turnover rates is 8.8 % to 37.0%, depending on geographic location and nursing specialty.

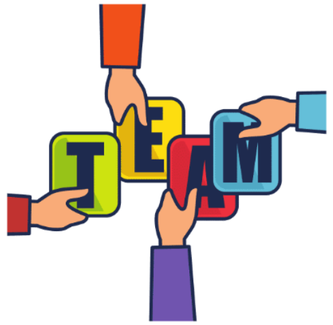
2021 Cohort had 48 Nurse Care Managers and Care Coordinators complete the gLearn NCM Core Curriculum

Activities

Learners will complete NCM core curriculum training program and present capstone presentations at Best Practices in Team Based Care meetings

https://www.ncbi.nlm.nih.gov/books/NBK493175/

Strengthen team based care; Build primary care work force, wellbeing and development



Pediatric Community Health Worker training program

Objective

Create opportunities for pediatric CHW training in RI.

Data

Currently, there is no pediatric CHW training offered in RI

Activities

CHW/other staff members will successfully complete a strength based training program; practices participating in the DULCE learning initiative will participate in regularly scheduled team meetings and obtain Medical Legal Partnership and reflective supervision

Trainings to include:

Brazelton Touchpoints
Newborn Behavioral Observations

Strengthen team based care; Build primary care work force, wellbeing and development

Wellness Visit

Objective

In collaboration with RI AAP, develop and test use of a wellness visit with 50 families and measure provider and family experience.

Data

52% Children with a medical home ranking; 29% Children without a medical and dental preventive care visit, 25% Children without all recommended vaccines

29% of children under 19 enrolled in Medicaid had a mental health diagnosis;

Activities

Host listening sessions to learn about current family experiences, develop new wellness visit, test new visit with at least 50 families, collect provider and family experience data.

(Commonwealth Fund 2022 Scorecard).

Strengthen team based care; Build primary care work force, wellbeing and development

Medicaid Pediatric Relief Fund Behavioral Health Initiative

Objective

To provide pediatric and family medicine providers and staff educational and peer learning opportunities in behavioral health

Data

55 - 85 Attendees participated in each previously offered technical assistance sessions (Brief Intervention Training for Pediatric Staff, Impact of COVID on children's social-emotional development, Behavioral Plan Basics)

46.9% (75 individuals) suggested that they are interested in customized Psychosocial / Behavioral Health technical assistance.

Activities

Upcoming behavioral health session topics will be:

Difficult conversations
Navigating schools to improve connections
School Avoidance
CBT / Anxiety
Medication Management in pediatrics
Suicide risk/prevention/tools

Strengthen team based care; Build primary care work force, wellbeing and development

NCQA Distinction in BHI

Objective

Prepare to apply for NCQA Distinction in BHI by the end of 12 months

Data

All practices have achieved PCMH status, and all have integrated behavioral health programs
Distinction criteria must be met in 4 areas: BH Workforce, Information Sharing,
Evidence-Based Care, Measuring and Monitoring

Activities

Monthly practice facilitation meetings, learning collaborative meetings to share best practices

Discussion

What other workforce development opportunities are there?

Are there any other gaps in care that need to be addressed?

Are there other opportunities that have not been discussed?

Goal 1: Improved Clinical Outcomes (preventive, chronic, complex care)	Goal 2: Improved Transitions of Care and care coordination for children and youth with special health care needs	Goal 3: Improved Coordination with community based organizations	Goal 4: Strengthen team based care; Build primary care work force, wellbeing and development
• Medicaid Pediatric Relief Fund • Asthma ECHO Initiative • Pediatric Weight Management ECHO • RI Moms PRN	• Health Transfer of Care • Care Coordination	• Healthy Tomorrows • DULCE Learning Initiative • Rhode to Equity	• Resiliency Learning Series • Nurse Care Manager Core Curriculum Training Program • Pediatric Community Health Worker training program • Wellness Visit • Medicaid Pediatric Relief Fund Behavioral Health Initiative • NCQA BH Distinction

Please Complete the Post Meeting Evaluation

https://www.surveymonkey.com/r/PCMHKIDS100622

Upcoming Meetings

Coffee Break with Pat and Beth

Thursday, November 3, 2022, 7:30am -8am EST

Zoom Meeting
https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09
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Best Practices in Team Based Care – Lead Screening

Tuesday, November 15, 2022, 8am – 9am EST

Zoom Meeting
https://ctc-ri.zoom.us/j/93572867243?pwd=L1h2dDkvc2VMeklRRW1iRlZ2NnJTQT09
One tap mobile: +16468769923,,93572867243#,,,,,,0#,,646876#

Breakfast of Champions

Friday, December 9, 2022, 7:30am – 9am EST

Zoom Meeting
https://ctc-ri.zoom.us/j/712460640?pwd=cWpIYUNTc2RxK0oyemNMUGRUZzFhdz09
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Improving Child Health in RI (formerly PCMH-Kids Stakeholder Meeting)

Thursday, January 5, 2023, 7:30am – 8:30am
Zoom Meeting
https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09
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THANK YOU

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