CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome

Care Transformation Collaborative of Rhode Island

Patricia Flanagan, MD, FAAP, PCMH Kids Co-chair
Elizabeth Lange, MD, FAAP, PCMH Kids Co-chair

Improving Child Health in RI Meeting | January 4, 2024

Agenda

Topic Presenter(s)	Duration
Welcome & Opening Remarks *Pat Flanagan and Beth Lange, Co-chairs*	5 minutes
Review of 2023 Programs *Pat Flanagan and Beth Lange, Co-chairs*	20 minutes
Asthma Spotlight *Sue Dettling, CTC-RI Practice Facilitator and PRIMA*	15 minutes
Review 2024 Programs & Discussion of Priorities and Gaps *Pat Flanagan and Beth Lange, Co-chairs*	20 minutes

Pediatric Strategic Plan

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

- Medicaid Pediatric Relief Fund
- Asthma ECHO Initiative
- Pediatric Weight Management ECHO
- Restrictive Eating Disorder
- RI Moms PRN
- Sexually Transmitted Infection

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

- Health Transfer of Care
- Care Coordination

Goal 3: Improve 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

- Nurse Care Manager Core Curriculum Training Program
- Increasing Pediatric IBH Capacity Using Community Health Workers
- Wellness Visit
- Medicaid Pediatric Relief Fund Behavioral Health Initiative
- UMASS Chan Medical School's Online Certificate Course in Primary Care Behavioral Health
- Healthy Happy Teams
- Expanding Pediatric IBH Capacity

Goal 5: Eliminate health disparities; RI health results for kids, are among the best in the nation.

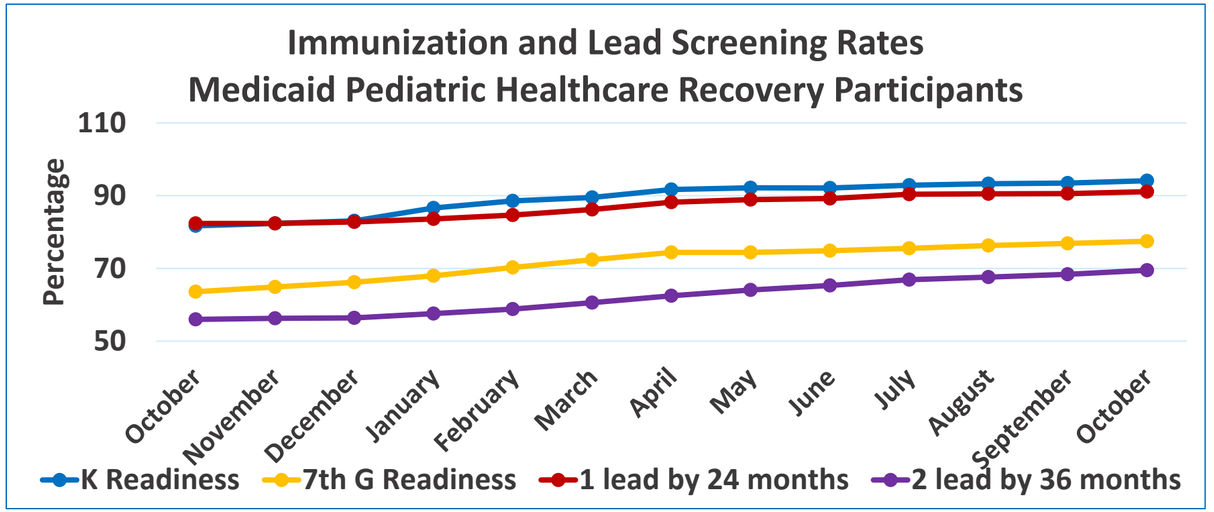
- Demographic Data

Review of completed 2023 Projects

Medicaid Pediatric Healthcare Recovery Program

- $7.3 million funded through the American Rescue Act, paid to pediatric and family medicine practices.
- Payments were contingent on practices meeting Immunization and Lead Screening targets or demonstrating prescribed improvement.

Payment Reporting Periods	% of practices meeting 3 out of 4 targets / improvement targets
October 2022 (Baseline)	100% for participation
January 2023	75%
April 2023	75%
July 2023	77.5%
October 2023	80%



- In addition, practices were paid to participate in a six-month ECHO Behavioral Health (BH) Learning Initiative.
  - 100% of the practices met the payment requirements for BH ECHO participation.

Suicide Risks, Prevention & Tools | Presentation | Recording
Medication Management in Pediatrics | Presentation | Recording | Quick Reference
CBT/Anxiety | Presentation | Recording
School Avoidance | Presentation | Recording
Navigating Schools to improve connections | Presentation | Recording
Difficult Conversations (with emphasis on vaccine hesitancy) | Presentation | Recording

Pediatric Weight Management ECHO and QI Initiative

- Funding provided by Tufts Health Plan

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- Project Goals
  - Improve pediatric care for children who are overweight/obese using a behavioral health approach to behavior change
  - Develop new skills, knowledge, and comfort through didactic learning, case sharing, data driven quality improvement activities, and monthly team meetings
  - Implement sustainable and standardized approaches for preventing, assessing and/or treating childhood obesity
  - Improve patient outcomes
- ECHO Series
  - Epidemiology of Obesity (AAP guidelines) | Recording | Presentation
  - Weight Bias/Stigma and impact on mental health | Recording | Presentation
  - Cultural Considerations | Recording | Presentation
  - Developmental Approach to Prevention of Childhood Obesity | Recording | Presentation
  - Difficult Conversations | Recording | Presentation
  - Family-Based Behavioral Treatment | Recording | Presentation
  - Empowering Parents | Recording | Presentation
  - Nutrition / Physical Activity counseling | Recording | Presentation
  - Role of IBH clinician / PEDIPRN / Triage Care | Recording | Presentation
  - Self-Monitoring, Engagement in Treatment | Recording | Presentation

Participating Practices
Anchor Pediatrics
Atlantic Pediatrics
Santiago Medical Group
St Joseph Health Center
Tri-County Community Action Agency
Waterman Pediatrics Coastal Medical
Westerly Medical Center

Care Coordination ECHO Learning Series

Funded by RI Department of Health

7 ECHO® learning sessions focused on strategies to improve care coordination for families with young adults, with special healthcare needs, transitioning from pediatric to adult care.

1. *Family Voice & Entitlement to Eligibility* • Recording | Presentation
2. *Maximizing Autonomy: Guardianship and Less Restrictive Alternatives* • Recording | Presentation
3. *Understanding BHDDH Developmental Disability and Behavioral Healthcare Transitions of Care* • Recording | Presentation
4. *Disability and Accommodations in Higher Education* | Recording | Presentation
5. *Healthcare Transition from Pediatric to Adult Providers for Youth in Foster Care* | Recording | Presentation
6. *Durable Medical Equipment and Medical Services* | Recording | Presentation
7. *Autism* | Recording | Presentation

Moms Psychiatry Resource Network (MomsPRN)

Behavioral health conditions have adverse impacts on the health of perinatal individuals and their children, and are often under recognized, underdiagnosed, and undertreated.

Statewide initiative funded through a RIDOH grant award that helps providers screen and manage the depression, anxiety, and/or substance use of their pregnant or postpartum patients through:

1. **Behavioral health teleconsultation line staffed by WIH clinicians**
2. **Prenatal care practice learning collaboratives offered by CTC-RI**

Women & Infants

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RI MomsPRN
Maternal Psychiatry Resource Network

2023-2024 Continuing Projects

Developmental Understanding and Legal Collaboration with Everyone (DULCE)

Year 1:

- Funded by UnitedHealthcare and RIDOH (Early Childhood Comprehensive Systems)
- 2 teams
  - Coastal Toll Gate Pediatrics
  - CNEMG Family Care Center

Year 2:

- Added Congressional Direct Spend and Tufts Healthy Tomorrows:
- 3 teams
  - Tri-County Community Action Agency
  - Hasbro
  - Blackstone Valley Community Health Center (BVCHC)

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United Healthcare
Point32Health
Congressional Direct Spend

DULCE Outcomes from Cohort 1

Coastal Toll Gate Pediatrics

Enrollment Data:

- 99 babies overall

DULCE services:

- FS present at 95% of routine WC visits
- 52 families with positive SDOH screens; 28 families linked to resources

PDSA Statement: Toll Gate Pediatrics Family Specialist will monitor well child visit adherence for patients who are enrolled in DULCE. In addition, we will look at Lauren's attendance and introduction to the program during well child visits for families that are not currently enrolled and work to increase those rates of families enrolled.

- **Rate of No Shows at all WCVs 0-6 mos**
  - **Baseline** 2022 = 2.9%
  - **Results: DULCE babies April 2023-Oct 2023 = .6% NS Rate**
- Enrollment increased when Lauren's hours increased from 16 to 20 hrs in June; 30 families enrolled in August alone

CNEMG Family Care Center

Enrollment Data:

- 34 prenatal moms
- 24 babies
- 84% public insurance
- 93% English speaking

DULCE services:

- FS present at 77 routine WC visits
- 100% of families screened for SDOH and maternal depression

PDSA Statement: Through the DULCE project and our family specialist, we are hoping to improve WCC attendance for patients 0-6 months by implementing specific supports to families.

  - **Baseline: January 1, 2022-December 31, 2022 - 67.3%**
  - **Results: March-October 2023: 84% of DULCE babies received all WCCs on time**
- The team implemented a shared patient list for tracking WCCs
- Jalyn provided reminders and helped arrange transportation when needed
- DULCE babies had very little ED usage – something to consider for future PDSA cycles

DULCE

A postpartum mother commented “I never thought that a pediatrician's office could provide support for me and be so resourceful, I thought this office really only focused on my baby, my family and I are so thankful for the conversations I have had with you (family specialist)."

Physician feedback includes “Where can I attest to the implementation of DULCE and my want for this to continue here, this role is so important to us!”

Why join the learning collaborative?

Assessing and monitoring families will allow our CHWs to intervene effectively in the community and home environments and will undoubtedly improve medical and relational outcomes for our patients. Access to legal consultation will also be critically important to our most vulnerable families as they often struggle to navigate our immigration system and some have complex legal concerns without adequate legal support.

Healthy Tomorrows Initiative

Funded by Health Resources and Services Administration (HRSA) and Tufts Health Plan - 5-year Program

Goals:

- PCMH-Kids practices and FHV programs have the tools, data and workflows needed to integrate care coordination
- PCMH-Kids practices and FHV programs acquire knowledge, skills and relationships for integrating care coordination through participation in a year-long Learning Collaborative
- PCMH-Kids practices and FHV programs develop and implement strategies to support family engagement in primary care and FHV programs
- Integrated Care Coordination activities will continue after the period of federal funding ends.

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- ***Year 1 (Mar 2020 – Feb 2021) – Planning Year***
- ***Year 2 (Mar 2021 – Feb 2022) – Pilot with Meeting Street & Blackstone Valley Community Action Program + Hasbro Pediatric Primary Care & Providence Community Health Center – Central***
- ***Year 3 (Mar 2022 – Feb 2023) – Expanded to 2 more practices + 2 Family Visiting programs + PAT***
- ***Year 4 (March 2023-February 2024)-Expanded 3 more practices + 3 Family Visiting Programs + PAT***
- ***Year 5 (March 2024 – February 2025) – Expand to 4 more practices + Family Visiting Programs + PAT***

Health Care Transitions: Pediatric to Adult Care

Funded by RI Department of Health and Tufts Health Plan

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Objectives

- Pediatric and adult team ***partners work together*** to improve transition of care for youth as they transition from pediatric to adult care.
- Teams are asked to ***test the transfer of care concept*** on a small sample of identified “transfer of care” young adults.
- Teams apply selected Core Elements from Got Transition’s approach, using the performance improvement process, and ***develop and implement a more intentional and structured approach to the transfer of care process.***

2 Cohorts with 14 practices completed the program

Cohort 3 participating practices :

Pediatrics	Adult
Anchor Pediatrics	Anchor Medical - Lincoln
Atlantic Pediatrics	Matt Rocheleau, MD
East Greenwich Pediatrics	University Family Medicine
Richard Ohnmacht, MD	Chad Lamendola, MD
Concilio Pediatrics testing the RIPCPC transition of care process	

Demographic Data Collection Pilot

Project Overview

- Funded by CDC/Rhode Island Department of Health/Rhode Island Executive Office of Health & Human Services.
- 15 Primary Care Practices Selected Trainers – Adult, Peds, Family Practice
- Project Timeline: May 2023 – May 2024 – Educational Focus
- Environmental Scan Reports – Best Practice, RI Demographic Data Collection Performance, Current & Anticipated Standards
- Baseline Needs Assessment (8/15 – 9/15) – Practice Assessment (15), Patient Survey (1190), Staff Survey (89), Walk Around Tool (15)
- Baseline Needs Assessment Summary Report (October)
- 6 Session Train the Trainer Webinar Series (October – March)
- Quality Improvement component with 15 practices starting in April

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EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Concilio Pediatrics
East Bay Community Action Program
The Center for Primary and Specialty Care
The Miriam Hospital Medical Clinic
University Internal Medicine
Atlantic Pediatrics
Children First Pediatrics
East Bay Pediatrics
Family Doctors Group, PC
Jamiel Ambrad, MD
Olga Tverskaya, MD
Richard Ohnmacht, MD
Smithfield Pediatrics
Snow Family Medicine
Your Health

Prepared by Care Transformation Collaborative of RI

Restrictive Eating Disorder ECHO

- Funding provided by UnitedHealthplan
- Project Goals
  - Increase capacity of pediatric practices to support children and adolescents with restrictive eating disorders
  - Educate clinicians in Family Based Treatment, the gold standard for restrictive eating disorders
  - Improve patient outcomes
  - Be part of a learning community for behavioral health providers and pediatric care teams
- ECHO Series
  - Recording, presentation and resources

ECHO Curriculum	Date
1. Kickoff and ECHO session on Eating Disorders 101	Sept 21, 2023
2. Medical Basics	Oct 19, 2023
3. FBT Basics	Nov 16, 2023
4. Food is Medicine	Dec 21, 2023
5. Externalizing the Illness	Jan 18, 2024
6. Family Meal/Meal Coaching	Feb 15, 2024
7. Partnering with Caregivers	Mar 21, 2024
8. Collaborative Weighing	Apr 18, 2024
9. One Team, One Message	May 16, 2024
10. Harnessing Parental Anxiety	June 20, 2024
11. Navigating Challenging Family Dynamics	July 18, 2024
12. Brain Recovery	Aug 15, 2024

- **Full participation practices**: Aquidneck Pediatrics and East Greenwich Pediatrics
- **ECHO only practices**: Atlantic Pediatrics, Coastal - Bald Hill Pediatrics, Barrington Pediatrics Associates, Coastal - Narragansett Pediatrics, Coastal - Toll Gate Pediatrics, Smithfield Pediatrics

Increasing Pediatric IBH Capacity Using Community Health Workers

Project Objectives

- This project aims to increase the capacity of Rhode Island pediatric providers and integrated behavioral health (IBH) programs by training Community Health Workers (CHWs) in behavioral health care coordination and providing support to a practice's IBH team.
- This project will support CHWs to work effectively with families as part of a primary care team.

Participating Practices:

- Coastal Medical Bald Hill Pediatrics
- Coastal Medical Waterman Pediatrics
- CCAP
- Family Care Center, Care New England Medical Group
- Wood River Health
- Pediatric Primary Care, Hasbro Children's Hospital

TEAM UP FOR CHILDREN

TEAM UP (Transforming and Expanding Access to Mental Health Care in Urban Pediatrics) has worked to build the capacity of pediatric primary care to deliver high-quality, evidence-informed integrated behavioral health care to children, families and expand the practice team.

Funding provided by

Blue Cross Blue Shield of Rhode Island

United Healthcare

Hassenfeld CHILD HEALTH INNOVATION INSTITUTE BROWN UNIVERSITY

Expanding Pediatric IBH Capacity

- Project Objectives
  - This project aims to increase the number of Rhode Island pediatric providers who work in integrated behavioral health (IBH) programs by connecting interested clinicians with practices in need.
  - CTC-RI is partnering with the Foundation for Integrated Care (FIC) to match an IBH clinician to the participating practices at no cost to the practice. The IBH clinician will be available to the practices for 20 hours/week and will conduct evaluations/assessments, implementing short term (6-8 sessions) treatment, support with concrete resource needs and providing referrals for higher levels of care if indicated (such as partial hospital, outpatient individual therapy).
- Participating Practices (staggered start dates):
  - Barrington Pediatrics
  - Northern RI Pediatrics
  - P.R.I.M.A
- Funding provided by

Blue Cross Blue Shield of Rhode Island

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Healthy Happy Teams

- Funding provided by UnitedHealthcare

- Project Objectives
  - Support team-based care through a health equity lens as it applies to high-functioning primary care teams
  - Review best practices across core values and skills for relational building in primary care
- Participating Practices:

July Start	October Start
Atlantic Pediatrics	Barrington Pediatric Associates, Inc
Santiago Medical Group, Inc	Hasbro Children's Hospital Pediatric Primary Care
CCMA Cranston	University Internal Medicine, Inc
Richard K Ohnmacht, MD, Ltd	Wood River Health
	Brown Medicine Primary Care- Warwick

BH Workforce Development Efforts

UMASS Chan Medical School's Online Certificate Course in Primary Care Behavioral Health

- Training BH clinicians to work effectively in primary care centers, and to understand connections between physical health and behavioral health
- 22 self-paced modules, and participants can receive 36 CEU credits
- 18 individuals enrolled in training in 2023
- Post-training results
  - On the 1-5 scale, mean scores improved from an average of 3 in the pre-test to 5 in the post-test, showing clear improvement in IBH skills

"Overall, this was a fantastic program that covered a lot of topics in depth."

"Very helpful in illustrating all the ways IBH can function more effectively."

University of Michigan Training

- One participant is attending the pediatric-focused online training: 'Certificate in Integrated Behavioral Health and Primary Care, Pediatric Track' course developed by the University of Michigan School of Social Work.
- This training begins in Spring 2024, consisting of 21 live, interactive virtual sessions, and 14 asynchronous, self-paced sessions

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Blue Cross Blue Shield of Rhode Island

United Healthcare

AAP Family Strengths Assessment Visit

- Goal: To empower families in Rhode Island by fostering resilience, promoting positive mental health, and reducing the impact of adverse childhood experiences through the implementation of Family Strengths Assessment Visits within pediatric medical homes. **By identifying and leveraging the unique strengths of each family, practices aim to create a supportive environment that prioritizes early relational health, family well-being, and long-term positive outcomes for children.**
- Project Objectives/Milestones
  1. Conduct an environmental scan and facilitate meetings with key stakeholders to co-design family strengths and health goals for the Family Strengths Assessment pilot program.
  2. Collaborate with pediatric practices to integrate the Family Strengths Assessment Visit, pilot the program, and collect essential data on family and provider satisfaction.
  3. Each practice to conduct 25 strength-based visits, providing $25 gift card incentives to participating families and gather feedback on the visit regarding family satisfaction
     - **East Greenwich completed all 25 visits at the end of Dec 2023**
     - **Hasbro to start in Jan 2024 and has gone through IRB process**
  4. Analyze pilot results to inform policy recommendations, advocate for inclusion in the EPSDT schedule, and develop educational resources to support community awareness and implementation
- Participating Practices:
  - East Greenwich Pediatrics
  - Hasbro Pediatric Primary Care
- Funding provided by RI AAP

Rhode Island Chapter
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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Asthma Spotlight

Asthma Work to Date

Asthma Essentials ECHO

IMPROVING POPULATION HEALTH AND ADDRESSING HEALTH DISPARITIES FOR

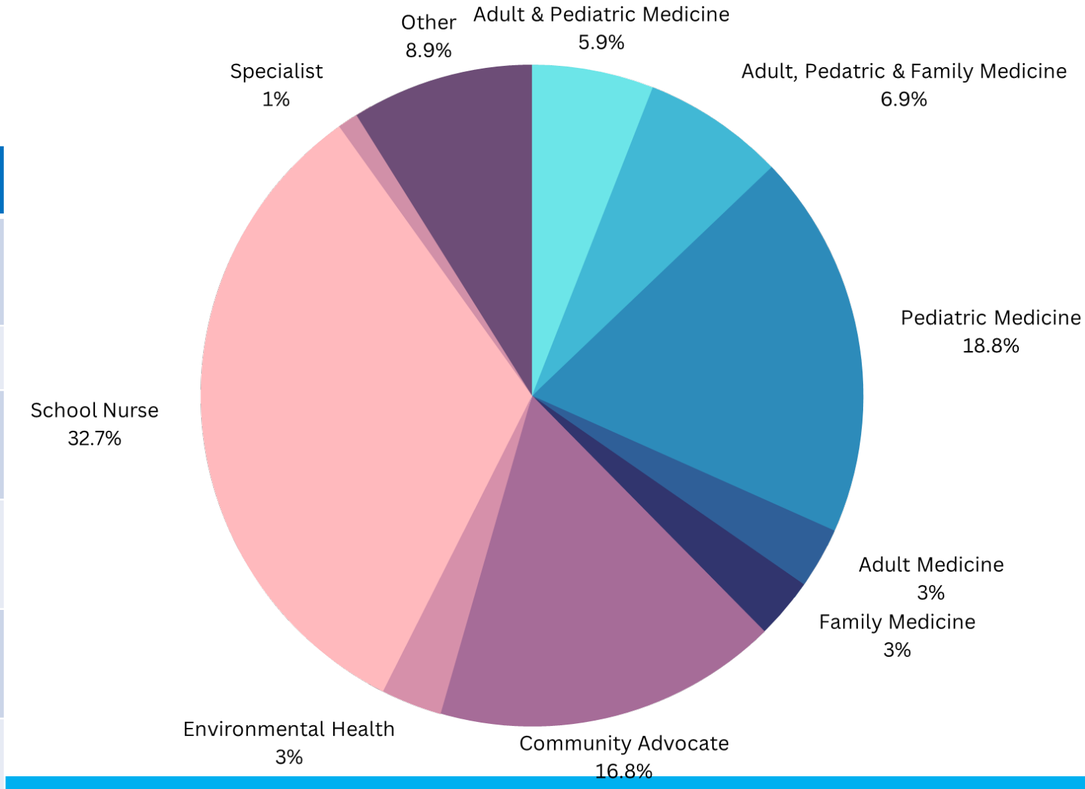
In October 2022, CTC-RI kicked off a 6-month ECHO focused on Asthma with the following goals:

- To share didactic and case presentations to enhance learning about best practices and evidence-based care for patients
- Help providers and care teams, community partners, respiratory therapists, acquire and enhance skills, competencies, and best practices in asthma care
- Engage in collaboration, support and ongoing learning with subject matter health experts & health care staff

ECHO Curriculum
Session 1: Asthma Clinical Guidelines with *Dr. Mansi James, DO Allergy/Asthma*
Session 2: Use of Asthma Medications/Asthma Action Plans with *Lillian Nieves, PharmD*
Session 3: Assessing and Managing Environmental Triggers with *Jim Ginda, MA, RRT, AE-C, FAARC*
Session 4: Patient and Family Education with *June Tourangeau, Certified Asthma Educator*
Session 5: Working with Community Partners with *Daniel Fitzgerald, MPH, ICPS and Ashley Fogarty, MPH*
Session 6: Managing Asthma Exacerbations with *Dr. Andrew Foderaro, MD, Pulmonologist*

Participants

- 69 Participants consisting of
  - 13 Providers from 12 orgs & SOC including Lifespan, Coastal, & EBCAP
  - 14 CHWs from CBOs, HEZs,
  - 23 school nurses



Asthma Work to Date

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Asthma Quality Improvement Initiative

2 pediatric practices participated in 6 month learning collaborative (May – Oct 2023) : Dr. Concilio and P.R.I.M.A. Inc.

- Provide practices opportunity to develop, implement and enhance a sustainable team-based structured approach to improve care for patients with asthma.
- Two practice facilitators (one w/ expertise in quality improvement; one certified asthma educator)
- Identify and measure practice improvements using evidence-based guidelines and implement performance improvement plans that incorporated:

1. Core Measure: Total Population Measure: numerator (outpatient visits) and denominator (outpatient visits plus emergency visits and inpatient days based on uncontrolled asthma.

2. Practice selected Measure (based on baseline assessment)
    1. Give/review Asthma Action Plan (AAP) for all patients w/ asthma
    2. Provide patient "teach back" education on how to use inhaler medication

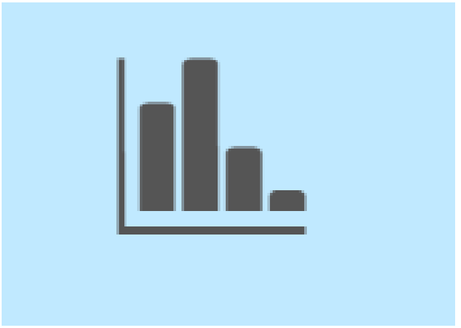
3. Improved care coordination: Coordination with school nurse and asthma action plan; referral to HARP (Home Asthma Response Program) for children with uncontrolled asthma.

4. Funding to purchase supplies (spacers, masks, nebulizer)

Asthma Action Plans (AAPs) given to patients

Asthma Care "Pop T" score*

a. **Baseline** (Oct 1, 2022-April 27, 2023): N = 39/ D = 46 (39+7); **39/46 = 85%**
b. **Midpoint** (4/28 – 6/28/23): N = 8/ D = (8+1); **8/9 = 89%**
c. **Final** (6/29 – 9/28/23): N= 4/D = (4+1); **4/5=80%**



Final data Reference:
Number of office visits related to asthma symptoms (June 29th -Sept. 28th 2023): 4
Number of ER/UC visits related to asthma symptoms (June 29th -Sept. 28th 2023): 1

Asthma Action Plans given to patients: (Practice specific measure data):

a. **Baseline** (5.1.2022 - 4.27.2023): percentage of patient w/ asthma who have AAP: **5/36=13.8%**
b. **Midpoint** (5/29 – 6/28/23)**:** percentage of patients w/ asthma seen who were given/reviewed AAP: **2/3= 67%**
c. **Final** (6/29 – 9/28/23)**:** percentage of patients with asthma seen who were given/reviewed AAP: **4/4= 100%**

Total AAP given April 28 – September 28th, 2023 = 103

Reference: *chart review/manual tracking for 20 patients with Asthma; Baseline data: manual review of 38 patients (codes J45.3, .4,.5), 2 inactive, 5 had AAPs;

Asthma Action Plans (AAPs) given to patients

PDSA – Plan, Do, Study, Act - Quality Improvement:

Describe the measured results and how they compared to the predictions

- The population T started off at 85% ending at 80% (however due to the short time and small sample this is not statistically significant).
- Provision or review of Asthma Action Plans started at 13.8%, midpoint at 67% and final at 100%. Due to the small numbers and season aspect of patients visits for asthma related projects further study is needed.

Act: Describe what modifications to the plan will be made for the next cycle from what you learned
Because of participation in the Asthma QI project, what changes to your workflow, if any will be sustained?

- P.R.I.M.A. will continue to give or review the AAP at every visit with patients with asthma; the practice will continue to make copies of the AAP;
- Use of the AAP is a routine part of workflow now.
- Practice looks forward to enhancements to KIDSNET for the AAP and referrals.
- Practice would consider using KIDSNET to print AAP (blank or filled out); would also consider use for referrals
- Funding for the asthma supplies was extremely helpful as well as the practice has these extra spacers and nebulizers on hand if patients need them.

- ❑ **Sustainability since conclusion of Asthma QI project**
  - ❑ **AAP template in eClinical Works electronic health record**
- ❑ **Connections with school nurses/AAP**
- ❑ **Referrals to HARP**

Upcoming Learning Collaborative 2024

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January 2024 - June 2024

Goal: provide four more practices / school nurse teams (elementary schools) to work together to improve asthma outcomes through improved communication and collaboration looking at asthma action plans, children at risk for chronic absenteeism due to asthma and aligned educational resources

Recruitment strategy

- Invite pediatric practices, then identify school nurses

Pilot a test for improved communication between school nurses and pediatricians that may be transferrable across all schools

Funding:

$5,000: up to $1,000 which can be used for purchasing asthma equipment/supplies

What's Next?

Pediatric Strategic Plan

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

- •Medicaid Pediatric Relief Fund
- •Asthma ECHO Initiative
- •Pediatric Weight Management ECHO
- •Restrictive Eating Disorder
- •RI Moms PRN
- •Sexually Transmitted Infection
- Optimizing a BH approach to Children's Sleep in Pediatrics ECHO

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

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Goal 3: Improve Coordination with community-based organizations

- Healthy Tomorrows
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- Rhode to Equity

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

- Nurse Care Manager Core Curriculum Training Program
- Increasing Pediatric IBH Capacity Using Community Health Workers
- Wellness Visit
- Medicaid Pediatric Relief Fund Behavioral Health Initiative
- UMASS Chan Medical School's Online Certificate Course in Primary Care Behavioral Health
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- Expanding Pediatric IBH Capacity

Goal 5: Eliminate health disparities; RI health results for kids, are among the best in the nation.

- Demographic Data

2024 new opportunities

- Optimizing a BH approach to Children's Sleep in Pediatrics ECHO – funding provided by BCBS-RI
- Sexually Transmitted Infection – funding provided by Unitedhealthcare
- Asthma – funding provided by RIDOH and Unitedhealthcare
- Expanding Pediatric IBH Capacity (continuing) – funding provided by BCBS-RI and Tufts Health PLan
- Demographic Data QI – funding provided by RIDOH, EOHHS, RI Foundation and UnitedHealthcare
- Autism ECHO & QI Initiative – seeking funding
- AAP Family Strengths Assessment Visit expansion – seeking funding
- Oral Health ECHO & QI Initiative – seeking funding

What are the practice priorities?

What are we missing?

The Art of Medical Leadership

Leading Effective Clinical & Administrative Teams

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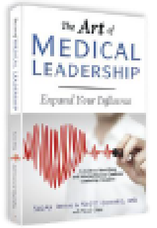
Goal: Leaders attend abbreviated program to determine the value of full 10 session program for their organization.

Intended Audience:
System of care, health plan, & medical practice leaders

Purpose of Five Session Intro Program:
Participants will gain new insights and strengthen their communication skills within their teams. After attendance, determine if full program will be helpful for your organization.



Live Group Discussion Sessions + Self-Paced Pre-Recorded Videos + Books:

Each participant will receive a copy of the book & read each chapter prior to the corresponding module.

Self-Paced Video Modules:
One pre-recorded video for each of the five chapters offered
Video length range 25-40 min.

Facilitated Live Group Virtual Discussion Modules starting January 2024:
Each person attends one Live Group Session (1 hr.) for each of the five chapters.

Proposed dates/times (choose one session for each chapter, 7:30 am or 12 pm):

- Chapter One: Monday Jan 8th
- Chapter Two: Thursday Jan 25th
- Chapter Four: Thursday Feb 1st
- Chapter Five: Monday Feb 19th
- Chapter Six: Thursday Mar 7th

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Converging Health
Saving Money Improving Lives

Friendly Reminders of Upcoming Meetings…

Date	Meeting
Jan 16th	Best Practices in Team-Based Care, 8:00-9:00AM, https://ctc-ri.zoom.us/j/93572867243?pwd=L1h2dDkvc2VMeklRRW1iRlZ2NnJTQT09 Meeting ID: 935 7286 7243; Passcode: 646876; One tap mobile: 6468769923,,93572867243#,,,,,,0#,,646876# ***CME credits available***
Feb 1st	Virtual Coffee Break with Pat & Beth, 7:30-8:00AM **https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09** Meeting ID: 959 6302 4930; Passcode: 646876; One tap mobile: 6468769923,,95963024930#,,,,,,0#,,646876#
Mar 8th	Breakfast of Champions, 7:30-9:00AM Register in advance for this meeting series: https://ctc-ri.zoom.us/meeting/register/tZUqdeCqrT0sGN0bQMf5VdMBLCx9PRh0zl2F ***CME credits available***


thank you
danke
格雷西
ngiyabonga
આભાર
рахмат
teşekkür ederim
баярлалаа
дзякуй
faafetai lava
dank je
misaotra
paldies grazzi
mahalo
tapadh leat
gracias
благодаря
asante
manana
kiitos
dankie
dhanyavad
mauruuru
hvala
bedankt
enkosi
dziękuję
djiere dieuf
mochchakkeram
mamnun
go raibh maith agat
धन्यवाद
gracias ago
aitäh
sulpáy
sukriya
kop khun krap
taiku
obrigado
sobodi
dëkuji
sagolun
ありがとう
tanemirt
toda
хвала
takk
dakujem
trugarez
měrsi
najis tuke
terima kasih
rahmet
dhanyavadagalu
shukriya
дякуємо
diolch
salamat
고맙습니다
xièxie
eskerrik asko
ти благодарам
ευχαριστώ
dankewol