**CTC 2020 Annual Conference: “Investing in Primary Care: Learning in Action”**

Agenda 5 27 21

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| 7:00-7:30am | **Registration** | | | |
|  | Morning Session | | | |
| 7:31-7:45am | **Welcome:**  *Debra Hurwitz, RN, MBA Executive Director CTC-RI* | | | |
| 7:46-8:00 am | ***Affordability Standards***  *Marie Ganim PhD MPA* | | | |
| 8:00 to 9:15 | **Keynote Speaker: Ann Greiner President and CEO Primary Care Collaborative: “Investing in High Value Primary Care”** | | | |
| 9:15 -: -9:30 am | **Pano Introduces the Plan for the Breakout sessions: Break** | | | |
| 9:30  to 10:45 am | **Learning in Action : Session 1** | | | |
| “What’s Next: After Screening for Social Needs  Content expert: Nelly Burdette  Lessons learned: Panel Discussion: IBH practices who addressed both behavioral health and social needs | Investing in Value Based Primary Care  Content expert: Ann Greiner 30 minutes  Lessons learned:  Payment models (panel discussion people doing capitation models : CPC+, BCBS pilot with FQHC | Investing in Pediatric/Adult Care Coordination  Content expert: Person from “Got Transitions:  Lessons learned: practices that participated in Health Care Transitions learning collaborative | Investing in complex care management  Content expert: Jennifer Ritzau MD  Acute Care for the Elderly Lessons Learned: Hearing from patients/families what works |
|  | **Break:** | | | |
| 11:00 to 12:15 | **Learning in Action: Session 2** | | | |
| Investing in Community Linkages  Content expert: Somava Saha MD  Lessons learned: Panel discussion: Health Equity Challenge participants | Investing in Value: What’s working among the Accountable Entities?  Content expert: TBD  Best practices:  Or do we want to have something on the HUB payment model? | Trauma Informed Care in Pediatrics  Content expert: person recommended by Pat | Emergency Preparedness: Lessons learned COVID 19 |
| Lunch and Meet the Venders 12:15-1:00  Afternoon Sessions | | | | |
|  | **Learning in Action: Session 3** | | | |
| 1:00-2:00 | Investing in Pharmacy  Content expert: Kelley or Steve?  Lessons learned: practices that participated in pharmacy QI program | Collaborative Care Model in Primary care:  Content expert: Medicaid in Maryland  And What’s worked in RI: Women’s Medicine Collaborative  Jill Welte (Psychiatrist from Coastal) | Improving care through collaboration with schools  Content expert? Genius Village | Improving Care through data aggregation (maybe Craig Jones) |

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|  | **Learning in Action: Session 4** | | | |
| 2:10-3:10 | Improving care for patients and families affected by substance use disorders: Investing in Peer Recovery Coaches: What’s Working | Investing in Telemedicine:  Content expert: TBD | Investing in Pediatric Integrated Behavioral Health  Content expert: Liz Cantor/Sarah DeCarvalho and practices that participated in IBH pilot (including Coastal) | Transition of Care:  Developing exacerbation plans to decrease ED and IP  Content expert: Jackie  McCole from G Learn |

Topics: Top areas selected in each category: (rank order was calculated by adding “extremely interested” and “interested” percentages”; Bolded area of focus: highest percentage score for “extremely interested”

**Team based care: 1. IBH: brief interventions that work;** 2. IBH: learning from other states in implementing models that work for smaller primary care practices; 3. BH: improving care through telemedicine; 4. Improving care for young adults transitioning to adult health care; Using IBH to assess and treat patients with ADHD; 6. Clinical mindfulness

**Complex care management: 1. Skills, knowledge and abilities needed to support patients with complex needs;** 2. Suicide assessment and intervention; 3. NCM: developing exacerbation plans to decrease ED and IP utilization; 4. Improving care for people with serious illness; 5. Improving care for people with SUD; 6. NCM: social needs and how they impact self-care capacity

**Social Needs: Population health;** **1.** What next: positive screens for social determinants of health and operationalizing next steps;2. Learning from other states: addressing social needs; 3. Local successes in addressing social needs; **4. Community based organizations and primary care;** 5. Best practices around addressing patient transportation needs; 6. Partnering with housing;

**Care Coordination:** 1. Referral management: implementing systems to track outcomes; **2. Improving care through collaboration with** community resources (i.e. CAP agencies, senior centers); 3. Lessons learned: implementing pathways to population health to improve **community linkages;** 4. Improving care through collaboration with schools;

**Special topics:1.**  Incorporating patient voice: identifying and hearing from patients “what matters most”;**2. Using telemedicine as alternative visit type;** 3. Motivational interviewing; 4. The 4 M’s of age Friendly Care (What matters, using age friendly medications, mentation and mobility) 5. Patient and family advisory councils;

**Conditions:** 1. Emergency preparedness: Coronavirus; 2. **Obesity;** 3. Update on RI Affordability Standards; 4. Tobacco/Vaping/Marijuana use; 5. Sleep disorders; 6. Pre-diabetes

**Data Management:** **1. Using QI to solve complex social problems;** 2. Using Viewer to reduce unnecessary tests; use of Alerts to reduce hospital readmissions; 3. Best practice: implementing value based care: lessons learned from CPC+ practices; 4. Administrative simplification 5. Designing an effective leadership structure for achieving patient centered excellence in an ACO

**Patient centered medical home NCQA recognition** 1. How to hard wire and sustain PCMH recognition; 2. Practicing PCMH in a value based environment; **3. IBH: improving outcomes through meeting NCQA behavioral health distinction standards**