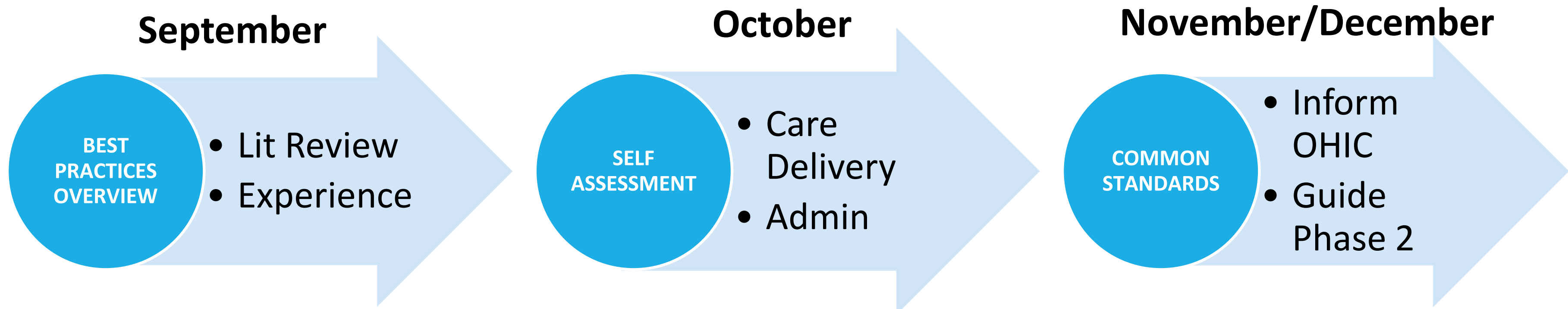
Phase I

GOAL: Further develop the ability of RI primary care practices to implement care delivery models that maximize success in comprehensive primary care capitation and total cost of care risk contracting.

DELIVERABLES:



Defining Success in Primary Care Capitation

- High value care
- More flexibility and innovation
- Financial sustainability for practices
- Improved provider satisfaction and decreased administrative burden
- Data and workflows identify patient needs; care experience addresses patient needs

Achieving Success in Primary Care Capitation

Core components of care delivery model

Our focus

Also needed

- Administrative capabilities
- Infrastructure
- Policies and workflows

Seeking Input: Pediatrics Component of Care Delivery Model for CPCC/TCOC

MUST HAVE

Expanded care teams

- IBH
- Care management (Rx, nursing)
- Health/wellness support
- Community health teams *(schools)*

Specialist referral network

Telehealth
(video visits as well as phone, text, email)

NICE TO HAVE

Open access scheduling

E-consult

Oral health

Group medical appointments

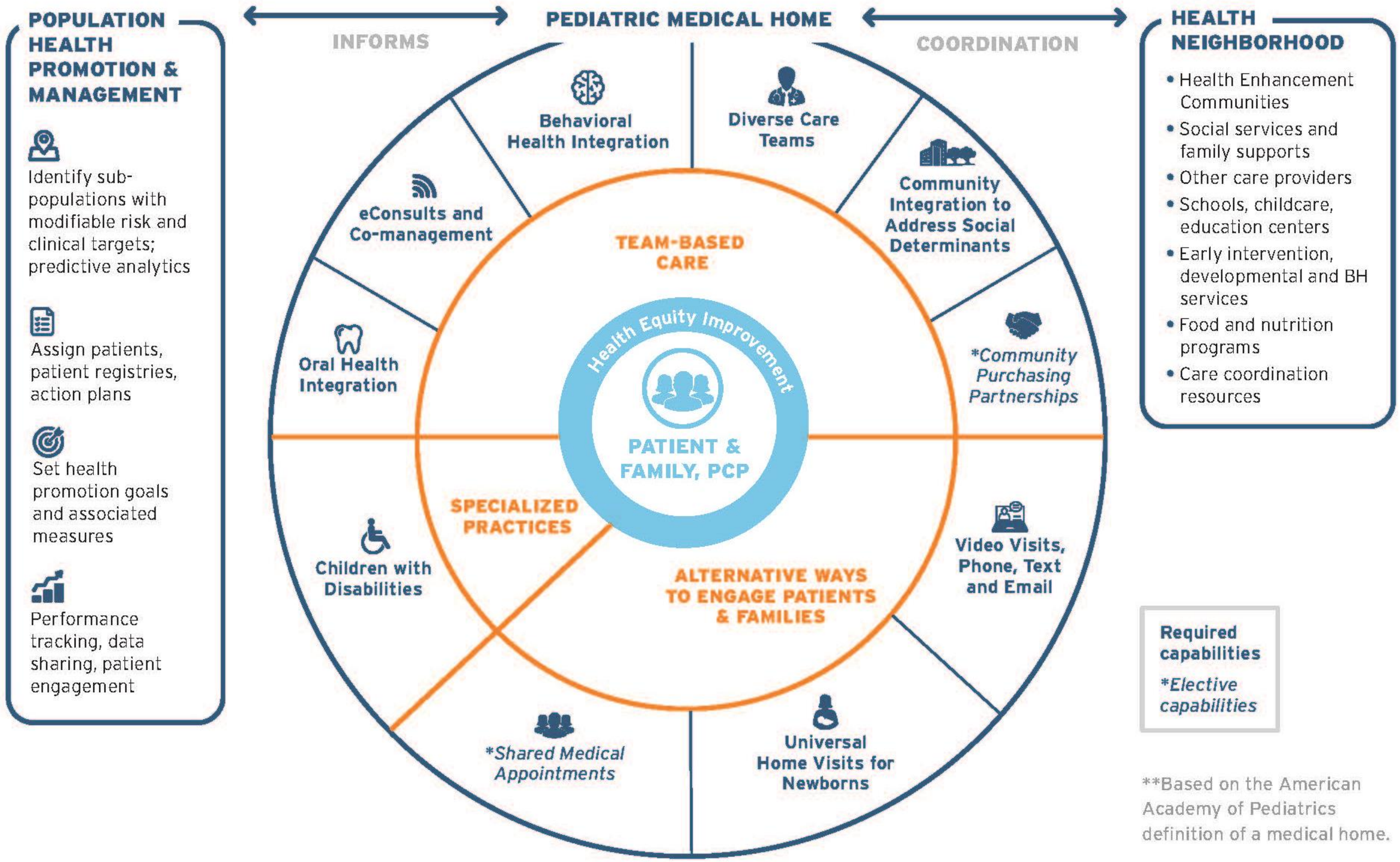
NOT NECESSARY

Contracts with community-based organizations

Remote patient monitoring

PEDIATRICS PRIMARY CARE MODERNIZATION CARE DELIVERY CAPABILITIES

Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.**

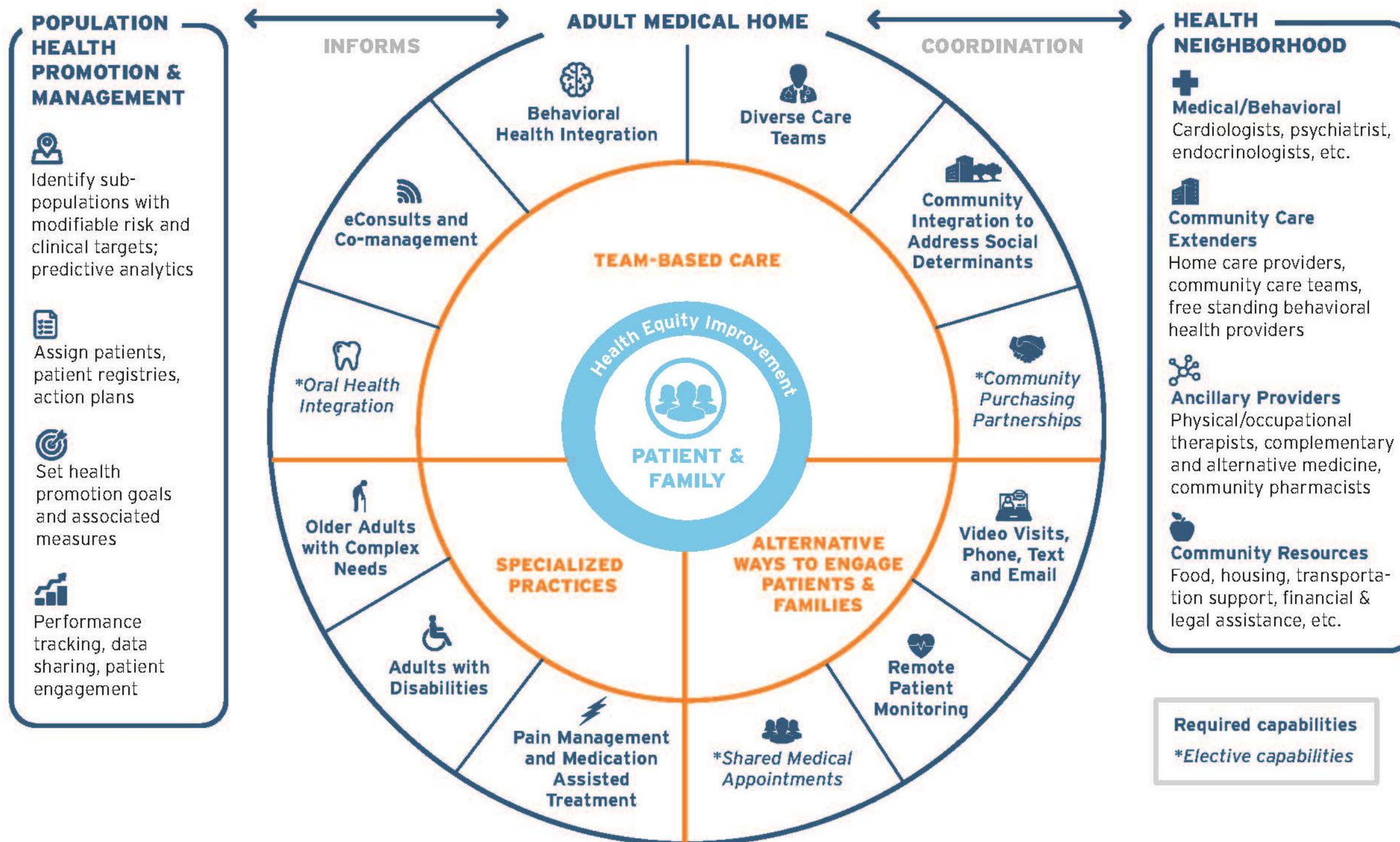


**Based on the American Academy of Pediatrics definition of a medical home.

NOTE: Developed by Freedman HealthCare for CT OHS Primary Care Modernization Initiative

Seeking Input: Adult Components of Care Delivery Model for CPCC/TCOC

MUST HAVE	NICE TO HAVE	NOT NECESSARY
Expanded care teams • IBH • Care management (Rx, nursing) • Health/wellness support • Community health teams	**Remote patient monitoring**	**Oral health**
Specialist referral network	**E-consult**	**Contracts with community-based organizations**
Telehealth (video visits as well as phone, text, email)	**Specialized practices** (e.g., geriatric care, substance use disorder treatment)	**Group medical appointments**
	Open access scheduling	



NOTE: Developed by Freedman HealthCare for CT OHS Primary Care Modernization Initiative

Steering Committee Input

- Majority of poll respondents agreed with classifications of care delivery components
- Strong support for remote patient monitoring as a “very nice to have”
- Less interest in open access scheduling
- Discussion of specialist referral network as necessary for TCOC, less so for CPCC

Discussion

- What are your priorities for developing additional core competencies to support success in CPCC/TCOC?
- How can our deliverables best support practices in developing these competencies?
  - Best practices summary document
  - Self assessment
- What did we miss?
  - Pediatrics
  - Adults

Appendix

Health in Rhode Island: A Long Term Vision

Vision: Rhode Island is the healthiest state in the nation.

All Rhode Islanders:

- Have opportunity to be in optimal health
- Live, work, learn, and play in healthy communities
- Have access to high-quality and affordable healthcare.

Goals:

1) Eliminate disparities in health and contributing economic factors.
2) Provide access to high-quality, affordable healthcare for all.
3) Focus on resources to maximize health and reduce waste

From: *Health in Rhode Island: A Long Term Vision*, Report from the Long Term Health Planning Committee, produced by Rhode Island Foundation, January 2020

Health in RI Outcome Measures

- Nearly 40 indicators based on Commonwealth Fund health measure as well as Health Equity measures.
- Includes areas such as
  - Financial burden healthcare
  - Access BH providers
  - Low birth weight
  - Infant and maternal mortality
  - Multiple utilization measures
  - Death rates chronic disease, alcohol, opioid, suicide
  - Housing cost and burden
  - Food insecurity
  - Transportation
- From: *Health in Rhode Island: A Long Term Vision, Evaluation Framework*. Report from the Long Term Health Planning Committee, produced by Rhode Island Foundation, January 2020

PCMH lays the groundwork for "Comprehensive Primary Care"

"Core Functions"
PCP/Team – Patient/Family

High Functioning Team based care

Population Health

Data Driven Quality Improvement

Sustainable Business Operations

Integrated Behavioral Health

- Mental Health
- Substance Abuse
- Pain Management
- Behavioral Change

Seamless Care
PCP-Specialist Collaboration
Hospitals/ ACOs
Aligned Financial Incentives

- Patient/Family Engagement
- Clinical Collaborations
- CHF, Palliative Care, etc.
- Pain Management

Community Health Teams

- Schools / CBOs
- Government
- Health Plans
- Employers