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

Agenda 5 27 21

|  |  |
| --- | --- |
| 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 NeedsContent 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 minutesLessons learned: Payment models (panel discussion people doing capitation models : CPC+, BCBS pilot with FQHC | Investing in Pediatric/Adult Care CoordinationContent expert: Person from “Got Transitions: Lessons learned: practices that participated in Health Care Transitions learning collaborative  | Investing in complex care managementContent 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 LinkagesContent expert: Somava Saha MD Lessons learned: Panel discussion: Health Equity Challenge participants  | Investing in Value: What’s working among the Accountable Entities? Content expert: TBDBest 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) |

|  |  |
| --- | --- |
|  | **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: JackieMcCole 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**