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pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Next Steps on the RI Roadmap to Comprehensive Primary Care

Care Transformation Collaborative of R.I.

CLINICAL STRATEGY COMMITTEE

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Vision of Comprehensive Primary Care

All Rhode Islanders live in the **healthiest communities** in the nation where the health of children, individuals and families is a primary goal. The health effects of **racism**, **poverty** and other factors are recognized and improved through ongoing strengthening of communities and community voices. **Strong community—clinical linkages** through **public—private partnerships** foster a high-quality, efficient, and cost-effective primary care based health care delivery system that works with community-based organizations and other stakeholders to improve **health equity and population health**.

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Defining and Implementing Comprehensive Primary Care Capitation (CPCC) in Rhode Island

In order to most effectively achieve the Quadruple Aim, all Rhode Islanders need access to strong and vibrant primary care that engages patients and families and contributes to community partnerships where they practice.

- **Key Outstanding Goals:**
  - Finalize practice and systems of care delivery models to maximize performance in CPCC and Total Cost of Care risk.
  - Promote Population Health and Health Equity through multi-sector alignment to address unmet social needs for patients, families, and communities.
  - **OHIC/Medicaid to handle CPCC payment**

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Proposed Work Streams: Guiding Questions

- What's missing?
- What needs to be modified?

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Improving Practice and Systems of Care Delivery Models to Maximize Performance

- Patient-Centered: **Embrace patient and family engagement and "persons with lived experience"**;
- Advanced Team-Based Care: (MA, NCM, PharmD, IBH clinical, CHW) In-person **and** virtual access at larger sites and in-person **or** virtual access at smaller sites. Responsible for universal screening and in-person or virtual hand-off for social and BH needs "community–clinical linkages" with CHW role specialized for pediatric/family/geriatric needs. **Balance SOC/practice-based services**;
- Data Aggregation: Work with stakeholders to optimize timely and actionable data through effective data gathering and aggregation and ongoing quality improvement.

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Improving Practice and Systems of Care Delivery Models to Maximize Performance (continued)

- Administrative Simplification / Improved Clinical Team Well-Being: Maximize technology use to enhance preventive and chronic disease care management and best practice workflows. **Support building a culture of health and health equity**. Help practices achieve a **flexible balance** of in-person, video and telephonic/ telemedicine visits, as well as texting, emails, virtual group visits, etc.;
- Low-Value Care: Focus on use of data, multi-sector projects and ongoing learning. Need COST TREND COMMITTEE ENDORSEMENT.
- Improve PCP–Specialist Collaboration: Agree on principles and implement ways to align incentives and payment.

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Proposed Care Delivery Work Stream

- Confirm basic care delivery model.
- Special attention for integrated pediatric care.
- Incorporate findings/information from Telemedicine, Integrated BH, Health Equity Challenge, and other collaboratives.
- Recommend common standards to consider in CPCC.

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Promote Population Health and Health Equity

- Define Roles of Practices, System of Care and Community-Based Organizations in Building Population Health: Need multi-sector alignment and **funding** to be successful. Current focus on building practice/SOC resources and CHT/HEZ network, that maximizes community–clinical linkages to better respond to place-based social/community needs and improves social determinants.
- Health Equity: Obtain multi-sector agreement for obtaining data to better understand and respond to adverse health effects on patients as well as children and families from poverty, systemic racism, behavioral health, poor schools and other environmental and social contributors.

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Population Health Work Stream

- Incorporate learning from Health Equity.
- Health Equity Challenge / Pathways to Population Health and consider other models to maximize community—clinical linkages.
- Evaluate best practice state and regional multi-sector population health payment models.
- Recommend multi-sector payment model to cover backbone CHT/HEZ network and potential population health PMPM for CPCC.

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Discussion

- What's missing?
- What needs to be modified?
- What else?