Transitional Payment Model (TPM) Deliverables

Physicians participating in TPM are expected to provide the following four main deliverables:

1. Establish a longitudinal relationship with patients, by providing ongoing family medicine services to a dedicated patient panel, which includes screening, prevention activities, chronic disease management, and comprehensive care:

- Physicians will be expected to document patient understanding and consent to the Most Responsible Physician (MRP) relationship with each empaneled patient. An empanelment process will be developed by Ministry of Health and the Saskatchewan Medical Association.
    - Physicians will be responsible for maintaining an accurate list of empaneled patients for whom they have accepted responsibility as the MRP as well as retain copies of all documentation.
    - The empaneled patient list will inform the next phases of the Saskatchewan made blended capitation model and will not be used to calculate payment under TPM.
- Physicians are expected to adhere to best practices in Chronic Disease Management.
    - Completion and submission of Chronic Disease Management-Quality Improvement Project (CDM-QIP) flow sheets are mandatory to ensure care aligns with approved guidelines.
    - Physicians participating in TPM should submit the currently available flow sheets. Updated flow sheets will be available by July 1st, 2024.
- Physicians participating in TPM are no longer eligible for program payments under the CDM-QIP (specifically, the $75 bonus for all indicators met per patient and per chronic condition in a 12-month period flow sheet). Fee-for-service payments for 64B through 68B services will continue.
- Physicians are expected to provide comprehensive care to their empaneled patients shared by a TPM clinic/group, including hospital and supportive care, nursing home care, pre- and post-natal and infant care, complete physicals including PAP smears, and phone calls from AHCP, where applicable. Fee-for-service payments for these services will continue and will be monitored.
- Physicians are expected to adhere to a set of Primary Care Quality Indicators, which will be jointly developed by the SMA and Ministry.
    - The Primary Care Quality Indicators will include existing CDM-QIP indicators in addition to newly developed indicators for health prevention, screening, and mental health.
    - Development of the primary care quality indicators will occur within the first six months of the implementation of TPM.
- Physicians are expected to adhere to common work standards for EMR/eHR patient- centered information exchange, as developed by the EMR Co-management Committee.
    - Work standards will include effective use of interoperability features, conditional upon availability of features, awareness of and training of features, and improved user experience of those features.
    - The SMA's and eHS's EMR teams will support physicians in this work.

2. Commitment to transition towards the Patient's Medical Home (PMH) framework:

- Physicians are expected to be part of a group with more than one Most Responsible Physician (MRP) participating in TPM.
    - There must be agreement among the group to share patient information to provide coverage among providers and deliver comprehensive care within the clinic/group.
    - Group identification should be maintained and available upon request.

- For solo clinics, joining a group of physicians in the same community or catchment area is encouraged, with all physicians willing to share patient information for coverage and comprehensive care. A minimum of two-family physicians enrolled in TPM per community or catchment area is required. This will reinforce the PMH framework by aligning clinic resources, cross-covering patients, and organizing to provide a full spectrum of care.
    - The SMA and the Saskatchewan Health Authority (SHA) are available to help the formation of physician groups. Please email PMH@sma.sk.ca for more information.
- Appointment of at least one family physician lead from the clinic or group to be a point of contact and liaison with SHA.
    - Physician leads should participate in PMH learning opportunities, SMA's Enhanced Use Program, HQC's QI in Clinics Program, and other relevant capacity-building activities.
    - Physician leads are paid an hourly rate from the Quality and Access Fund and identification of each lead must be available upon request.
- Providing on-call coverage for the group's patients.
    - Call schedules should be maintained and available upon request.

3. Commitment to address multiple relevant patient issues/concerns during one visit.

- To ensure a patient-centered approach, physicians must reasonably address multiple patient issues in the same visit.
- The Ministry will incorporate the functionality in the claims system to submit multiple diagnostic codes per patient contact. Once available, physicians are expected to utilize this functionality to demonstrate the frequency of multiple patient issues being addressed in one visit.

4. Physicians commit to assist the SMA and the Ministry to achieve improvements in longitudinal community-based family medicine delivery and patient outcomes:

- TPM Physicians will receive and utilize the Primary Care Panel Report from Health Quality Council SK.
    - A request for your individualized Primary Care Panel Report is available at https://www.bestpracticesask.ca/.
    - Physicians and clinics are encouraged to enroll in related education programs for the panel reports as they become available.
- Individual and clinic-level reports developed by the Ministry will be provided to physicians once available.
- Physicians will commit to necessary data tracking, sharing, and reporting that demonstrates improvements to longitudinal community-based family medicine delivery and patient outcomes as jointly developed by the MoH and the SMA.