

**State of Connecticut  
State Innovation Model Design  
Care Delivery Work Group**

**Monday, May 13, 2013  
Meeting Minutes**

**Location:** 500 Enterprise Drive Suite Hartford Room (Suite 3D) Rocky Hill, CT

**Members Present:** Robert McLean, MD; Mark Schaefer, PhD; Peter Bowers, MD; Meredith Ferraro; Alice Forrester; Jeff Howe, MD; Dawn Johnson; Sal Luciano; Adam Mayerson, MD; Lynn Rapsilber; Rosemary Sullivan; Thomas Woodruff, PhD; Bill Young; Robert Zavoski, MD

**Meeting convened at 7:30 a.m.**

**Introduce care delivery work group team**

The work group described the State Innovation Model (SIM) Grant and provided context for the work ahead. The goal is to align care delivery and payment across the state so that they may be measured in the same way. The model must demonstrate substantial savings while maintaining outcomes, with a meaningful impact on costs over the next 3-5 years.

The work group reviewed the goal to create an overarching model that the State can begin implementing in a standardized way and the Connecticut SIM design effort's governance structure. There is the State Healthcare Innovation Planning Team and three working groups: Care Delivery, Payment, and Health Information Technology.

**Share Connecticut's State Innovation Model context, vision, and roadmap**

The work group reviewed the context of the work ahead: determining the target population, the architecture of the model, the sources of value (areas of waste), and behaviors that the group will need to overcome.

**Review target population and align on prioritized sources of value**

The work group discussed the SHIP steering committee's recommendations to build a foundational model for the general population (e.g., chronic or at-risk elderly/adults, healthy elderly/adults, pregnant women/newborns, and children) upon which provisions could be added to accommodate the needs of Medicare-Medicaid dual eligibles and other special needs populations in future stages.

The group discussed three types of delivery models: population health, episodes of care, and discrete encounters, and discussed the benefits and limitations of each model.\

- A population-health based model would be more conducive for the state to achieve the scale of 80% of lives within 3-5 years, while an episode-based model would pose a significant challenge to scaling.
- The three models could potentially be complementary. Population management would require more of a "heavy lift" that would be a long term goal. The work could be rolled out in small pilots. In Arkansas, the work began with episodic care but they are now moving towards medical homes.

- ProHealth Physicians is implementing medical homes at all of their locations; they are discussing bundled payments with specialties; and they are looking at ways to reduce costs (i.e. using generics).

The group had a discussion around potential sources of value to prioritize for capture in the new care delivery model.

- It was shared that a recent CMS report was published regarding pricing data at hospitals showing significant pricing variability.
- The work group noted that in acute care situations, most people tend not to ask about prices.
- There was discussion regarding the use of emergency departments for primary care. It was noted that there are access and cultural reasons as to why people go to emergency departments rather than primary care physicians.
- An example of how a child guidance clinic performed 100 screens of mothers and found that while mothers took their children to the pediatrician, they themselves did not go to the doctor was shared as an illustration of the underutilization of appropriate care.
- An example of how ProHealth addresses high ER rates was shared: care coordinating nurses contact clients with higher emergency room rates. They also have expanded their office hours and changed the voice mail message to recommend clients contact their doctor as opposed to going to the emergency room.
- A program in the Bronx where community outreach workers could help educate people on their care plans while providing social and behavioral health benefits was also discussed.
- The group also discussed health disparities in the State, including the social determinants of health that the state has looked into.

It was noted that there are parallel processes taking place with workforce alignment, education and training. One of the ways Connecticut can distinguish itself was to partner with the University of Connecticut and other training universities so that workforce training will align with the model.

The participants broke out into four groups. Each group picked a source of value and then generated a list of specific barriers.

Group 1's barriers included:

- Range of environmental barriers to reaching goals
- Lack of policies that institute changes in a positive way. For example, smoking cessation was most effectively promoted when an increased tax was implemented
- Lack of patient accountability

Group 1 noted that looking only at provider interaction was the wrong way to go

Group 2's barriers included:

- Access problems
- Lack of integration between primary care and behavioral health
- Limited peer to peer interaction and data-driven decision making
- Limited data flow back and forth between the payer and the provider

Group 3's barriers included:

- Lack of links between sites of care and knowledge of the way medical and non-medical providers work together
- Potential implement community based options
- Limited provider knowledge of the social causes of disease and consumer and patient literacy

Group 4's barriers included:

- Lack of understanding of individuals as “whole people” who could be encouraged to play a key role in their care

The work group discussed how it would share the work group's key takeaways with the members.

The co-chairs will synthesize the work group's recommendations and share at the SHIP Steering Committee. In advance of the next meeting (May 28), members were asked to think about interventions they had seen work and share them with the rest of the group.

**The meeting adjourned at 9:30 a.m.**