

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

**Tuesday, May 28, 2013
Meeting Minutes**

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

Members Present: Dr. Robert McLean (Co-Chair); Dr. Mark Schaefer (Co-Chair); Dr. Peter Bowers; Ms. Meredith Ferraro; Dr. Alice Forrester; Dr. Jeffrey Howe; Ms. Gaye Hyre; Ms. Dawn Johnson; Dr. Edmund Kim; Dr. Adam Mayerson; Ms. Laurel Pickering; Ms. Lynn Rapsilber; Dr. Elsa Stone; Ms. Rosemary Sullivan; Dr. Thomas Woodruff; Mr. William Young

Members Absent: Mr. Sal Luciano; Dr. Robert Zavoski

Meeting convened at 5:30 p.m.

Review SHIP's vision for care delivery, payment and HIT innovation

The State Health Care Innovation Planning team (SHIP) is crafting a vision for the model. An overview of the vision was provided.

Share care delivery work group roadmap/calendar through August

The work group reviewed the discussion from the previous meeting. The care delivery model must reach 80 to 90% of the state population, and therefore will first focus on the general population; however, there is interest in building in the foundational capabilities to provide quality care for special populations (e.g., those with highly complex medical or behavioral health needs). There was discussion on the use of patient navigators, community health workers, and other roles critical to the success of the model. Workforce strategy is a key component in the design of the model with the University of Connecticut and the Department of Public Health working in concert to determine how to adapt the workforce to the changing health care environment. Additionally, there will need to be effective engagement of consumers/patients. There was an overview of the tasks in the weeks ahead, and due to the amount of work required, there was discussion regarding adding an additional work group meeting in June.

Align on synthesis from the first work group discussion

There was discussion of the pros and cons of a population health versus episodes of care model. There were concerns that it may be difficult to reach the 80% population target within the five year period if an episodic model was used. The Connecticut State Employee Health Enhancement Program was discussed. Beginning in 2011, the state implemented a value based health care system designed to encourage the use of primary care over specialists/emergency room care. The program eliminates certain co-pays and requires certain screenings based on age/gender. If the employee does not participate in the program, or is not in compliance with all of the requirements of the program, he or she must pay an additional \$100 per month for insurance. To date, 98% of state employees had opted in with 98% of those currently compliant. Care Management Solutions (part of ConnectiCare) has been hired to manage the program. There is an internet portal where employees can track their progress.

The group discussed access to primary care and the difficulty consumers may experience trying to find a primary care provider. There is low availability/capacity of primary care providers and it can be difficult to recruit new ones. This issue is among those the group will try to address but some barriers may not be completely addressed within the 5 year period.

The group reviewed the hypothesis and rationale behind the pursuit of a population health based model. There was discussion regarding which health conditions could not be addressed in a population model (prenatal care, hip/knee/back surgery, cardiac surgery, oncologic care). Episodic care can be complicated and, as such, it can be difficult to determine the cost drivers. Standards and cost can vary from hospital to hospital. It may also require many episodes to be able to capture the total cost of care. However, it may be possible to layer episode based solutions onto a population health model.

The group discussed prenatal care and the number of possible birth outcomes based on health inequities. There may be pre-pregnancy interventions that can be put into place to encourage better outcomes. With hip and knee replacements, there could be tremendous up-front costs before the patient undergoes surgery. There are elements of care that take place outside of measurable periods. There was also discussion of the need to think about changes within the population during the five year performance period.

The group discussed looking at health care in other states. There is a movement in Vermont towards advanced primary care and universal coverage. While the economics/geography of Vermont may be different than Connecticut, their changes may be relevant for Connecticut.

Break out to identify and prioritize Connecticut-specific barriers along the stage of health that we want to address

Group members were asked to think about patient stories they had a personal stake in or use one of the provided examples. There was discussion of one example of a cardiac patient who suffered from a lack of care coordination. Among the issues raised was that one patient could be treated by as many as 90 people and there was a lack of communication with the patient and with the patient's primary care physician. No one took "ownership" of the patient's care to make sure prescriptions were filled and follow up appointments were kept, leading to a readmission. In Medicare, doctors must follow a post-operative code with a number of steps that must be completed. Once everything is documented, they receive a bulk payment. However, if the patient is readmitted within three days, the payment is returned. This practice could be expanded. Another potential solution came from California, where medical staff follow up with patients the day after they are discharged and they are provided with rides so they do not miss follow up appointments. Vermont uses community health workers to reach out to recently discharged patients. In the example, some of the barriers were lack of convenient access points, lack of coordination across providers, and lack of understanding of the broader person. The group discussed the importance of viewing patients as whole people with complex interrelated needs and not just individual problems.

Members broke out into three groups charged with thinking about behaviors that impede health, process changes that impede delivery (i.e. flow of information), and structure (IT/EHR needs). Each group was assigned a type of case: 1) a patient who is well until he/she is diagnosed with an illness; 2) a patient treated in an acute setting; 3) a patient with chronic condition management needs. After compiling a list of barriers encountered along the patient journey, each group prioritized them.

Group 1 discussed:

- The limited understanding of the whole person concept
- Limited use of health assessments within the primary care structure
- Lack of consistent touch points with a primary care physician
- The absence of one person who understood the full story of the patient's care
- Lack of patient health care literacy
- The limited ability of a provider to understand the patient's hierarchy of needs
- Lack of incentive for the patient to engage in healthy behaviors
- Lack of funding for non-health specific interventions

Group 2 discussed the need to build a structure around transition of care. This discussion included:

- Having one person accountable able to follow up with the patient such as a care coordinator who could put interventions into place
- The importance of communication during transitions
- How the choices a person makes in receiving care can impact the outcome
- Lack of whole person knowledge, including cultural and linguistic barriers
- The need to build processes on top of structure
- Overcoming patient phobias and providing them with tools they feel comfortable using

Group 3 discussed care coordination and chronic disease management. This discussion included

- The idea of using the right provider at the right time (the overuse of specialists, the emergency room)
- Communication between providers and the gaps in transitions
- The idea some patients have that the more doctors they see, the better care they are receiving
- Encouraging providers to work outside of their silos and with other types of providers
- The lack of time providers spend with patients
- Exterior factors (patient compliance)
- Access to and cost of care
- Information technology that enables care coordination across providers, diagnoses
- The use of financial incentives to encourage healthy behaviors

Discuss next steps

The goals for the June 10 meeting are: 1) to prioritize the set of barriers and determine which are easily addressable within a population health model; 2) determine what could be done differently; 3) reflect on the patient journey and examine sources of value in relation to the patient journey.

As much discussion has centered around community health workers, an upcoming community health work symposium was announced. The symposium, to be held on June 21 at Gateway Community College in New Haven, is focused on the role of community health workers in delivering public health programs and services in Connecticut. The symposium is sponsored by the Southern Connecticut State University Department of Public Health. Additional information on the symposium will be forthcoming.

Some adjustments were made to the meeting schedule. Meetings will now begin at 6 p.m. and members were asked to reserve June 17 for an additional meeting.

Meeting adjourned at 8 p.m.