

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

**June 17, 2013
Meeting Minutes**

Location: 500 Enterprise Drive, Rocky Hill, CT

Members Present: Dr. Robert McLean (Chairman); Dr. Mark Schaefer (Co-Chair); Dr. Daren Anderson; Dr. Peter Bowers; Ms. Meredith Ferraro; Dr. Alice M. Forrester; Dr. Jeffery R. Howe; Ms. Gaye Hyre; Dr. Edmund Kim; Dr. Adam Mayerson; Mr. Bill Morico (for Dr. Thomas Woodruff); Dr. Donna O'Shea; Ms. Laurel Pickering; Ms. Lynn Rapsilber; Dr. Elsa Stone; Mr. William Young; Dr. Robert Zavoski

Members Absent: Dr. Mehul Dalal; Ms. Dawn H. Johnson; Mr. Sal Luciano; Ms. Rosemary Sullivan

Meeting convened at 6 p.m.

Review synthesized interventions and prioritized top 2-3 within each element of CT's population health based model

The group reviewed the work from the previous meeting on care delivery interventions needed to capture sources of value. Members broke out into the same small groups as last week to prioritize the interventions based on their ability to deliver quality and cost savings improvements.

Group 1 considered interventions under care model elements "whole person centered care and population health management" and "consumer engagement." They discussed patients with complex care needs who may not appropriately self-manage and use services today. They discussed the need to improve these patients' health literacy – encouraging and educating consumers in healthy behaviors and the appropriate use of care services such as through the "Choosing Wisely" campaign. They also discussed the potential for a statewide employer education initiative.

Group 2 discussed "enhanced access to care" and "team-based, coordinated care" outside of face to face encounters. They discussed the opportunity for PCPs to consult specialists electronically – e-consults could be handled through secure e-mail, eliminating the need for a patient travel to the specialist's office. They discussed the role of a care coordinator in a primary care office that would, for example, facilitate care between different providers; do pre-visit planning; and follow up with referrals. They also discussed the importance of integrating behavioral health and primary care.

Group 3 focused on "evidence-informed clinical decision making" and "performance management." They discussed the need for practices to risk stratify patients, leverage actionable data and use predictive risk modeling. These interventions enable identification of high risk, high utilizers (e.g., frequent ED) patients and use a team approach to address their needs. The system could look at the whole population but allow for discrete interventions on certain sub-populations. They also discussed how a practice might measure performance on dimension of patient centeredness, as well as standardization of methods.

Discuss the types of individuals who need to be involved in the care delivery and how they should interact

Following the small group presentations, members broke back out into groups to discuss the potential health care roles in the intervention and how they would interact with one another. They looked at who they would want in a medical home and how community health and other workers might fit in. Members were encouraged to look beyond what currently exists. Due to a lack of time, group representatives were asked to help finalize output over email.

Discuss the nature of interactions between individuals required and implications on care delivery model design

The group had a lengthy discussion of whether, in care coordination, there should be one leader that is held accountable or an entire team. A primary care medical home would need to integrate behavioral health while a behavioral health medical home would need to embed primary care. The group touched upon the risk of conflict between potential leaders and how hand offs between leaders could occur. They discussed whether they needed to look at a closed system that encourages trust between primary care physicians and the other providers they worked with. They discussed accountability and liability and whether Safe Harbor provisions were needed. It is helpful to patients if there is someone to help them navigate the system. One provider example was given of successful hand offs occurring between different groups within the organization through use of electronic medical records and a supervising attending physician. The Payment Reform group is looking at attribution and moving from a fee for service pay structure to a value based payment system. Members were asked to think about who they wanted to be the lead, whether the medical home would be based around a physician, and how hand offs to specialists would occur.

Assess outcomes from today's meeting and outline open questions

- Group representatives will receive instructions in the next couple of days over e-mail to help finalize output from break out discussions.
- Group members were invited to tour the Family Medicine Center at Asylum Hill in Hartford which is a level 3 patient centered medical home.
- There were questions remaining about the use of community health workers. Group members will be sent information that shows how the field is evolving nationally. Additionally, there is a symposium on community health workers at Gateway Community College on Friday, June 21.

Meeting adjourned at 8:30 p.m.