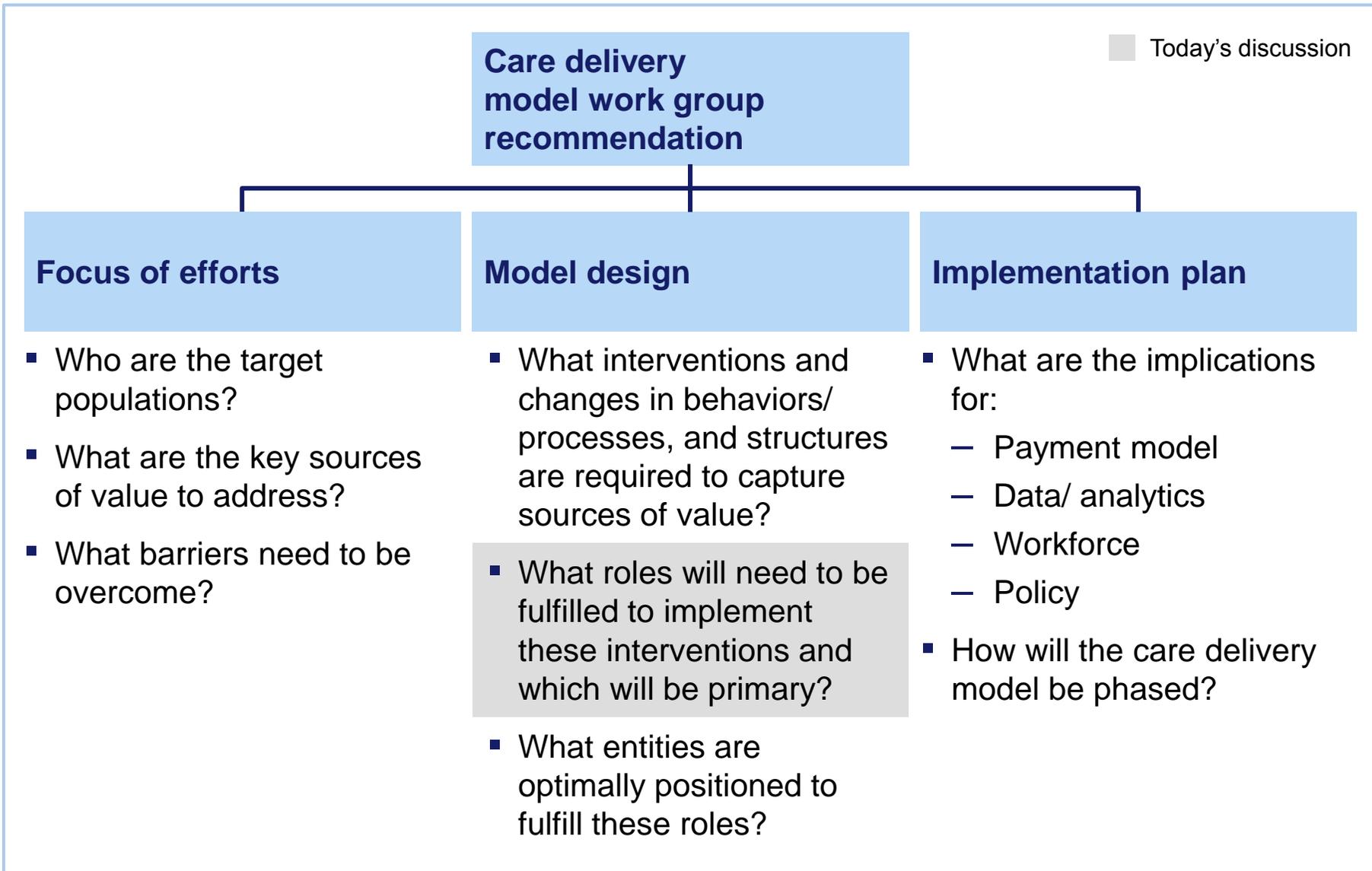




Care delivery model work group meeting #4

Discussion document
June 17, 2013

We are making good progress answering the key care delivery questions



Agenda

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

30 min

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

45 min

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

30 min

Assess outcomes from today's meeting and outline open questions

15 min



Today we will discuss who should deliver care in our new model

- Last week we discussed interventions along each element of a population health model
- Today we will prioritize the most critical interventions
- We will discuss which individuals should be involved in the model and how they should interact
- We will then discuss the implications of desired interactions on care delivery design



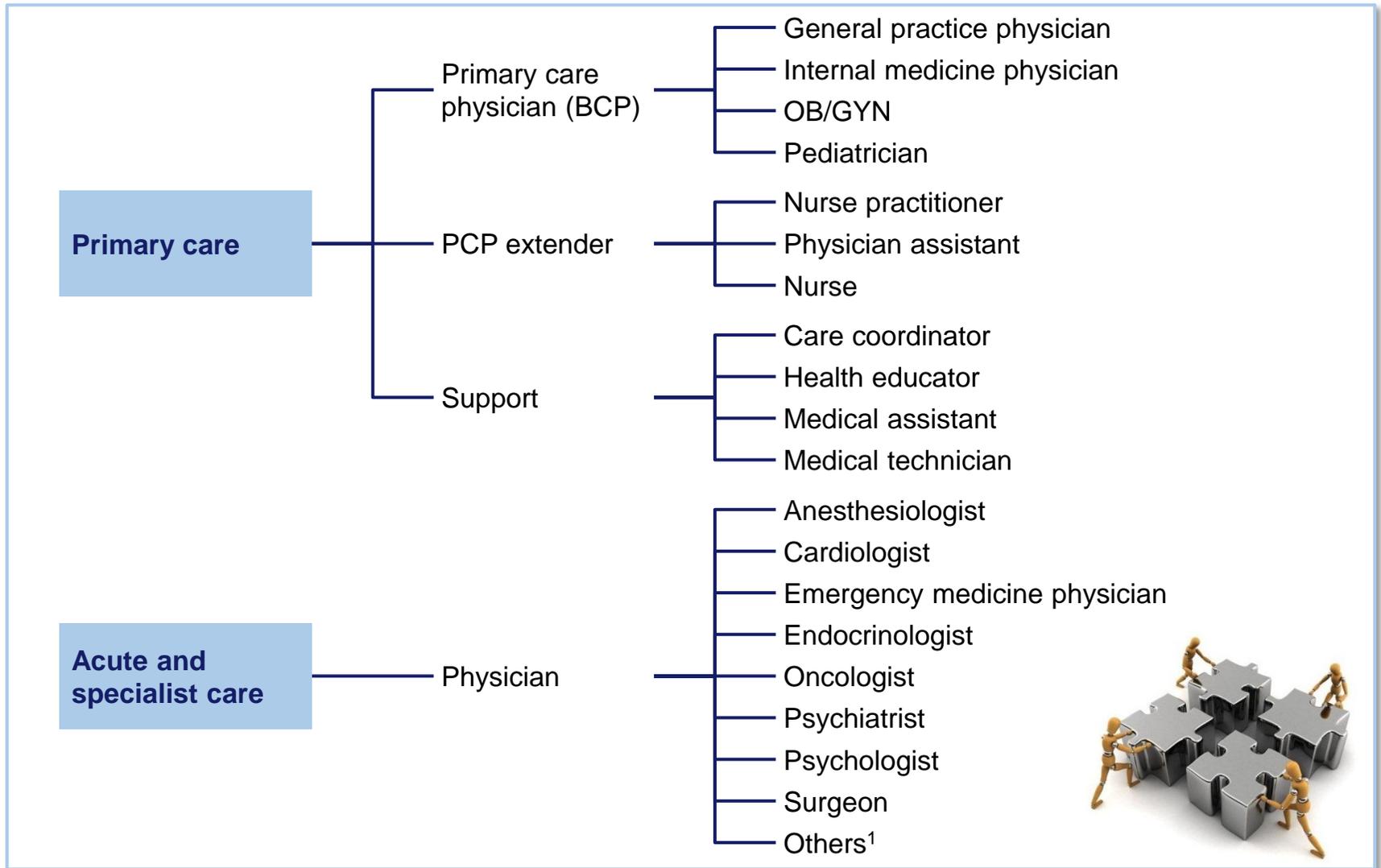
We will review the synthesis from last week's breakouts and prioritize among the interventions

BREAKOUT EXERCISE INSTRUCTIONS

- **Breakout:** Break out into the same 3 groups as last week to prioritize the most critical interventions (20 min)
 - Review synthesis of last week's discussion
 - Identify 2-3 most critical interventions to Connecticut's population health model from among this list based on ability to improve health outcomes and achieve cost impact
- **Report back:** Come back together to share group's thinking (10 min)
 - Playback the group's 2-3 prioritized interventions, with the tangible set of health outcomes and cost of care metrics each will impact

We will consider the individuals who should be involved in the care team and beyond (1 of 2)

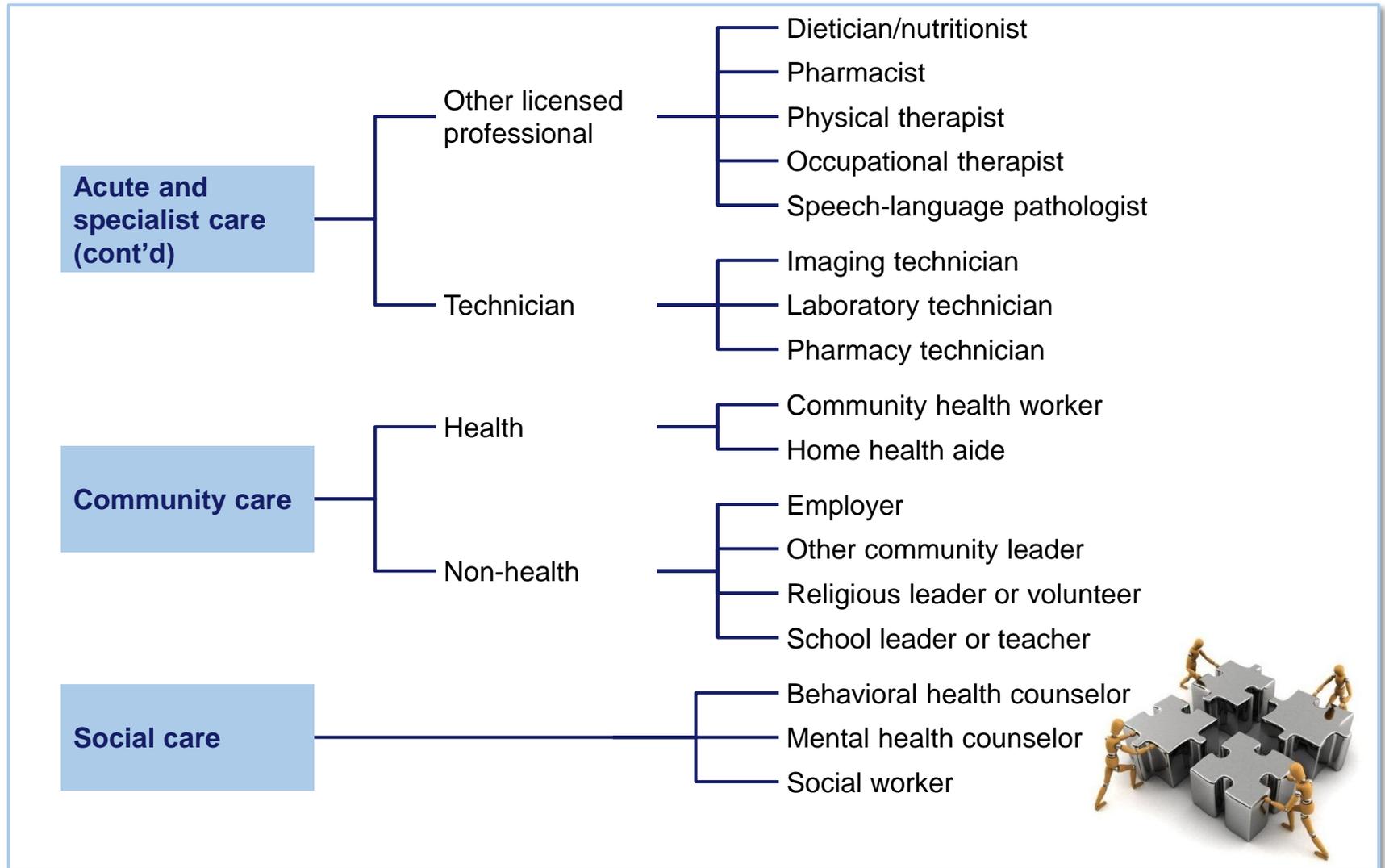
NOT EXHAUSTIVE



¹ Others include: allergist, dermatologist, geriatric physician, medical genetics physician, neurologist, ophthalmologist, orthopedist, otolaryngologist, pathologist, plastic surgeon, radiologist, urologist

We will consider the individuals who should be involved in the care team and beyond (2 of 2)

NOT EXHAUSTIVE



These individuals can play different roles in delivering care (1 of 2)

Role	Example
Supports consumers over time to help them maintain or improve their health	<ul style="list-style-type: none">▪ Primary prevention for healthy consumers▪ Care for chronically ill consumers (e.g., management of chronic heart failure (CHF))
Delivers care for a specific condition or health issue at the lowest possible cost	<ul style="list-style-type: none">▪ Acute procedures (e.g., hip replacement, coronary artery bypass graft (CABG))▪ Most inpatient stays, including post-acute care and readmissions▪ Acute outpatient care (e.g., broken arm, URI, some cancers, some behavioral health issues)
Delivers a discrete high-quality product or service at the lowest possible cost	<ul style="list-style-type: none">▪ Discrete services provided by an entity with limited influence on upstream or downstream costs and outcomes (e.g., imaging, drugs and devices, health risk assessments)

These individuals can play different roles in delivering care (2 of 2)

STRAWMAN DRAFT FOR DISCUSSION

	Supports patients over time	Delivers a specific outcome	Delivers a product or service
Primary care	<ul style="list-style-type: none"> General practice Internal medicine OB/GYN Pediatrician Nurse Nurse practitioner Physician assistant Care coordinator Health educator 		
Acute and specialist care	<ul style="list-style-type: none"> Endocrinologist Psychiatrist Psychologist Dietician/nutritionist 	<ul style="list-style-type: none"> Cardiologist Emergency medicine physician Oncologist Surgeon Other physicians¹ 	<ul style="list-style-type: none"> Anesthesiologist Pharmacist Physical therapist Occupational therapist Speech-language pathologist Imaging technician Laboratory technician Pharmacy technician
Community care	<ul style="list-style-type: none"> Community health worker Home health aide Employer Other community leader Religious leader or volunteer School leader or teacher 		
Social care	<ul style="list-style-type: none"> Behavioral health counselor Mental health counselor Social worker 		

¹ Others include: allergist, dermatologist, geriatric physician, medical genetics physician, neurologist, ophthalmologist, orthopedist, otolaryngologist, pathologist, plastic surgeon, radiologist, urologist

We will discuss in groups how individuals should interact to apply interventions

BREAKOUT EXERCISE INSTRUCTIONS

- **Breakout:** Break out into same 3 groups to identify individuals which can deliver interventions and prepare to share group's perspectives on: (25 min)
 - What individuals need to be involved in the delivery of care to an individual to be able to implement the specified interventions
 - Discuss how these individuals should interact with one another and who should play a leadership role
- **Report back:** Convene in the large group and share findings (20 min)
 - Present findings from each group (one representative)

Note that in addition to synthesizing each group's output, interventions that overlapped were placed into the most appropriate category so some may be missing from a given group's poster, but will be reflected elsewhere

For group discussion: the nature of interactions between individuals required has implications for care delivery design

STRAWMAN FOR DISCUSSION

What interaction model is required among the individuals involved in care delivery?

- Should there be a leader and if so, who should the leader be?
- What is the required frequency and regularity of interactions across individuals?
- How much HIT and other data need to be shared for effective delivery of care (e.g., direct messaging)?
- How standardized should clinical protocols be?
- Should we aspire to have providers share a common, standard panel of patients?
- What level of financial integration is required to support the level of desired interaction, standardization, and information sharing?

Care delivery work group: June 17 meeting areas of alignment and open questions

FOR DISCUSSION

- Where did we land on prioritized interventions?
 - *To be completed*
- What did we conclude about the individuals required to execute care delivery interventions and their interactions?
 - *To be completed*
- What are the implications on care delivery design?
 - *To be completed*
- What open questions do we need to address in the next work group meeting?
 - *To be completed*

**TO BE COMPLETED JOINTLY BY
WORK GROUP**



- Reflect on implications of today's discussion on Connecticut's workforce
- Synthesize findings and prepare for discussion on June 24th

Backup

System-level changes raised in break out groups, not included in provider-level list of interventions

- Attract primary care doctors and advanced practice registered nurses with loan forgiveness and other creative solutions
- Embed whole person care approach in medical system (e.g., throughout training, incentives)
- Enhance primary care practice for common clinical presentations to improve outcomes and/or reduce unnecessary reliance on specialist care
- Give provider practices quality improvement, outreach, and practice transformation support
- Improve health equity and preventive care
- Increase provider acceptance of Medicaid consumers
- Leverage minute-clinic model
- Provide portable data which follows the patient
- Reduce paperwork burden on primary care practices
- Remove co-payments for preventive care¹
- Support value based insurance¹

¹ This will need to be a payer-specific decision

Breakout group: Whole person centered care and population health management

1 Whole-person-centered care and population health management

- Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to identify high risk consumers

Interventions

- Identify consumers with high-risk or complex care needs
- Identify consumers with conditions related to health behaviors, mental health or substance abuse problems
- Identify socially vulnerable consumer populations (e.g., childhood exposure to trauma)¹
- Assess and document consumer risk factors and health literacy levels¹
- Assess consumer/family self-management abilities¹
- Assess oral health needs

Individuals delivering interventions & their interactions

¹ Can be outsourced but needs to be performed at point of care

2

Enhanced access to care (structural and cultural)

- Provide consumers access to culturally and linguistically appropriate routine/ urgent care and clinical and mental health advice during and after office hours
- Care should be accessible in-person or remotely (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

Interventions

- Provide access to culturally (e.g., bilingual clinicians), socially (e.g., in neighborhoods where patients have personal connections) and linguistically appropriate care near consumer populations (e.g., geographic proximity) to improve health equity
- Offer extended hours access to routine and urgent care and clinical advice (e.g., evenings and weekends)
- Communicate with consumers across multiple modes (e.g., email, text to ensure all have access to information)
- Enhance access to specialty care via non-visit-based access to specialist services (e.g., e-consult)
- Ensure human contact throughout the care journey (e.g., someone at office answers phone, knows patient)
- Provide information on where consumers should go for different care needs and on which physician offices are open at different times
- Enhance primary care practice for common clinical presentations to improve access to care traditionally delivered by specialists

Individuals delivering interventions & their interactions

Breakout group: Team-based, coordinated, comprehensive care

3

Team-based, coordinated, comprehensive care

- Leverage multi-disciplinary teams and enhanced data sharing to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and successful care transitions across care settings and care disciplines (e.g., medical, social, behavioral)

Interventions

- Provide team-based care from trained staff
- Embed care coordinator in practice
- Closely integrate behavioral and primary care with “warm hands offs” between behavioral and primary care practitioners (on-site if possible)
- Coordinate care including preventive, oral, behavioral, and complementary providers and services
- Emphasize pre-visit planning, assess consumer progress toward treatment goals, and address consumer barriers
- Use intensive case management across time and care settings
- Track, follow-up on and coordinate tests, referrals and care at other facilities (e.g., support hospital discharge planning)¹
- Reconcile consumer medications at visits and post-hospitalization
- Ensure consumer compliance with medications
- Deliver care at sites of intervention conducive to consumers’ environment (e.g., community centers) to be most effective
- Leverage peer support for consumers with chronic conditions or behavioral health issues
- Engage/coordinate with nonmedical services (e.g., housing), domestic violence resources) and other support groups as appropriate (collaboratives where available)

Individuals delivering interventions & their interactions

¹ Ensure provider accountable for this

Breakout group: Consumer engagement

4

Consumer engagement

- Appropriately educate and encourage consumers to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to follow-through on care plans, and administer self-care as needed

Interventions

- Work with and support consumers/families in developing a self-care plan and provide tools and resources, including community resources
- Counsel consumers on healthy behaviors (e.g., exercise, nutrition), targeting windows of change
- Institute shared decision-making with consumers
- Communicate at literacy level appropriate for consumers
- Advise consumers with chronic health conditions on methods to monitor and manage their own conditions
- Ensure consumers/caregivers are educated and actively engaged in their rights, roles and responsibilities
- Establish mechanism to engage consumers/care givers and potentially partner with community groups
- Provide consumers immediate, electronic access to their health care information
- Provide consumers transparent cost and quality data
- Host community group sessions (e.g., by disease type)

Individuals delivering interventions & their interactions

Breakout group: Evidence-informed clinical decision making

5

Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness

Interventions

- Adhere to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines
- Use e-prescribing to ensure medication orders are clear and accurate
- Demonstrate utilization of PCORI (Patient-Centered Outcomes Research Institute) data
- Apply principles of Choosing Wisely
- Use patient risk stratifiers to enable targeted effort based on evidence
- Leverage ADT (Admission, Discharge & Transfer) to optimize patient care workflow
- Update discharge medication lists and reconcile
- Use multi-layer, diverse team to enable data synthesis and reconciliation
- Use electronic medical record (EMR) which collects actionable data
- Maintain disease registry

Individuals delivering interventions & their interactions

Breakout group: Performance management

6

Performance management

- Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to improve and compare performance with other providers

Interventions

- Participate in external benchmarking activities to compare key performance measures¹
- Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits)¹
- Use performance and consumer experience data to continuously improve
- Establish learning collaboratives to disseminate best practices
- Demonstrate that ongoing improvement is occurring by conducting quality improvement studies
- Assess and monitor consumers/caregivers' capability in effectively performing self-care responsibilities
- Share data on provider cost and quality (data transparency) to influence referral patterns and consumer choice
- Share best practices and processes (not necessarily tied to payment)
- Maintain a current and comprehensive written quality management and improvement program

Individuals delivering interventions & their interactions

¹ Requires ability for provider to dispute outcomes

6/10 Care Delivery Work Group Output: Whole person centered care and population health management – Interventions

Identified as high priority abc Added by group

1

Whole-person-centered care and population health management

- Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer’s health
- Assess and document consumer risk factors to identify high risk consumers

Listed by accreditation or legislative bodies

- Identify consumers with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, behavioral health or substance abuse problems
- Identify **socially** vulnerable consumer populations (e.g., advanced childhood exposure to trauma)¹
- Assess and document consumer risk factors and **health literacy levels**¹
- Assess consumer/family self-management abilities¹
- Assess and develop plan for mental/behavioral health
- **Engage/coordinate with**, in appropriate cases, nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups (**collaboratives where available**)
- Use strategies to address stresses that arise in the workplace, home, school etc.
- Collect demographic and clinical data for population management

Added by work group for Connecticut

- Assess and develop plan for oral health
- Embed whole person care in medical system (e.g., in training, incentives)
- Provide “navigator”/coordinator role across full patient needs in a timely way (e.g., community health worker)

¹ Can be outsourced but needs to be performed at point of care

6/10 Care Delivery Work Group Output: Enhanced access to care (structural and cultural) – Interventions

Identified as high priority abc Added by group

2 Enhanced access to care (structural and cultural)

- Provide consumers access to culturally and linguistically appropriate routine/ urgent care and clinical and mental health advice during and after office hours
- Care should be accessible in-person or remotely (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

Listed by accreditation or legislative bodies

- Provide consumers with access to culturally and linguistically appropriate (e.g., bilingual clinicians) routine/urgent care and clinical advice during and after office hours (e.g., readily accessible 24-hour consultative services by telephone or quickly scheduled office appointments)
- Provide electronic access to data (e.g., consumers can receive a secure electronic copy of their health information, consumers and their families can correspond over email with providers, consumers can set up appointments online)

Added by work group for Connecticut

- Attract primary care doctors and APRNs to Connecticut with loan forgiveness or other creative solutions (e.g., immunity from medical malpractice claims)
- Expand behavioral health capacity or find ways to creatively deliver (e.g., through community centers)
- Provide consumers with information on where they should go for different care needs and on which physician offices are open at different times
- Offer consumer human contact throughout care journey (e.g., person who works at office picks up phone)
- Communicate with consumers in multiple ways to ensure those without access to computers are not left out
- Increase provider acceptance of Medicaid consumers
- Ensure geographic proximity of care to consumer populations
- Offer extended hours on weekends and late nights
- Deliver care in neighborhoods where patients have personal connections
- Remove co-payments for preventive care

6/10 Care Delivery Work Group Output: Team-based, coordinated, comprehensive care – Interventions

Identified as high priority abc Added by group

3

Team-based, coordinated, comprehensive care

- Leverage multi-disciplinary teams and enhanced data sharing to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and successful care transitions across care settings and care disciplines (e.g., medical, social, behavioral)

Listed by accreditation or legislative bodies

- Focus on team-based care with trained staff
- Coordinate and provide access to preventive, health promotion, and complementary and alternative services
- Emphasize **pre-visit planning**, assess consumer progress toward treatment goals, and address consumer barriers
- Track, follow-up on and coordinate tests, referrals and care at other facilities (e.g., hospitals) – **be accountable for following up**
- Provide discharge planning and counseling to consumers and their caregivers
- Reconcile consumer medications at visits and post-hospitalization
- Use e-prescribing (e.g., generate consumer specific alerts at site of care, including drug-drug interactions, informs clinicians of generic alternatives when appropriate)

Added by work group for Connecticut

- Tailor site of intervention to consumers' environment (e.g., community centers) to be most effective
- Leverage peer support
- Use intensive case management across time and care settings
- Ensure whole-patient approach - identify both physical and behavioral health issues leading to illness
- Build screening for mental/behavioral health issues into practice
- Closely integrate behavioral and primary care with “warm hands offs” between behavioral and primary care practitioners (on-site if possible)
- Engage patients with care
- Ensure compliance with medications
- Give practices quality improvement, outreach, and practice transformation support
- Embed care coordinator in practice

6/10 Care Delivery Work Group Output: Consumer engagement – Interventions

Identified as high priority abc Added by group

4 Consumer engagement

- Appropriately educate and encourage consumers to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to follow-through on care plans, and administer self-care as needed

Listed by accreditation or legislative bodies

- Work with **and support** consumers/families in developing a self-care plan and provide **tools and resources**, including community resources
- Counsel consumers on healthy behaviors, **targeting windows of change**
- Support consumers in setting and accomplishing goals related to exercise, nutrition, use of tobacco, and sleep
- Advise consumers with chronic health conditions on methods to monitor and manage their own conditions
- Ensure consumers/caregivers are educated and actively engaged in their rights, roles and responsibilities in the **shared decision-making process**
- Establish mechanism to engage consumers/care givers, **potentially partner with community groups**

Added by work group for Connecticut

- Institute shared decision-making with consumers
- Communicate at literacy level appropriate for consumers
- Host community group sessions (e.g., by disease type)
- Fully coordinate with available resources
- Provide patients immediate access to their health care information
- Offer transparent cost and quality data

6/10 Care Delivery Work Group Output : Evidence-informed clinical decision making – Interventions

Identified as high priority abc Added by group

5 Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness

Listed by accreditation or legislative bodies

- Adhere to professionally accepted standards of practice, manufacturer’s recommendations, and state and federal guidelines
- Put policies in place to assign and implement interventions for clinical condition based on clinical or evidence-based guidelines
- Ensure medication orders are clear and accurate

Added by work group for Connecticut

- Use e-prescribing to ensure medication orders are clear and accurate
- Demonstrate utilization of PCORI (Patient-Centered Outcomes Research Institute) data
- Use patient risk stratifiers to enable targeted effort based on evidence
- Maintain disease registry
- Leverage ADT (Admission, Discharge & Transfer) to optimize patient care workflow
- Update discharge medication lists and reconcile
- Provide portable data which follows the patient
- Use multi-layer team to enable data synthesis and reconciliation
- Use electronic medical record (EMR) which collects actionable data

6/10 Care Delivery Work Group Output: Performance management – Interventions

Identified as high priority abc Added by group

6 Performance management

- Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to improve and compare performance with other providers

Listed by accreditation or legislative bodies

- Participate in external benchmarking activities that compare key performance measures with other similar organizations, or with recognized best practices¹
- Track utilization measures such as rates of hospitalizations and ER visits and **drivers of utilization (e.g., after hours visits, diagnosis codes)**¹
- Use performance and **consumer experience data to continuously improve**
 - Demonstrate that ongoing improvement is occurring by conducting quality improvement studies
 - Assess and monitor consumers/caregivers' capability and confidence in effectively performing self-care responsibilities
 - Maintain a current and comprehensive written quality management and improvement program
 - Develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records

Added by work group for Connecticut

- Share data on provider cost and quality (transparent) to influence referral patterns
- Establish learning collaboratives to disseminate best practices
- Share best practices and processes (not necessarily tied to payment)

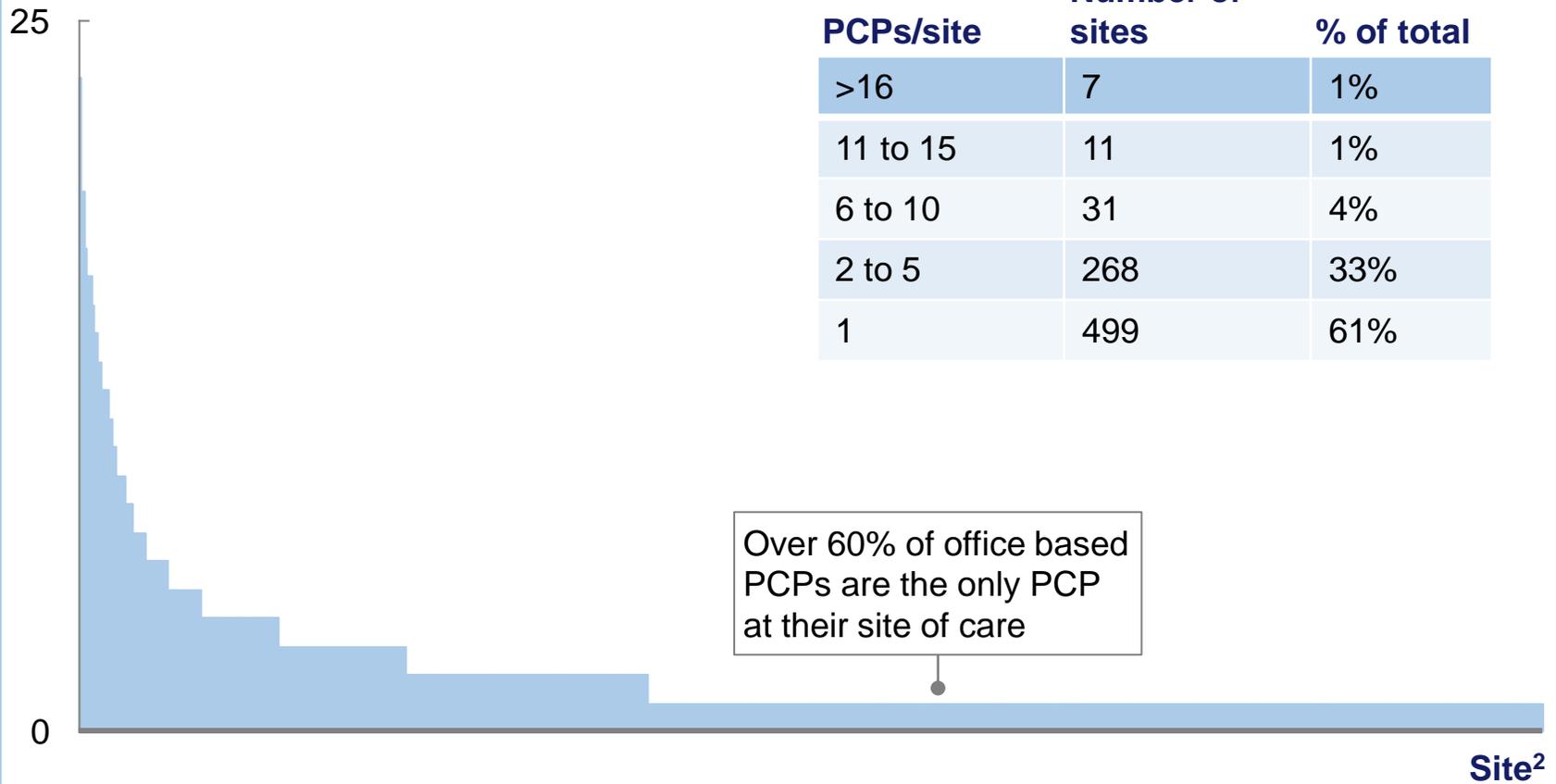
¹ Requires ability for provider to dispute outcomes

Long tail of sites of care with a single PCP

PCP fragmentation¹

PCPs per site in Connecticut (n=~800 sites, ~1740 PCPs)

PCPs on site



¹ PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists

² Total number of sites = ~800sites in Connecticut with at least one PCP

SOURCE: SK&A data (~800 sites captured). Methodology: information collected from medical trade associations , phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

Office based primary care physician landscape varies slightly across the counties in CT



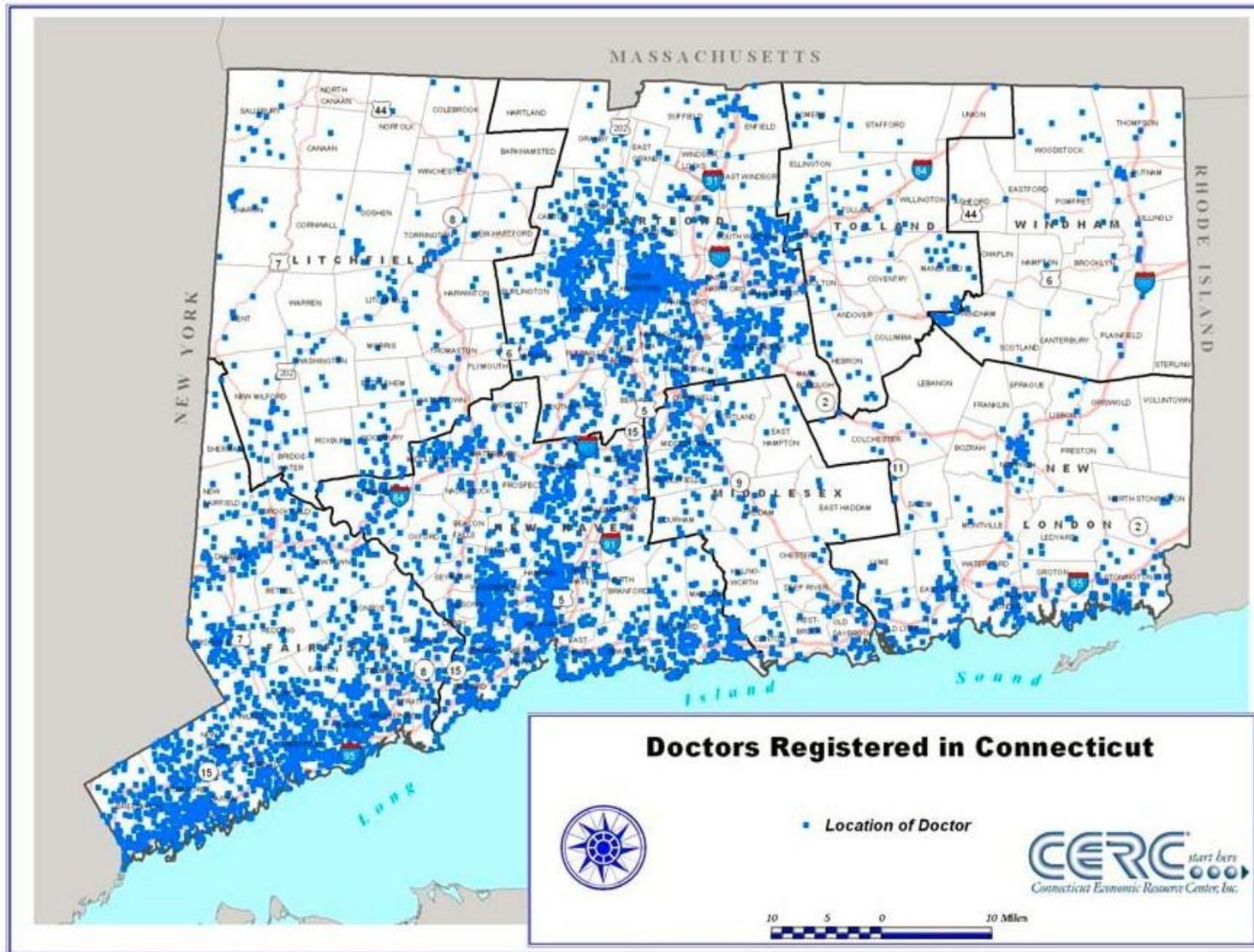
Legend
Office based PCPs¹/100,000 population

- >70
- 60-70
- <60

¹ Includes general practitioners, family practice, and internal medicine

SOURCE: SK&A data. Methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

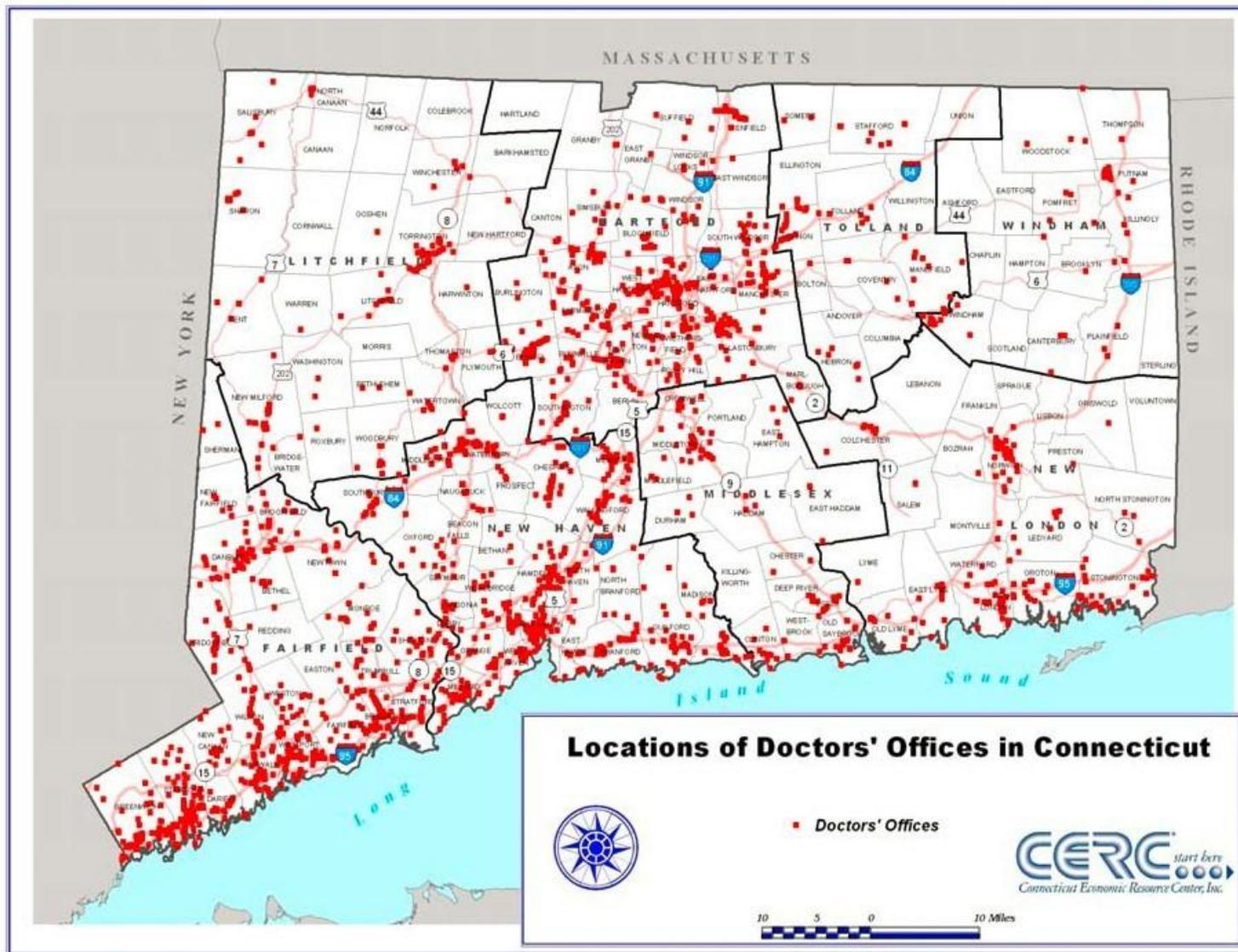
Location of physicians registered in Connecticut



SOURCE: 2011. Prepared by Connecticut Economic Resource Center, Inc. for Connecticut State Medical Society

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

Location of physician offices in Connecticut



SOURCE: 2011. Prepared by Connecticut Economic Resource Center, Inc. for Connecticut State Medical Society

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

The care delivery work group process will span the next five weeks with analysis and prep work in between

Workshop title	Description
June 24: Defining workforce needs	<ul style="list-style-type: none">▪ Review workforce capacity and capabilities against needs of new model▪ Discuss tools and other enablers required to support individuals in new delivery model <hr/>
July 8: Defining tools and enablers	<ul style="list-style-type: none">▪ Define how tools and enablers will be developed and/or promoted for future development▪ Discuss strategy for meeting workforce capacity and capability needs <hr/>
July 22: Implementing the care delivery model	<ul style="list-style-type: none">▪ Align on care delivery implementation plan with phasing, including plan to support provider transition▪ Align on communication plan

Criteria for identifying best practitioner to lead a consumer's care experience

STRAWMAN FOR DISCUSSION

Potential criteria

- Ability to influence consumer's care upstream and minimize downstream complications/ costs
- Ability to coordinate or oversee coordination of care across individuals, including community and social support organizations
- Exposure to breadth of a consumer's health complications across an extended period of time
- Strength of relationship with consumer
- Spends majority of time delivering primary care
-

Other considerations?

The majority of the organizations we profiled place primary care physicians in leadership positions

	Leader	Care management team(s)
	Primary care physician	Mental health, home health services and inpatient care management teams
	Primary care physician	Community based care team
	Nurse practitioner	Case manager; social services SWAT team made up of physicians, social workers, case managers, behavioral health professionals; home care team
	Primary care physician	Nurse case manager, social worker (behavioral health manager); specialized teams for transitional care, emergency post-partum, neonatal intensive care
	Pediatrician or family practice PCP	Care coordinator, nurse administrator
	Primary care physician or specialist (typically cardiologist, orthopedist, or oncologist)	Care coordinator; diagnostics, dental care, pharmacy and complementary medicine including acupuncture offered on site
	Primary care physician	Care coordinator
	Primary care physician	Nurses, case managers, social workers, and pharmacists
	Primary care physician	Care coordinator for all, dedicated behavioral health specialist for complex case management