District of Columbia State Innovation Model
Care Delivery Work Group: Meeting Summary

October 28, 2015
3:00 p.m. – 4:30 p.m.

Participants present: Lisa Fitzpatrick, Shelly Ten Napel, Sarah Rogue, Edwin Chapman, Linda Holifield, Meghan Davies, Justin Goforth, Lisa Alexander, Cathy Andertan, Michael Crawford, Layo George, Laura Nuss, Brendan Sinatro, Melissa McCarthy, Constance Yancy, Terri Thompson, Victoria Roberts, Nancy Murphy, Jennifer Zutz, Farshid Haque, Serina Reckling, Gwen Bell, Janice Llanos-Velazquez, DaShawn Groves, An-Tsun Huang, Robert Howard, Lauren Ratner, Chris Botts, Peter Tuths, Walter Faggett, Gwen Young, Bidemi Isiaq, Mark Weissman, Joe Weissfeld, Kandis Driscoll, Stephanie Hafiz, George McFarland Victor Freeman, Alan Watson, Cavella Bishop, Lara Pukatch, Erin Leveton, Elizabeth Garrison, Guadalupe Pacheco, Chiledum Ahaghotu

TOPIC	DISCUSSION
<u>Open Forum</u> Stakeholders discuss: 1. Data points on your high-utilizer population 2. Specific examples of care coordination related system breakdowns	• **To help assess who would benefit the most from a health home model, participants discussed profiles of high-cost, high-need patients, these include**: ➢ *Whitman Walker*: 121 high-utilizing patients with more than 12 FQHC visits per year; primary health issues include HIV, hypertension, and hepatitis C; common demographics include older men of color, receiving Medicaid and Medicare. ➢ *FEMS*: 509 residents consume 12 percent of FEMS services with many of the patients being transported over ten times. One high-utilizing patient had behavioral health and special education needs. The homeless population is the next tier of high-utilizing patients. ➢ *Dept. of Disability Services*: Patients with intellectual and developmental disabilities are well suited for health homes due to their extraordinary comorbidity conditions. o A health homes pilot with 50 patients showed a decrease in ER visits, a reduction in

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<u>Continued</u>	specialty care and the pattern of using specialists, and a decrease in clinic visits. ➢ *Community of Hope*: 250 patients had high ER use; housing and stability were an issue. Patients with asthma were high-utilizers in the pediatric population while those with diabetes and hypertension were high-utilizers in the adult population. ➢ *Howard*: 750 buprenorphine patients with average costs around $20k/year and average inpatient costs around $13k/year. ➢ *DHCF*: A few common characteristics in our high-cost, high-need cohort include: dialysis-dependency, schizophrenia, depression, alcohol abuse, sickle cell anemia, and obesity. • **A lack of communication between providers can impede care, common challenges include:** ➢ Coordinating care for patients who require (or have) a legally appointed guardian; ➢ Receiving real-time data to better understand patient utilization behavior; ➢ Receiving timely authorization from payers when service needs change for a patient; ➢ Communicating with outside pharmacies to determine a patient's prescription needs; ➢ Verifying receipt of documents before a patient receives health services related; and ➢ Failing to receive confirmations about specialty visits after referrals. • **Strategies for preventing high-need patients from becoming high-cost patients should:** ➢ Consider a risk management approach that utilizes stratification rather than the traditional disease prevention and/or management approach; ➢ Focus on patient outcomes rather than direct service costs; and ➢ Develop a systematic way of collecting real-time or near-real-time patient profile data.

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Open Forum Stakeholders discuss/define the CMS required Health Home services	• **Comprehensive Care Management** ➢ It is important to accurately define to appropriately target beneficiaries; could align with Medicare's Chronic Care Management program. ➢ Should include an initial assessment and care plan. • **Care Coordination** ➢ It is important to accurately define the core components of care coordination means (e.g. patient flow, linking patients to other providers, identifying community resources) ➢ It is important to clearly establish roles, responsibility, and accountability • **Patient and Family Support** ➢ Caregivers could benefit from increased patient support education, especially because needs are complex and vary tremendously with condition. ➢ Patient and family support services should be built into the health homes payment methodology to ensure financial sustainability. ➢ There is a need for a body of evidence that shows the benefit of these types of services. • **Referral to Community and Support Services** ➢ Referral to services outside of the care facility is often connected to what can be paid for because these services are not typically reimbursed by payers.