



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

November 12, 2015  
3:00 p.m. – 4:30 p.m.

**Participants present:** Lisa Fitzpatrick, Shelly Ten Napel, Joe Weissfeld, Leslie Lyles Smith, Lavdena Orr, Natasha Duggal, DaShawn Groves, Janet Jones, Liza Fues, Meghan Davies, Justin Gofeth, Cyd Campbell, Karen Dale, Lara Pukatch, Robert Howard, Melissa McCarthy, Rahwara Amare, Edwin Chapman, Chris Botts, Dena Hasan, Constance Yancy, An-Tsun Huang, Felicia Scans, Victoria Roberts, Ana Veria, Victor Freeman, Jennifer Ragins, Drucella Wheeler, Juliette Saussy, Yora Moshimi, Andem Effiong, Patryce Toye, Remy Szykier, Kandis Driscoll

TOPIC	DISCUSSION
<p><u>Open Forum</u></p> <p>Stakeholders discuss:</p> <ol style="list-style-type: none"> <li>1. Integrated models of care that other providers have used</li> <li>2. Reasons why some care coordination efforts have fallen short</li> </ol>	<ul style="list-style-type: none"> <li>• <b>Stakeholders discussed examples of integrated models of care used in the District, which include:</b> <ul style="list-style-type: none"> <li>➤ <i>Dept. of Disability Services:</i> A health homes pilot of 50 patients with intellectual and physical disabilities, showing a decrease in ER visits, a reduction in specialty care and the pattern of using specialists, and a decrease in clinic visits. <ul style="list-style-type: none"> <li>○ The challenge with this pilot was recruiting enough providers to participate despite the long patient visits.</li> </ul> </li> <li>➤ <i>Capital Clinic Integrated Network:</i> A nurse led team including community health workers and care managers, which was used to help better integrate the goals of providers with the goals of patients. The results included a decrease in cost, and an increase in the use of dentistry, primary care, and pharmaceutical services. <ul style="list-style-type: none"> <li>○ The challenge with this model was finding a sustainable funding source.</li> </ul> </li> </ul> </li> </ul>

TOPIC	DISCUSSION
<p>3. Specific examples of patients who would be well suited for a health home</p>	<ul style="list-style-type: none"> <li>➤ <i>Whitman Walker</i>: A multi-disciplinary care team, including nurses as case managers, community health workers, and addiction specialist when necessary. Referrals were made to meet the social service needs of patients. <ul style="list-style-type: none"> <li>○ The biggest challenge with this model was funding wrap-around services, which are not reimbursed by Medicaid but funded through competitive grants.</li> </ul> </li> <li>• <b>Care Coordination requires system integration and provider collaboration. Some efforts fall short for the following reasons:</b> <ul style="list-style-type: none"> <li>➤ Ineffective sharing of patient information through HIE systems;</li> <li>➤ Improperly tracking health outcomes and triaging patients according to severity;</li> <li>➤ Ineffective integration of behavior health into primary care practices;</li> <li>➤ Improperly aligning provider incentives with payment models; and</li> <li>➤ Failure to learn from other provider experiences.</li> </ul> </li> <li>• <b>Specific examples of patients that would benefit from a health home include:</b> <ul style="list-style-type: none"> <li>➤ Adults with intellectual and physical disabilities and comorbidities <ul style="list-style-type: none"> <li>○ Down syndrome and dementia are common chronic conditions in this population;</li> </ul> </li> <li>➤ Transplant patients and living donors;</li> <li>➤ Patients who are homeless/chronically homeless with high ER and ambulatory use rates; <ul style="list-style-type: none"> <li>○ More specifically, African American men older than 50 years in age with substance abuse and/or serious mental illness;</li> </ul> </li> <li>➤ Patients with chronic conditions such as congestive heart failure, chronic kidney disease,</li> </ul> </li> </ul>

TOPIC	DISCUSSION
	<p>alcoholism, and those who are home-bound; and</p> <ul style="list-style-type: none"> <li>➤ Patients who inappropriate utilize EMS services;</li> <li>➤ Patients infected with HIV/AIDS without comorbidities, but who have significant barriers to staying in care; and</li> <li>➤ “Rising risk” beneficiaries (e.g. those who are at-risk for becoming high-cost, high-need).</li> </ul>
<p><u>Open Forum</u></p> <p>Stakeholders react to data on Medicaid FFS and MCO high-cost beneficiaries</p>	<ul style="list-style-type: none"> <li>• <b>Stakeholders reacted to the data presented on Medicaid FFS and MCO high-cost beneficiaries and offered the following insights for consideration:</b> <ul style="list-style-type: none"> <li>➤ Physicians have to make a physical diagnosis for patients that present in the ER, even though the primary condition may be a behavioral health problem. There is a need to better document primary diagnoses in Medicaid claims data.</li> <li>➤ Criteria for stratifying patients and predictive analytics are critical to understanding granularity in patient data; consider acuity scores and coordinated assessment tools that account for comorbidities and social service needs (e.g. housing).</li> <li>➤ When thinking about program impact, it important to consider the difference between cost-effectiveness and cost-savings.</li> </ul> </li> </ul>