Connecticut Office of Health Strategy

Primary Care Modernization:
An Overview of the Design Process
and its Findings

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Table of Contents

Background 2
An International and National Movement 3
Building on Connecticut's Experience 5
Stakeholder Engagement in PCM Design 7
Stakeholder Engagement Phase 1 7
Stakeholder Engagement Phase 2 9
Capabilities to Transform Care 10
Adult Capabilities 12
Core Adult Capabilities 12
Elective Adult Capabilities 14
Pediatric Capabilities 15
Core Pediatric Capabilities 15
Achieving Health Equity 16
Technical Assistance and Peer Support 17
PCM Payment Model Design Options Overview 17
Recommendations of the Payment Reform Council 18
Basic Bundle 19
Supplemental Bundle 22
Adjusting the Supplemental Bundle 24
Attribution 25
Framework for Accountability 26
Monitoring Progress 26
Estimating Savings from New Primary Care Investments 30
Strawman Model Refinements Based on Stakeholder Feedback 32
Suggested Modifications Related to the Capabilities 32
Basic Bundle for Interested Providers 34
Evaluating Impact of New CMMI Programs 35
Provisional Approach to Payer Accountability 37
PCM and the Health Enhancement Communities Initiative 37
Actuarial Analysis of Capabilities Investment 39
Current Primary Care Investment in Connecticut 45

Wrap Up 47
Appendices 49
Appendix 1: Acronyms and Definitions 49
Appendix 2: Practice Transformation Task Force (PTTF) Members 55
Appendix 3: Incorporating Feedback in Payment Model Options 56
Appendix 4: Design Groups 58
Appendix 5: Patient Stories 59
Appendix 6: PCM Capabilities Compendium 62
Appendix 5: Payment Reform Council Members 109
Appendix 7: Hypothetical Hybrid Bundle Case Study 111
Appendix 8: CMS Codes 112
Appendix 9: Original Savings Estimates from Capabilities for Commercial Patients 116
Appendix 10: Access Tracking Options Considered 117
Bibliography 119

Background

Since 2017, the Office of Health Strategy (OHS) and the Practice Transformation Task Force (PTTF) have led the design of the Primary Care Modernization (PCM) model, which brought together hundreds of consumers, providers, employers, payers and state agency leaders to consider ways to improve primary care in Connecticut. This State Innovation Model (SIM) design process was intended to introduce additional payment innovations to advance healthcare quality and cost after the conclusion of the SIM grant in early 2020. Throughout the design process, the PTTF guided stakeholders through an evaluation of primary care capabilities and possible payment model options to support those capabilities. Their goal was to determine whether incremental, flexible investments in primary care would support patient-centered care delivered conveniently, effectively and efficiently. This report provides an overview of their process and findings.

Stakeholders clearly articulated their goals for primary care in Connecticut.

- Traditional primary care providers and new care team members connect and engage with patients in the office, home, community and virtually.
- Policies, workflows and funds recognize the importance of relationships and data sharing with other clinicians and community-placed providers.
- Behavioral and social contributors to health are identified and addressed in the primary care setting when possible, and through well-coordinated connections to other clinicians and community-based resources when needed.
- Increased, flexible investment in primary care generates improvements and cost savings across care settings, from the specialist's office to the hospital bed.
- Accountability ensures new dollars are spent on primary care and in ways that reduce total cost of care over time.

Though Connecticut typically performs well on overall rankings of health, the results shown in Figure 1 highlight significant disparities and the opportunity to improve care for those with chronic conditions and behavioral health needs (Kaiser Family Foundation, 2017) (United Health Foundation, 2019) (Commonwealth Fund, 2019). Like their peers nationally, Connecticut primary care providers report frustration with the current system and difficulty enticing new physicians into the field (Caffrey, 2019). Connecticut will need a 15 percent increase in primary care providers by 2030 to keep pace with demand (Robert Graham Center, 2019).

Connecticut ranks as one of the highest cost states for healthcare, particularly for those with Medicare coverage or private health insurance. Consumers, employers and payers have raised concerns about the value they receive for those investments, particularly as healthcare consumes a greater

FIGURE 1: Connecticut Ranks

Connecticut Ranks

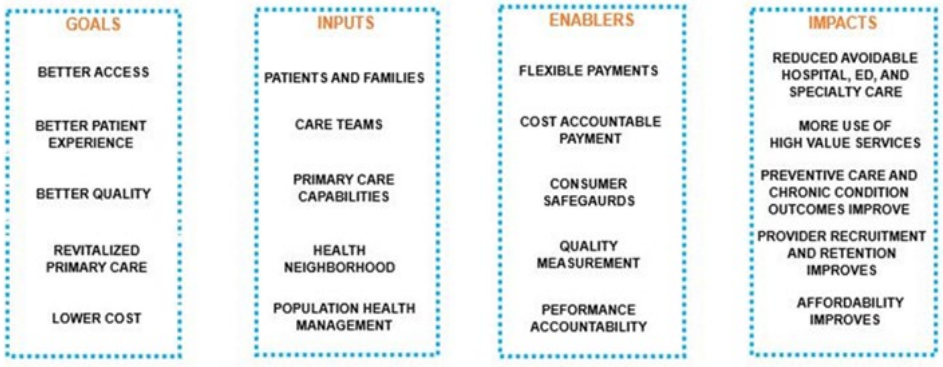
- 32nd highest per capita spending in the nation on avoidable hospital use and costs, largely driven by avoidable ED use in Medicare and commercial populations
- 43rd worst in the nation in health disparities across all populations
- Only six states have a higher rate of adults with diabetes without a hemoglobin A1c test
- 33rd worst performance in the nation in adults with mental illness reporting unmet need across all populations
- 39th highest rate in the nation in deaths from drug use across all populations
- 6th highest private health insurance spending per capita and 5th highest for Medicare

portion of employee paychecks and the state's budget. Connecticut payers and providers have embraced payment reform as a means to drive improvements in quality and reductions in total cost of care. The most widespread model is the shared savings program in which providers try to improve quality and lower cost, and in return have an opportunity to share in the savings. Approximately 85 percent of the state's primary care practices participate in a shared savings arrangement with at least one payer, although their performance has been mixed. The Department of Social Services ("DSS") has found that providers participating in its shared savings program, PCMH+, have saved money while improving quality. However, the Centers for Medicare and Medicaid Services (CMS) has found that most Connecticut providers have not saved money in the Medicare Shared Savings Program (MSSP) and similar programs from other payers (CMS, 2018).

Providers that participate in shared savings arrangements say that the current design of these programs stifles innovation, offers inadequate upfront investment and in turn, makes it difficult to fund investments in care delivery improvements. These arrangements don't allow for providers to leverage and expand their primary care teams to provide necessary services to meet the needs of their patient population or build infrastructure to support high needs patients with chronic conditions.

The limitations of the shared savings program model and potential solutions were first examined by the Practice Transformation Task Force in 2018 and summarized in their report *Primary Care Payment Reform: Unlocking the Potential of Primary Care* (State Innovation Model, 2018). This report served as the foundation for the PCM planning process. In the course of this process, stakeholders' identified a vision for a new system of primary care in Connecticut, which was translated into the five goals shown in Figure 2. To achieve these goals OHS engaged patients and families, providers and care teams, and community organizations and advocates to empower patients through discussions on improved primary care delivery. The multi-stakeholder perspective enabled OHS to identify major inputs into an improved primary care system that were aligned with relevant research.

FIGURE 2: PCM Logic Model



Throughout all phases of this work, many state agencies informed the design process including the Department of Social Services (DSS), the Office of the State Comptroller (OSC), the Department of Public Health (DPH), the Office of Workforce Competitiveness (OWC) and the Office of Early Childhood (OEC). The Office of Health Strategy appreciates their valuable time and insights.

An International and National Movement

Internationally and nationally, the highest performing health systems recognize primary care as the most inclusive, effective, and efficient approach to enhance people's physical and behavioral health as well as

social well-being (WHO, 2018). In 2019, The World Health Organization renewed its 40-year commitment to primary care, saying it "aims to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health," (Global Conference on Primary Health Care, 2018) (Galea & Kruk, 2019).

Higher numbers of primary care providers per capita are associated with increased life expectancy and reductions in early death from cancer, cardiovascular disease and other conditions (Lazris et al., 2018). Regions of the United States with higher ratios of primary care providers to specialists have better outcomes, lower costs, reduced hospitalization rates, and more satisfied patients (Basu et al., 2019). Further, a lack of primary care investment has been shown to hinder innovative care delivery models that ensure care is more accessible, coordinated, continuous, and comprehensive (Miller et al., 2018).

For children, pediatric primary care fosters important protective factors. These include helping parents build their own resiliency, create social connections, find support in times of need, increase their knowledge of parenting and child development and improve the social and emotional competence of their children. Research shows that when parents have these protective factors in place, children are more likely to thrive, even when their families face poverty, violence, mental illness, and other stressors in their homes, communities, and work. During a comprehensive review of the pediatric primary care system in Connecticut, the Child Health and Development Institute of Connecticut (CHDI) and Connecticut Health Foundation convened the Pediatric Primary Care Payment Reform study group. Their work built on CHDI's research which outlines that protective factors cultivated by primary care and community supports and connections often initiate in primary care, and increase children's ability to learn, function, and achieve healthy physical, social-emotional and intellectual development (Alter and Cornell, 2019).

States that have focused on primary care redesign show impressive results. Two examples are below.

1) Oregon's Patient-Centered Primary Care Home (PCPCH) saved $13 for every dollar invested during its first three years while improving quality (Patient-Centered Primary Care Collaborative, 2019). In light of this return on investment, Oregon now requires all payers spend at least 12 percent of total medical spend on primary care.

2) In Rhode Island, primary care spending increased from 5.7 percent in 2008 to 9.1 percent in 2012. Over this same period, total healthcare spending fell 14 percent. The state continues to work on ways to bolster its primary care system including establishing affordability standards that increase the primary care spend standard to 11% without the inclusion of payer administrative fees (RI OHIC, 2019). RI is one of the regions participating in the CMS' Comprehensive Primary Care Plus (CPC+) initiative, a medical home model that aims to strengthen primary care through regionally-based, multi-payer payment reform initiatives and care delivery transformation (RI OHIC, 2014).

Recent work by the RAND Corporation, a non-partisan, non-profit, international health policy think tank based in California, found primary care spending among Medicare fee-for-service beneficiaries ranges from less than 2 percent to less than 5 percent nationally, depending on the definition of primary care services used and whether nurse practitioners, physician assistants, geriatricians and gynecologists are included (Bannow, 2019). Among all states, Connecticut ranked in the lowest tier of primary care spending as a percent of total spending for commercial and Medicare populations when all primary care

services were included and in the second lowest tier when the broader definition of primary care services was used. While primary care spending in Connecticut's Medicaid program was higher than in commercial plans, primary care spending as a percent of total spending was below the national average for the Medicaid programs around the country (Jabborpour et al., 2019).

Many states including Rhode Island, Oregon, Delaware, Massachusetts, and Vermont have passed or are considering legislation that would require payers to increase spending on primary care as a percent of the total cost of care. Other states such as Colorado, Maine, Washington, and West Virginia have passed legislation to study primary care investment in their states. The Milbank Fund, a national foundation focused on state health policy, is working to standardize this measurement across states. Across payers, primary care measurement efforts typically estimate less than 5 percent of healthcare dollars currently are spent on primary care and most state initiatives aim to at least double that percentage.

Building on Connecticut's Experience

In Connecticut, OHS has facilitated several SIM initiatives focused on improving primary care service delivery, payment and benefit design and learned from CMS' CPC+ initiative in CT. Through OHS' experience with these reform efforts we have gained insights into key lessons, opportunities, issues, and barriers to primary care reform.

CPC+, which CMS describes as "the largest and most ambitious primary care payment and delivery reform ever tested in the United States" increased investment in primary care through a combination of risk-adjusted care management fees and performance-based incentive payments. These fees and payments are based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. In addition, practices can decide to shift a portion of Medicare FFS payments into an advanced bundled payment. With the support of the additional and more flexible payments, practices aim to focus on five important elements of care delivery transformation: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

More than 3,000 primary care practices and 79 public and private payers across 18 regions participate in CPC+. Mathematica recently released an evaluation of the first year of the CPC+ program, which then included approximately 2,900 primary care practices and 63 payers. Several findings align with PCM model design (Mathematica, 2019).

The CPC+ experience provided three important findings to inform the PCM work:

1) Transformation Takes Time: There were "few, very small differences" in use of services, care quality or cost between beneficiaries served by CPC+ and those served by comparison practices during the first year of the program. After adding in the cost of the program, patients in CPC+ practices cost 2 to 3 percent more than patients visiting comparison practices.

2) Sufficient Funding Requires Multi-Payer Participation: Though CPC+ is a multi-payer initiative, practices received additional payments for only a third of their patients, yet they were expected to achieve care delivery reforms for all of their patients. Most of the additional payments came from CMS for Medicare beneficiaries, which reflects the higher needs of Medicare patients. However, some providers felt commercial payers did not pay enough to cover the additional costs of achieving CPC+ goals for commercial patients.

3) Reducing Total Cost of Care Requires A Broader Strategy: Several primary care practices from hospital-owned and multispecialty systems said goals of reducing hospital admissions, emergency department visits, and unnecessary specialist visits conflicted with their health system's revenue goals.

The Community and Clinical Integration Program (CCIP) was launched by OHS in 2017 for the purpose of helping Advanced Networks (ANs) and federally-qualified health centers (FQHCs) meet evidence-based standards across their networks of primary care providers. The standards focused on using comprehensive care teams to meet the needs of patients with complex health needs, strategies for identifying and addressing health disparities, and methods for identifying and addressing behavioral health needs. Although CCIP focused on the 14 organizations participating in the Connecticut Medicaid shared savings program, Person Centered Medical Home Plus (PCMH+), the organizations were required to meet the standards for all populations. Despite the fact that these organizations were participating in shared savings programs for a majority of their patients, they relied on SIM grants or relatively modest per member per month (PMPM) payments to support the achievement of capabilities. Most providers reported that they would be unable to sustain CCIP capabilities unless additional funding and reimbursement could be provided beyond today's billable office visits, tests and procedures. The additional funding would allow providers to gradually build the infrastructure necessary to deliver the capabilities, hire and train teams on improved care delivery, and establish relationships with stakeholders to foster care redesign.

The Prevention Services Initiative (PSI) Led by OHS and the Department of Public Health (DPH) was intended to create financial partnerships between health care organizations and community-based organizations (CBOs) in order to improve the outcomes of patients with poorly controlled asthma and diabetes. These services also aimed to reduce associated emergency department and hospital visits. PSI supported CBOs in building their capacity to contract with accountable provider organizations, such as ANs and FQHCs, and sharing accountability for improving patient outcomes. It also helped CBOs develop stronger relationships with providers to increase awareness of available resources and make referrals. Early learnings from this pilot project underscored the importance of community purchasing partnerships to enable ANs and FQHCs to better serve their most challenging populations.

The Value-Based Insurance Design (VBID) Consortium and Technical Assistance program led by OHS and the Office of the State Comptroller (OHS) helped employers redesign their benefits to remove financial barriers to high value care. The program emphasized benefit designs that would promote patient engagement in primary care for prevention, health promotion and the management of common chronic illnesses. Through this work, OHS and the OSC helped many Connecticut public and private healthcare purchasers better understand primary care's ability to improve health while lowering cost. Continuing efforts to engage employers on benefit design to encourage their employees in primary care is an important element in primary care reform.

The multi-stakeholder Connecticut Pediatric Primary Care Payment Reform study group, convened by the Child Health and Development Institute of Connecticut and the Connecticut Health Foundation, recently explored how the pediatric primary care practice can better support improving the health of all Connecticut children (Seifert & Deignan, 2019). In its report, *Transforming Pediatrics to Support Population Health: Recommendations for Practice Changes and How to Pay for Them,* the group discusses ideas to improve pediatric primary care to better address health disparities, ensure healthy growth within the family, and coordinate with the community. The report recommends a multi-payer solution with

adequate, flexible payments. These payments would support adding care team members focused on a wide range of goals including prevention, health equity, and care quality, all of which have been shown to lower costs. They recommended measuring outcomes over time to understand the long-term return on investment. Many study group members participated on the PCM Pediatric Design Group.

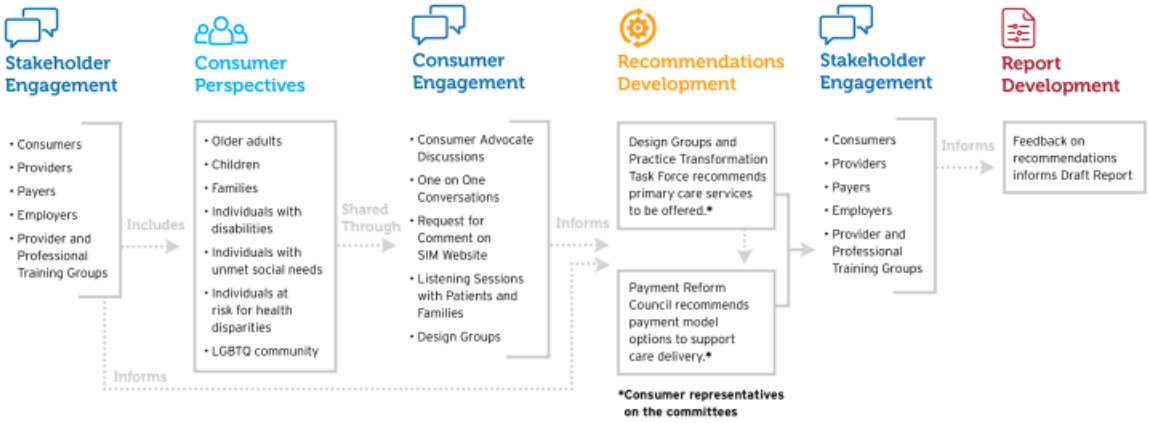
Facilitation of these reform efforts reinforced stakeholders' assumption that a phased-in approach would allow needed time to change culture and workflows. Additionally, implementation of these programs made clear that a multi-payer process was pivotal to achieve system-wide changes and that increased investment in primary care alone would be unable to contain the total cost of care and could be inflationary.

Stakeholder Engagement in PCM Design

Stakeholder Engagement Phase 1

Following the publication of the PTTF's report in June 2018, OHS began the PCM design process in accordance with the Advisory Process that was agreed upon with the PTTF, the Consumer Advisory Board (CAB) and the Healthcare Innovation Steering Committee. OHS began by contracting with Freedman Healthcare (FHC) to support the design process under the direction of OHS and in consultation with the PTTF and CAB.

FIGURE 3: Stakeholder Engagement Process



Beginning in July 2018, FHC engaged over 600 Connecticut stakeholders from the following stakeholder groups in a series of discussions: providers including primary care physicians, other care team members, clinical and administrative leaders from ANs, FQHCs, and health systems; consumers; employers; payers; and medical schools and residency programs.

Stakeholders shared their priorities for primary care, whether capabilities being considered reflected those priorities and considerations for implementation. They discussed potential payment model options that would provide increased funding and flexibility necessary to achieve the capabilities. Stakeholders expressed particularly strong support for diversifying care teams, integrating behavioral health into primary care, and offering more convenient ways to connect patients and providers such as through phone, text, email and video visits. They had questions about how the payment model options would ensure appropriate and equitable reimbursement for providers and how providers would be held accountable for implementing the capabilities. These questions were addressed by the Payment Reform

Council (PRC), a multi-stakeholder workgroup formed to develop payment model options to support PCM goals. Its recommendations were provided to the PTTF. More information on how the payment model options reflect stakeholder questions and concerns can be found here.

Consumer Perspectives and Consumer Engagement

Consumers and those who advocate for consumers brought real-life experiences and a strong understanding of health policy to the design process. OHS hosted several discussions with consumer advocates representing older adults, children, individuals with disabilities, residents in need of social support, consumers more likely to experience the health effects of racism, the LGBTQ community, and other groups. Each offered important suggestions for PCM model design based on their direct work with consumers. Participants for these conversations were identified in collaboration with the OHS Consumer Advisory Board (CAB).

Key themes emerged from these conversations:

1. Recognition of the potential benefits of additional care team members
2. Support for the opportunity for patients to access care virtually such as through email, text, phone calls and video visits
3. Concerns regarding whether a payment model that bundles these new primary care services into a single upfront payment would result in some patients not receiving necessary care, also known as under-service

OHS also hosted consumer listening sessions, each centered on the perspectives of patient and caregiver communities with significant health needs. These discussions offered unique insights into how primary care functions for members and families in these communities, and how we can strengthen that care. Each of the consumer groups wanted to ensure that there were sufficient resources and other safeguards so that all patients would receive the level of care they needed. They also noted that they understood that the way that providers are currently paid can lead to less flexibility in how care is delivered and how much time they can spend with patients as well as lead to less care coordination.

Parents of Children with Behavioral Health and Other Complex Medical Needs: Two, two-hour conversations were organized in partnership with the National Alliance on Mental Illness (NAMI) and the Alliance for Children's Mental Health Connecticut, an affiliated group of NAMI. Parents discussed the challenges faced by families who have family members with mental illness, the lack of trained doctors who can prescribe medications to children with complex behavioral health needs, and the need for greater communication and coordination among behavioral health care teams and pediatricians' offices. They shared that primary care is not able to address many of their children's behavioral health needs and liked the idea of having more ways to connect behavioral health and primary care.

Older Adults: OHS joined discussions with representatives of the Connecticut Association for Retired Americans and Connecticut AARP to better understand the primary care needs of older adults. Many of the participants were both patients and caregivers. They shared how upsetting and scary it can be when providers do not communicate well with each other or completely understand how the medications they prescribe interact with other medications.

Individuals with Disabilities: In partnership with *Access Independence,* OHS hosted a discussion with adults with disabilities. Consumers shared their frustrations with physically inaccessible examination equipment, a lack of compassion from providers regarding their disabilities and how little providers understand the impact their disabilities have on other aspects of their health. One consumer explained how long waits for

an office visit are very frustrating when transportation is arranged for a specific time and then the provider's office is not prepared with the correct equipment to complete a thorough exam.

OHS also hosted one-on-one conversations with consumer advocates and asked Connecticut residents to submit comment on PCM through the OHS website.

FIGURE 4: PCM Design Groups

PCM Design Groups

- Diverse Care Teams
- Behavioral Health Integration (adult and pediatric)
- Community Integration
- Older Adults with Complex Needs
- Pain Management
- People with Disabilities
- Pediatric
- Federally Qualified Health Centers

Recommendations Development

OHS and the PTTF established a series of multi-stakeholder design groups to assist with the design of specific primary care capabilities, while considering the needs of special populations. These groups were comprised of experts, providers, payers, and consumer advocates. Design group members contributed their time and insights based on their experience as consumers, practitioners, academics and policy experts. Each design group considered the goals, requirements and impacts of a specific capability. Design groups reviewed national and Connecticut program experience, academic research on each capability and input from stakeholders and consumers. Recommendations were presented to the PTTF for review, refinement and approval. Summaries of each capability are included in the PCM Capabilities Compendium.

On a parallel track, the PRC began its work with a review of CPC+, the advanced primary care medical home model developed by CMS, and how other states are utilizing more flexible payment models to enhance primary care. This led to the development of strawman payment model options including two risk-adjusted, advance payments. Once the PTTF approved an initial set of capabilities, the PRC began a review of the capabilities with three key questions in mind.

1. Would the strawman payment model options adequately support implementing the capabilities?
2. Would the capabilities generate sufficient savings to offset the increased funding?
3. Would the new payment model options generate any unintended consequences? If so, could they be addressed or mitigated?

Stakeholder Engagement Phase 2

OHS prepared a comprehensive provisional strawman payment model based on stakeholder discussions and the recommendations developed in phase one. The strawman model included detailed information on primary care capabilities, example case studies, and details on a potential payment model and the payment limitations that they were intended to address. The strawman model also asked stakeholders to consider the trade-offs of incorporating a bundled payment for primary care office visits as described below.

During Phase 2 of the stakeholder engagement process, OHS presented the provisional strawman model and requested feedback on the proposed capabilities and payment model options. Stakeholder groups were asked whether the capabilities and the proposed payment model would enhance primary care. Stakeholders provided feedback on the reasonableness of costs and savings estimates. And, some groups of stakeholders outlined their priorities for accountability. They discussed how data should be collected

and presented. They considered various oversight structures and how to balance flexibility with accountability. ANs shared that while many of them are moving towards value-based contracts and hope to develop the infrastructure to support capabilities envisioned by the PTTF, they feel internal pressure to make the transition gradually. They expressed an interest in further understanding how the increased investment in primary care would affect funds flow. OHS met with these ANs frequently to provide them with tools to use their own data to assess the impact that PCM would have on their organizations, including funds flow scenarios and revenue projections. Based on this feedback OHS suggests several refinements, all of which are reflected at the end of this report.

Capabilities to Transform Care

PCM was intended to transform primary care by expanding and deepening its capabilities. With the support of increased primary care investment and more flexible payment model options, evidence-based capabilities would create a primary care system that is more patient-centered, effective, efficient, and convenient. The capabilities were developed and refined by the PTTF after a thoughtful and extensive review of the evidence and informed by the insights of Connecticut experts, providers and consumers. All PTTF recommended adult and pediatric capabilities are shown in the wheel graphics below. More information on the capabilities including requirements to fulfill each capability, examples of how the patient experience would change and other expected impacts can be found in the PCM Capabilities Compendium.

Many of the recommended capabilities were first considered by the PTTF in its June 2018 report, *Primary Care Payment Reform: Unlocking the Potential of Primary Care* (State Innovation Model, 2018). Beginning in July 2018 and over the next six months, multi-stakeholder design groups each focused on a specific capability formed. As discussed above, these design groups included representatives of providers, payers, consumers and researchers with expertise in the capability. They reviewed multiple approaches in the literature and compared specific national and state program models. The PTTF considered input from the design groups in making their recommendations. Capabilities with a single recommended approach did not undergo a design group process. For these capabilities, the PTTF reviewed the evidence and made its recommendations. All capabilities considered how care can be delivered with the needs of the patient, their family or caregivers, and their provider at the center of model design.

All capabilities were evaluated based on their ability to achieve the PCM goals:

- Improve Access
- Improve Patient Experience
- Improve Quality
- Revitalize Primary Care
- Lower Cost Growth

As shown in Figure 5, the capabilities design process was a phased approach of seeking stakeholder input, gathering evidence from peer-reviewed research and reviewing the evidence with experts in Connecticut and nationally. Design groups and the PTTF also considered whether the capability should be core or elective and whether all practices within the AN/FQHC would need to offer the capability or whether the capability could be deployed by the network. The PTTF ultimately recommended that participating ANs and FQHCs be required to achieve nine adult core capabilities over the five-year period. Three additional

elective capabilities would be optional. For pediatrics, stakeholders recommended eight required or core capabilities and two optional capabilities.

FIGURE 5: Capabilities Development Process

Capabilities Development Process

- Consider provisional capabilities from 2018 PTTF Primary Care Payment Reform Report
- Request feedback on provisional capabilities from stakeholder groups
- Compile evidence on capability impact and national and Connecticut models with expert advice
- Review impact and models with design groups for feedback and modifications
- Discuss design group recommendations with the PTTF
- PTTF determines whether capability should be included in PCM and whether it should be core or elective pending analysis of capability cost

Throughout the design process, stakeholders noted that the capabilities should be phased in over a defined period. Workforce members would need to be trained and hired, culture and workflows would need to evolve to meet new care delivery goals, and policies and processes would need to change. OHS also met with the OWC at the Connecticut Department of Labor to begin to better understand workforce planning efforts that would be necessary to support care team expansion. With these complexities in mind, stakeholders weighed the trade-offs of a more flexible approach to implementation versus a more prescriptive approach. The model design recognized that a more flexible implementation approach would be needed to reflect the needs of different patient populations, and differences in technology, workforce, workflows and culture across the state's ANs and FQHCs.

The PTTF recommended that each participating AN and FQHC develop a five-year implementation plan. Plans would be reviewed by OHS as part of the PCM accountability process. In addition, payers would review and approve AN/FQHC plans for their own programs, which is further discussed here. Auditing would be used to ensure dollars were spent according to the plan. A high-level overview of a hypothetical AN implementation plan is shown below in Figure 6.

FIGURE 6: Hypothetical implementation approach, each AN/FQHC would submit their own implementation plan to OHS for approval.

Five Year Primary Care Modernization Implementation Plan

YEAR 1

CARE TEAM EXPANDS. Pilot practices include RN care managers, pharmacists, CHWs. Care transitions are a focus.

PCPs and care team receive technical assistance to support workflow redesign.

Phone, text, email upgraded for better patient experience.

eConsult, remote patient monitoring offered.

YEAR 2

INTEGRATED BEHAVIORAL HEALTH PILOTED with hiring of LCSW.

Patients connected to community resources after analysis of social determinants data.

Care team expands to additional practices; new care team roles introduced. Technical assistance continues.

YEAR 3

FORMAL PARTNERSHIP LAUNCHED with local housing referral service.

Integrated behavioral health expanded to all practice sites.

Care team expansion and technical assistance continues.

YEAR 4

TWO SPECIALIZED PRACTICES DEVELOPED. One supports older adults with complex medical needs. Another focuses on chronic pain management.

Existing capabilities refined and expanded.

YEAR 5

ALL PRACTICES ACHIEVE ALL CORE CAPABILITIES.

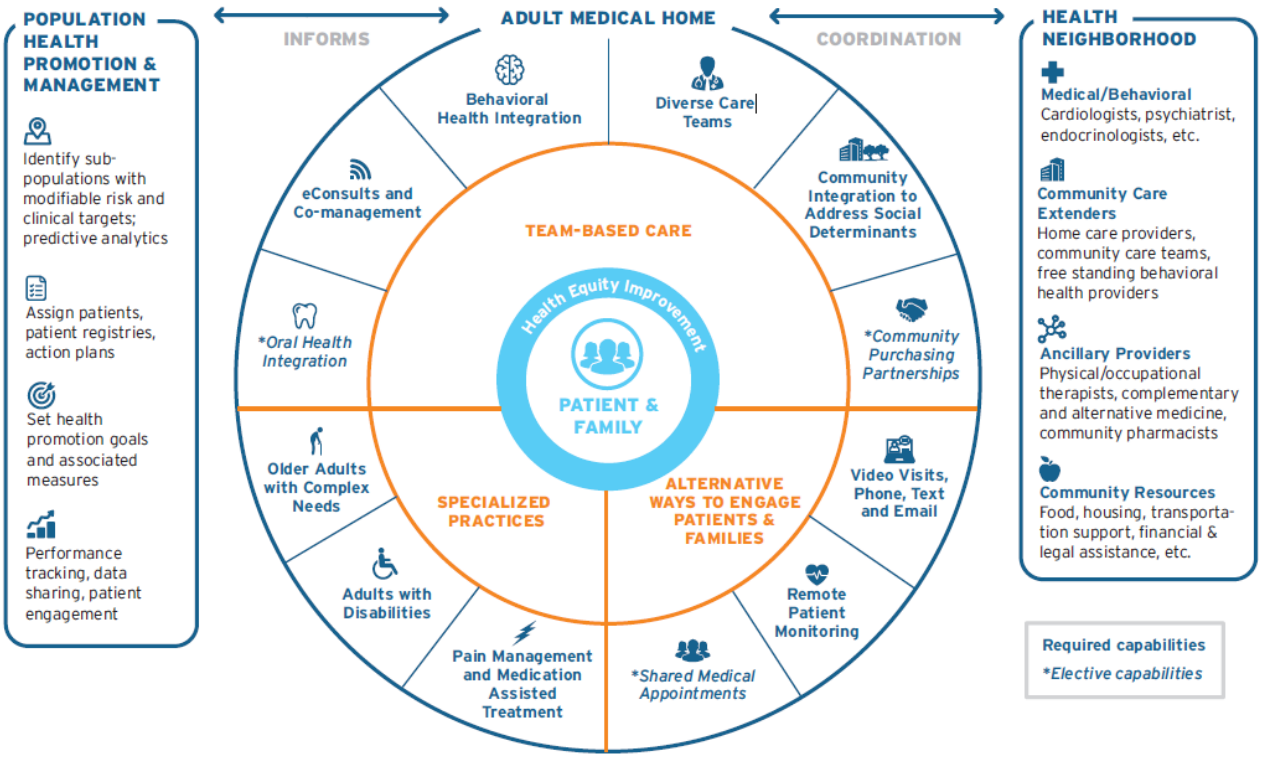
Technical assistance continues.

Two additional partnerships with community-placed resources launch.

Adult Capabilities

Figure 7 illustrates the adult capabilities in the PCM strawman model. Elective or optional capabilities are denoted with an asterisk and italics. A key theme throughout the design groups ensuring the patient,

FIGURE 7: Adult Capabilities Overview



family and primary care clinician should be at the center of each capability. The model recognized it may be more efficient for some capabilities, particularly those requiring certain investments in health information technology, to be fulfilled by the AN or FQHC rather than each individual primary care practice. Consistent with the research, methods for communicating among and between care team members was considered essential, but co-location was not required.

Core Adult Capabilities

Diverse Care Teams bring together professionals with different skills and expertise to provide patients with needed support throughout their care experience. Stakeholders participating in the PCM design process envisioned ANs/FQHCs would design their own care teams to meet the needs of their patients. The model design recognized that a more prescriptive approach (i.e. X community health workers per y patients) would be complex to administer and may not allow providers sufficient flexibility to address the needs of their patients and to modify their approach over time. Examples of new care team members contemplated in the PCM model included care coordinators, community health workers, pharmacists, and nutritionists. The PTTF decided staff member to patient ratios be should be recommended but not required. Research shows expanding and diversifying care teams would increase access and help patients receive care more quickly (PWC). The result is that patients receive more preventive care and chronic conditions improve. This reduces avoidable visits to the emergency department and hospital stays.

Patient financial responsibility approaches for care provided by the expanded care team were also reviewed and the model design recognized that care received likely would not generate out-of-pocket costs for patients if it was delivered by a provider who could not currently bill for their time under a fee-for-service model.

Adult Behavioral Health Integration (BHI) was proposed to add a behavioral health clinician to the primary care team. This clinician would perform three primary functions: 1) assessment and screening, 2) support patients in need of a brief intervention (e.g. 3-5 visits), often to improve coping skills or offer support through a difficult life event such as death or divorce 3) connect the patient to specialized behavioral health services in the network or in the community. Research shows BHI helps identify and treat behavioral health conditions, achieve better outcomes, improve patient satisfaction with treatment and reduce total cost of care over time (Tice, et. al., 2015) (Unutzer, 2008).

Phone, Text, Email and Video Visits would offer patients more convenient access to providers who may be able to diagnose and treat them without a face-to-face visit. These virtual communications could also support periodic check-ins to offer patients ongoing support, advice and coaching. Research shows this type of access improves patients' ability to manage chronic illnesses and reduces avoidable trips for specialty care and the associated costs (Strumpf, 2016) (Bishop, et. al., 2013).

e-Consults and Co-management were intended to allow primary care providers and specialists to work together efficiently to create care plans for the patient. During an e-Consult, a primary care provider electronically consults with a specialist for a non-urgent condition before or instead of referring a patient to a specialist for a face-to-face visit. Co-management offers patients the opportunity to receive more coordinated, collaborative ongoing management by the PCP, specialist and patient. In addition to offering patients faster, more convenient access to specialty expertise and cost savings, another goal was to support primary care providers in increasing their own knowledge and most report high satisfaction with the process (Anderson, et al., 2018) (Vimalananda, et al., 2015) (Olayiwola, 2016).

Remote Patient Monitoring uses connected digital services and technology to move patient health information from one location, such as at a person's home, to a healthcare provider in another location for assessment and recommendations. It is most helpful for patients with certain conditions, like congestive heart failure (CHF) and diabetes. Research shows patients who utilize remote patient monitoring give their providers an opportunity to identify changes in their condition sooner, treat them accordingly and in turn, prevent some hospital stays (Broderick, 2013).

Care for Older Adults with Complex Needs would offer enhanced primary care from a practice specially designed to improve outcomes for patients aged 75 and older. Specialty practices will be equipped to serve patients with multiple chronic conditions, functional challenges and trouble traveling to in-office visits and therefore more likely to have potentially avoidable emergency department visits and require nursing home placement (Counsell et. al., 2009). The care team would provide support outside of a traditional office visit including in a patient's home or community. Research shows that these types of teams can improve health outcomes, prevent some hospital stays, improve provider and patient satisfaction and lower costs (Institute for Strategy and Competitiveness, 2019).

Pain Management and Medication-Assisted Treatment offers patients access to providers that understand and are trained to treat the complex medical, behavioral and social components of their conditions. Pain management focuses on preventive, routine and advanced pain management in primary care. The PCM model design envisioned that all practices would be equipped with basic competence in pain management while a subset would specialize expertise, supported by the Centers of Excellence in pain management. Access to pain management expertise brings patients meaningful improvements in function, reduced time off work and can lead to dramatically lower healthcare costs (Prakken, et. al., 2017). Under the PCM design, some practices would be specially equipped to administer Medication Assisted Treatment (MAT), a proven treatment for opioid addiction.

Enhanced Primary Care Services for Adults and Children with Disabilities offers patients access to enhanced primary care including experienced care teams, access to preventive screenings and care, accessible services, and home- and community-based services and care teams. These practices would treat all patients and receive additional training for their patients with disabilities. Access to specialized enhanced primary care practices improves patient experience with convenient, timely, and accessible care from a team with appropriate experience, expertise and resources (AADMD, 2013). Research shows that care teams with experience and expertise in treating people with disabilities improve their patients preventive care, chronic illness outcomes, and reduce avoidable visits (Hostetter, Klein, McCarthy, 2016).

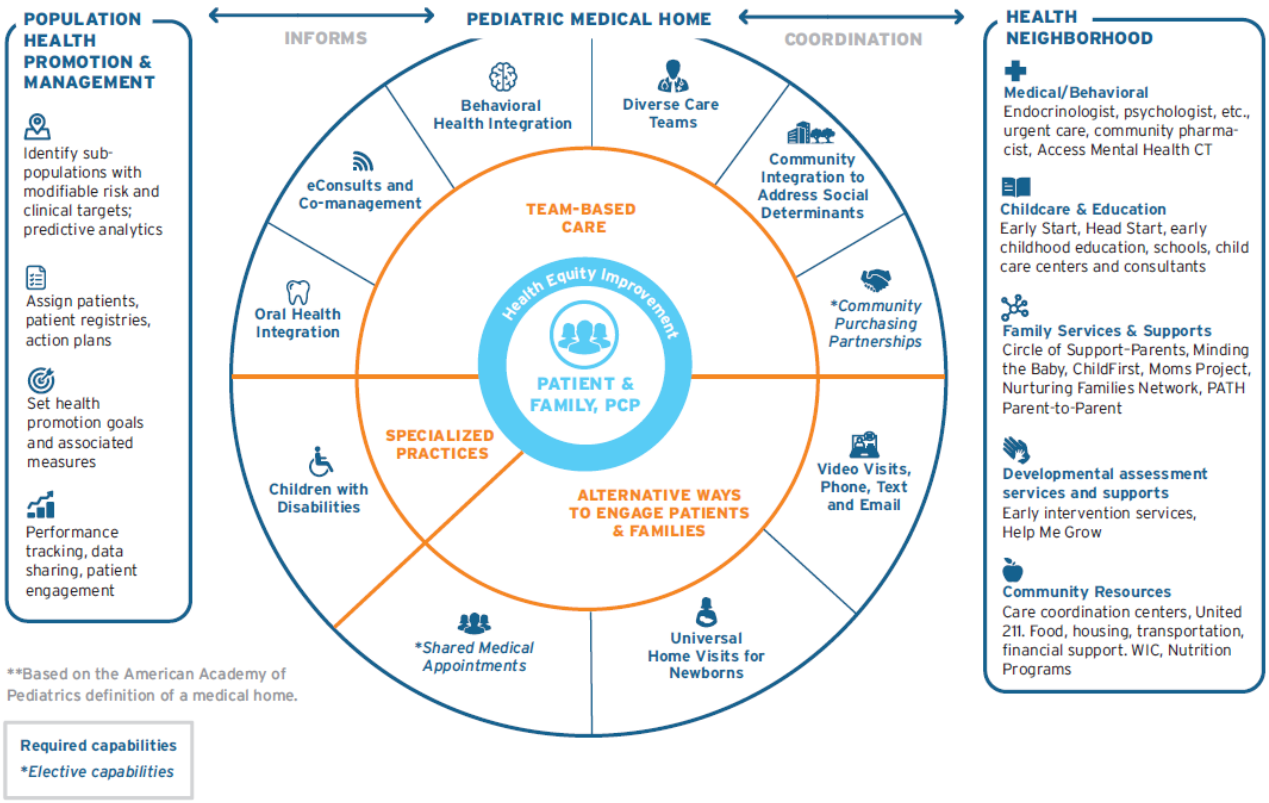
Elective Adult Capabilities

Oral Health Integration provides oral prevention services in primary care offices during regular checkups, including screenings, fluoride varnish, oral hygiene education, and when necessary, referrals to oral health providers. Oral health is an important contributor to overall health and improved access to preventive oral healthcare in the primary care setting will offer more Connecticut residents access to certain basic dental services.

Shared Medical Appointments bring together patients with similar medical conditions for physical exams, education and peer support to address their medical, social and behavioral health needs and strengthen patients' ability to manage their health.

Pediatric Capabilities

FIGURE 8: Pediatric Capabilities Overview



Core Pediatric Capabilities

Pediatric Diverse Care Teams were to be guided by the pediatrician in collaboration with the patient and family, integrated with other professionals (e.g. community health workers, lactation consultants, dental hygienists, etc.), and coordinated with community supports with the goal of promoting the strengths of families and optimizing health for all children. This type of collaborative, coordinated care has been shown to increase preventive care, offer families additional resources for health promotion, reduce the risk of chronic conditions in adulthood and potentially reduce health care costs over a child's lifetime (HealthySteps, 2017).

Stakeholder Input: Primary care has a strong role to play in health promotion, particularly in pediatric medicine.
Model Impact: Required pediatrics capabilities include care team members focused on health promotion and home visits to promote infant health and development.

Pediatric Behavioral Health Integration was intended to offer a team-based approach to promote the developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community. Care team members focus on screening, early identification of emerging issues, brief assessments, and coordinating community-based treatment when needed. Research shows this approach to pediatric behavioral health improves health outcomes, increases school readiness and attendance, helps families communicate better and lowers the risk of chronic conditions in adulthood

(Gleason, Goldson & Yogman, 2016). These improvements are driven in part by the increased access that comes from having a behavioral health clinician part of the primary care team.

Alternative Ways to Engage Patients and Their Families was included to offer more convenient ways for patients and families to engage with the pediatric medical home such as video visits, phone calls, text messages, emails. Pediatric primary care teams could choose whether to offer group visits based on provider and patient preferences. For example, a pediatrician's office might find additional benefit to patients when infant well visits are conducted in a group setting. Such a setting offers parents the opportunity to connect with each other, share success stories and lessons and learn about their child's health and development from the primary care team. Stakeholders noted the benefit of convenient access to busy families, particularly those caring for children who would benefit from frequent check-ins but face barriers traveling to the office.

Universal Voluntary Home Visits for Newborns was recommended to offer families a home visit with a nurse and a community health worker, if desired. Visits would offer new parents important tips about infant health and development including strategies for eating, sleeping and play. The visit would aim to begin building a relationship between the primary care team and the family. These visits could identify families in need of social support or parents facing undiagnosed behavioral health conditions including post-partum depression and anxiety (Dodge, et. al., 2014).

e-Consults and Co-management were intended to support primary care providers and specialists to work together to create care plans for the patient in an efficient way. During an eConsult, a primary care provider electronically consults with a specialist for a non-urgent condition before or instead of referring the patient and family to a specialist for a face-to-face visit. Co-management offers patients the opportunity to receive more coordinated, collaborative ongoing management by the PCP, specialist, patient and family.

Achieving Health Equity

Three additional capabilities were designed to help identify and prioritize opportunities to reduce healthcare disparities. These capabilities included a core Health Equity Improvement capability, a core, Community Integration to Address Social Determinants (SDOH) capability, and an elective, Community Purchasing Partnerships capability for both adults and pediatrics.

Health Equity Improvement capability was envisioned to require that ANs/FQHCs implement policies and procedures to collect race and ethnicity data, analyze it to identify disparities in care and conduct root cause analyses to implement interventions to address those disparities. This capability was intended to provide a better understanding of population health while reducing disparities within the community.

Stakeholder Input: Achieving health equity requires a data driven strategy that connects the patient and family to primary care integrated within the larger community.
Model Impact: ANs/FQHCs will conduct network-level data analysis and patient-level SDOH assessments to connect patients to needed community support.

Community Integration to Address Social Determinants capability was designed to further support these efforts by requiring care teams to conduct social determinants of health screenings to identify patients' barriers to care and connect them to community resources to address these barriers. The primary care team was to serve as a resource for patients to address social determinants of health with the help of resources within their community.

Community Purchasing Partnerships was intended to provide an opportunity for ANs and FQHCs to contract for community-based services. Through this mechanism community-based services could build capacity to address further needs of patients and better support health in the community.

Technical Assistance and Peer Support

Many stakeholders shared that successful implementation would require technical assistance and peer support. Therefore, the PCM strawman model design included technical assistance to support changes in workflows and culture, capabilities implementation, using data to identify priority interventions and at-risk patients, and other needs. To reflect variation in needs across providers, stakeholders recommended that ANs and FQHCs identify technical assistance priorities and secure external vendors to provide this support.

Stakeholders also discussed the benefits that can come from peer learning and support. With this in mind, the model design included a Learning Collaborative convened by OHS to enable PCM participants to share experiences, build shared knowledge and discover partnership opportunities.

Stakeholder Input: Lessons from tailored, phased-in implementation plans should be shared.
Model Impact: OHS to promote sharing experiences through a Learning Collaborative.

PCM Payment Model Design Options Overview

To enable providers to most efficiently implement the capabilities approved by the PTTF, stakeholders envisioned more flexible payments would be needed. Today, primary care providers are typically paid fee-for-service. Under a fee-for-service payment model, payment is made when a specific type of provider, most often a physician, nurse practitioner or physician assistant, cares for a patient under a specific set of circumstances (e.g. location, length of time). Primary care providers often are not paid for services provided by community health workers, health coaches and pharmacists, even when those providers would substantially improve care experience and outcomes. These rules have led to most primary care being delivered face-to-face in a provider's office, even when a phone call, text, email or video visit would be clinically-appropriate, more convenient for the patient and more efficient for the provider. Fee-for-service payment models are becoming less restrictive as payers and providers recognize the benefits of diverse care teams and virtual care. However, during the PCM design process providers in Connecticut and nationally said the new codes and fees to support diverse care teams and virtual care come with their own complexities and administrative hassles.

The PRC was formed to consider payment options that would enable primary care providers to achieve the recommended capabilities. The PRC developed a set of key principles listed in Figure 9. The PRC was asked to focus on payment model design options for Medicare fee-for-service and develop recommendations for other payers. Its recommendations were presented to the PTTF for discussion, refinement and approval.

FIGURE 9: Payment Reform Council Key Principles

Payment Reform Council Key Principles

- Consider input from consumers, providers, payers and employers
- Review financial effect of capabilities recommended by the PTTF
- Determine methods of accountability and safeguards to protect against underservice and patient selection
- Design an implementation strategy that ensures a return that offsets the investment – builds over time
- Customize "best in class" federal and state initiatives

The PRC began by reviewing the payment model design options used in CPC+, the advanced primary care medical home model developed by CMS. The PRC then determined a series of modifications that would be necessary to best support PCM and the specific needs of Connecticut patients, providers, employers and payers. This section of this report provides an overview of the PRC's discussion regarding primary care payment model design options and information on the trade-offs considered.

Recommendations of the Payment Reform Council

As noted above, the PRC spent considerable time discussing whether paying for primary care with one or more upfront, bundled payments would offer primary care teams the financial flexibility necessary to deliver the recommended capabilities and in turn, deliver optimal care to patients. These discussions led to five key provisional recommendations outlined below, all of which provided a framework for future conversations with the PRC and stakeholders.

1. Create two bundled payments: A basic bundle would reimburse primary care providers for office visits and most other services currently paid fee-for-service. A supplemental bundle would cover the incremental cost associated with delivering the capabilities. Some services, such as minor procedures in the office, and expenses, such as the cost of vaccinations, would still be paid fee-for-service.

2. Risk adjust: Early in its discussions, the PRC determined that both the basic bundle and the supplemental bundles should be risk-adjusted to reflect the differences in patient populations.

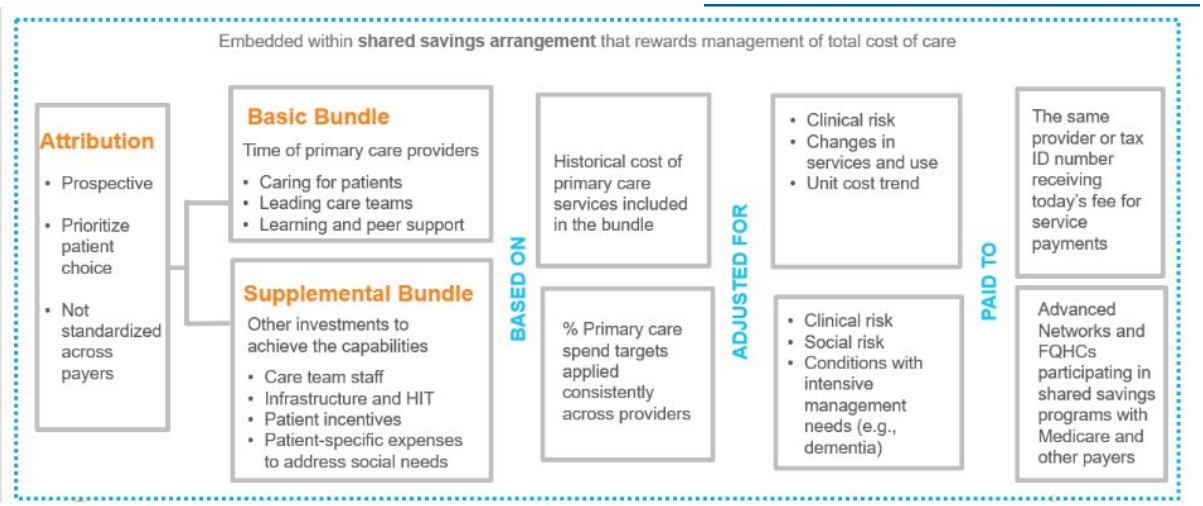
3. Make payments to primary care teams and advanced networks: Basic bundle payments would be made to the same entity previously received office visit payments. Providers described these payments serve as "keep the lights on" dollars for practices and said that it was important to maintain stability. Supplemental bundle payments would be made to the AN or FQHC so investments in new care team members and technologies could be leveraged across practice sites and deployed most efficiently.

4. Only attribute patients to a primary care provider: For this purpose, primary care provider was defined as Family Practice, Internal Medicine with no subspecialty, Internal Medicine with subspecialty of geriatrics, Pediatrics with no subspecialty, General Practice or a Nurse Practitioner or Physician Assistant practicing with one of the above subspecialties.

5. Create Accountability: To help ensure increased primary care reimbursement would not be inflationary, the PRC recommended the bundled payments would only be available to ANs/FQHCs in

MSSP or similar programs that reward accountability for total cost of care. The PRC did not make a recommendation on whether ANs/FQHCs would need to be responsible for losses if the cost of the provider's patient population was higher than expected, often referred to as "downside risk." The PRC also noted stakeholders' concerns regarding the potential for under-service and reviewed a multi-dimensional accountability model that included access tracking, guidance on provider compensation and other components.

FIGURE 10: PCM Payment Model Design



Basic Bundle

The basic bundle was designed to offer primary care teams the flexibility to treat patients based on clinical need and patient preference without the financial and administrative constraints of fee-for-service payment. It would provide an upfront, "bundled" payment to reimburse primary care providers for office visits and most other services currently paid fee-for-service.

Conceptually, the basic bundle would serve as an advance payment for primary care providers' time, freeing them to use their days in ways that best meet the needs of patients. Providers receiving bundled payments report they lengthen office visits with more complex patients, and offer convenient phone, email, text and video visits when its clinically appropriate. Time spent leading care teams, collaborating with colleagues and participating in learning opportunities increases professional satisfaction, helps all members of the care team work at the top of their license and benefits patients.

The model design envisioned that the basic bundle would be based on the historical use of basic bundle services and the price of those services negotiated between the provider and the payer.

Services Included: Research finds that when developing a primary care bundled payment it is important to include services that comprise a meaningful portion of patient care. This approach helps ensure the bundled payment is sufficient to enable the financial flexibility and cultural shift necessary for success (Basu, et. al., 2017).

For adults, the bundle would be based on historical reimbursement for sick office visits. This decision was consistent with the design of CPC+, which does not include preventive visits in its bundled payment. For children, the basic bundle would be based on historical reimbursement for sick and preventive or well visits. The PRC had several discussions regarding whether to include preventive visits in the basic bundle, particularly for pediatric care. Child health and development advocates offered public comment noting the considerable portion of total pediatric practice revenue coming from well visits (Baker & Honigfeld,

2018). Therefore, the model design determined that not including these visits in the pediatric basic bundle could inhibit these practices' ability to have enough flexible revenue for care transformation. These child health and development advocates also noted the potential benefits to patients of offering well visits in innovative formats, such as through a group visit where parents could learn from each other and the primary care team.

The PRC envisioned that the basic bundle would completely replace the payer's portion of the payment for all services included in the basic bundle. The PRC contemplated a "hybrid bundle" similar to what is currently being used by CPC+. In its review, the PRC determined that a hybrid bundle would stifle transformation by financially penalizing providers whenever care was delivered virtually or by another member of the care team. This is because the payment for those services would only be comprised of the bundle component and would be missing the fee-for-service component. A hypothetical case study can be found here.

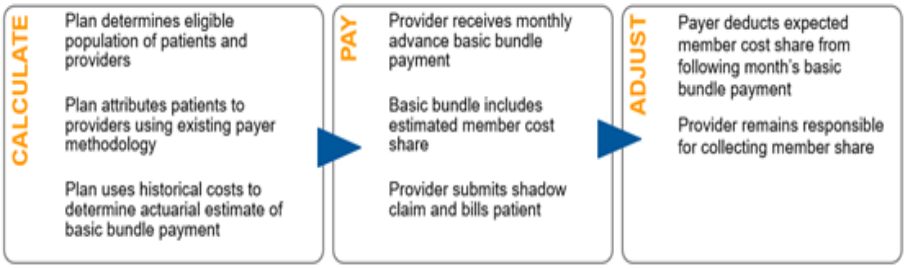
Patient Cost Share: Providers paid via a basic bundle would continue to collect patient cost share according to the patient's benefit design. This fee collection would support the development of a shadow claim, a claim that has the provider payment amount set to zero. Shadow claims are helpful in documenting care without triggering payment and are needed to administer member cost share in costs (e.g., copays). Those designing PCM anticipated some care would transition to phone calls, text messaging and other modes of care delivery that today do not include a member cost share. Payers would evaluate the impact of this change and reflect the impact in premiums and budgets for self-insured employers, who assume financial risk for employee health care benefit provision.

Notably, the design of the payment model was intended to align with existing benefit plan design to offer a smoother, even seamless, transition for consumers and employers. Patients, even those with high deductible health plans, would continue to contribute to the cost of primary care services as they to do today. Primary care providers' basic bundle payments would be adjusted to reflect these payments as shown in Figure 11. Over time, some payers and plan sponsors might have reduced or removed cost share requirements for PCP-provided primary care services to better align with the payment methodology. Reduced cost sharing for primary care services has been shown to increase primary care utilization, improve provider performance on quality measures and support patients in taking medications as prescribed (Ma et al., 2019). For qualified high-deductible health plans with health savings accounts, payers and plan sponsors could increase contributions to health savings accounts for members that designate a primary care physician and receive recommended screenings, preventive services and chronic care.

Documenting Patient Care: In addition, providers receiving payment through the basic bundle would be required to document patient encounters by care team member credentials (e.g. physician, community health worker, pharmacist) and type of encounter (e.g. office visit, phone call, email). More information on Access Tracking can be found here.

Provider Payment Flow: The PRC envisioned basic bundle payments would be made to the same entity that receives office visit payments today. Providers said these payments serve as "keep the lights on" dollars for practices and that it was important to maintain stability in how the payments would be made from the payer to the provider. A graphic showing the administration of the basic bundle is displayed in Figure 11.

Figure 11: Administering the Basic Bundle



Adjusting the Basic Bundle

The basic bundle would be adjusted over time for several factors including changes in the population and services provided.

Payers would use the equation below as a framework to develop the basic bundle. Actuaries at each payer would determine the specific methodologies used to complete the equation. Some factors included in the equation may not have been relevant for all adjustment periods.

FIGURE 12: PCM Basic Bundle Equation

(Base Period Claims (+/-) Addition or Deletion of Services Included) * Population Risk Adjustment * Use Trend * Unit Cost Trend

Added or Deleted Services: The basic bundle equation anticipated that new services may be added to primary care. During the course of the PCM design work, CMS added several new codes and fees to support virtual check-ins, eConsult and remote patient monitoring. Since the basic bundle was based on historical use of services, there may not have been sufficient history of these new services to fully reflect their expected use. With this in mind, payers could have considered utilizing this adjustment to reflect these new services. Another approach would be for payers to recalculate the basic bundle after three years to ensure that it reflects all changes in care delivery.

Population Risk: Risk adjustment was an important component of the basic bundle equation. Since the basic bundle was designed to be based on historical use of primary care services, it already reflected differences in populations across primary care providers with regard to how they used those services.

Recognizing that populations may change over time, the PRC also envisioned a clinical risk adjustment strategy. Typically, clinical risk adjustment is based on clinical conditions that predict total cost of care. As with most payers nationally, no Connecticut payer has implemented a risk adjustment methodology designed specifically to predict primary care cost, rather than total cost, of a patient or population. However, research has found there are relatively small differences in primary care spend across primary care practices within a specific payer's population (Ellis, Ash, Fernandez, 2015). Therefore, the PRC determined that adjusting payments using standardized, validated methodologies designed to reflect total cost of care would be adequate. Each payer would use its existing, preferred total cost of care risk adjustment methodology. Data from shadow claims for bundled services and traditional claims from

other health care services provided to the patient, such as visits to specialists, an emergency department or a hospital, would support this risk adjustment. The risk of each provider's population would be normalized to the overall population.

Changes in Use or Cost of Services: Changes in benefit design can lead to changes in primary care service use. If primary care use changed significantly due to changes in benefit design or need i.e. flu outbreak, the basic bundle would be adjusted to reflect those changes. Similarly, if the cost of primary care services changed, the basic bundle would be adjusted to reflect those changes.

Under the PCM model design, fee for service payments would be used to compensate providers for some primary care services including adult wellness visits, injections for vaccinations and any other covered service that are not part of the basic bundle. Fee for service payments also would be made for any primary care service provided to a patient by a primary care provider that is not his or her attributed primary care provider.

Supplemental Bundle

Currently, most shared savings arrangements offer limited, if any, upfront payments to defray a provider's investments in care delivery transformation (e.g. hiring care team members, improving health information technology). Providers cite concerns about their ability to generate savings sufficient to cover upfront investments as one of the primary reasons they are reluctant to make such investments. For this reason, the PRC recommended the use of a supplemental bundle payment or PMPM to cover the cost of new care team members and other investments that are needed to achieve the recommended capabilities.

The importance of up-front payments and their role in spurring investments in primary care were not obvious to payers and many other stakeholders. For this reason, a case study was used to illustrate how an advance supplemental payment would enable providers to invest in capabilities that they are unable to invest in today.

Hypothetical Case Study

When ABC Health Partners began MSSP, it hired three new care team members including a nurse care manager, a licensed clinical social worker and a pharmacist as part of a new pilot. They immediately improved healthcare outcomes and also saved money. Patients loved the program. Then, ABC Health Partners abruptly ended the pilot.

Why did ABC end the pilot?

- The new employees cost about $300,000.
- It estimated savings of $450,000 due to avoided ED visits, hospital stays and at least one skilled nursing facility stay.
- ABC had to split those savings with Medicare, 50/50. After expenses, its share of the savings ($225,000) becomes a net loss of -$75,000. For ABC, there is no reward for incremental improvements in efficiency.
- Hiring the care team members highlighted other gaps too. ABC had insufficient data to identify high-needs patients; weak connections to community resources; and lacked certain care team members to address specific needs such as pharmacists to troubleshoot medication problems.
- ABC realized it needed advance funding across its payers to redesign its systems and maximize the shared investment as shown in Figure 13.

FIGURE 13: PCM Basic Bundle Equation

THE MATH TODAY	
Cost Paid by Provider	$300,000
Savings	$450,000
Provider Share of Savings	$225,000
Provider Loss after Costs	$225,000 - $300,000 **- $75,000**

THE MATH WITH PCM	
Cost Paid with Advance Funding	$300,000
Savings	$450,000
Savings Net of Investment	$150,000
Payer Share of Savings	**+$75,000**
Provider Share of Savings	**+$75,000**

The PRC envisioned the supplemental bundle as an additional, upfront payment to support activities and investments necessary to achieve the capabilities. Examples of these expenses include salaries and benefits of diverse care team members, new investments in technology and infrastructure, incentives to patients to receive high-value care, and patient-specific expenses to address social determinant of health needs such as food security/food as medicine, housing instability, and transportation. Supplemental bundle dollars also would support coordination with and referral to community resources. ANs/FQHCs could also choose to utilize supplemental bundle dollars to fund formal partnerships with community-placed organizations. For services paid via supplemental bundle funds, providers would not collect a cost share from patients.

Stakeholder Input: Transformation requires investments in more than just salaries. It requires technical assistance, infrastructure development, training, and funding to address social determinants.
Model Impact: The supplemental bundle can be used for any of these purposes.

The PRC recommended that PCM supplemental bundle payments be standardized across ANs and FQHCs participating in each payer's PCM program. This means that unlike the basic bundle, the supplemental payments would not reflect differences in negotiated unit costs across providers. The rationale for this approach was to ensure that the supplemental bundle would add incremental revenue without perpetuating inequities or perceived inequities in current negotiated rates. In contrast, the basic bundle was developed to replace existing revenue without resulting in dramatic changes in that revenue.

Payers would be responsible for developing supplemental bundle targets. Payers would implement separate supplemental bundle targets for adults and pediatrics to reflect the differences in those populations and ensure each population had sufficient funds to benefit from the capabilities. More information about the supplemental bundle glide path can be found here.

Maximizing supplemental bundle investments would require that they be spread over a larger population than a single primary care practice. Therefore, the PRC recommended that supplemental bundle

payments would be calculated for each AN and FQHC and paid to the AN or FQHC. Then, the AN or FQHC would leverage health information technology and other investments across the network and staff each primary care team with the right complement of professionals to meet the needs of their patients.

Adjusting the Supplemental Bundle

Research suggests that traditional risk adjustment methodologies do not adequately predict the expected total cost of care for patients for patients with serious behavioral health conditions and those facing certain social barriers to health (Ash, et. al., 2017). Further, since these patients often benefit from more intensive care management including connections to community-based resources, the PRC recommended participating payers be required to develop a risk adjustment approach that reflects patients' medical, behavioral and social needs. This approach would be reviewed by OHS as part of the payer's annual PCM application. A hypothetical approach to meet this requirement is discussed below.

Hypothetical Risk Adjustment Approach:
Using a tiering structure, supplemental bundle payments would be adjusted to reflect the specific needs and expected costs of each AN and FQHC's population. These expected costs would include the impact of social, behavioral health, and care management needs. This adjustment is similar to the approach used by CPC+ and recognizes key principles established by Bridges to Health, a methodology that groups patients into eight categories based on need to better plan for their care delivery and identify other necessary supports (CPC+, 2017)(Lynn, et. al., 2007).

Supplemental bundle risk tiers would be based on existing risk adjustment methodologies and augmented by additional widely available data to better reflect the impact of four key drivers of primary care team intensity:

1) differences in the clinical needs of pediatric and adult populations,
2) severe behavioral health conditions,
3) dementia, and
4) unmet social needs

For the supplemental bundle, first payers would apply the same total cost of care risk adjustment methodology used for the basic bundle. Then, payers would sort the risk scores and identify the 25th, 50th, 75th, and 90th percentiles.

FIGURE 14: Neighborhood Stress Score Metrics

Neighborhood Stress Score Metrics

- % of families with incomes < 100% of federal poverty level
- % < 200% of federal poverty level
- % of adults who are unemployed
- % of households receiving public assistance
- % of households with no car
- % of households with children and a single parent
- % of people age 25 or older who have no HS degree

Diagnostic data found in medical and pharmacy claims would be the basis for flagging patients with conditions requiring intensive care management such as dementia and severe behavioral health conditions such as schizophrenia, bipolar disorder and major depression. As a next step, payers would use zip code information to identify patients more likely to face unmet social needs. For example, in Massachusetts, a composite measure of "economic stress" was based on seven metrics found in census data. Performance on these metrics translated to whether beneficiaries in the zip code were assigned a neighborhood stress flag signaling increased risk of social barriers to health (Ash, et. al., 2017).

Figure 15 provides a hypothetical example of a supplemental bundle tiering framework for adults. A similar tiering framework would be developed for children. Note adult and child tiers would be based on

different supplemental bundle payment schedules. It was envisioned that future phases of work would refine this approach.

FIGURE 15: Hypothetical Supplemental Bundle Risk Adjustment Tiering

Adult	Definition
Tier 1	risk score <50th percentile, no secondary factor
Tier 2	risk score <50th percentile and Neighborhood Stress Score and/or Severe BH Diagnosis flag
Tier 3	risk score 50th percentile ≤ risk score < 90th percentile, no secondary factor
Tier 4	risk score 50th percentile ≤ risk score < 90th percentile and Neighborhood Stress Score and/or Severe BH Diagnosis flag
Tier 5	risk score 50th percentile ≤ risk score < 90th percentile and Neighborhood Stress Score and Severe BH Diagnosis flag

It is important to note the limitations of claims and demographic data in capturing these risks. Further, all mental illnesses have the potential to require significant care team support and all persons no matter their diagnosis or geography may face complicating factors that make it challenging for them to achieve their best health. In addition, payers would be encouraged to explore other factors as they developed the methodology for supplemental bundle risk tiers.

Attribution

Attribution occurs when a patient is assigned to a provider or a group of providers for a specific purpose such as payment or measurement. Attribution methods typically rely on data from medical claims information, such as the number or percentage of services provided by a clinician or group of clinicians, or the dollars associated with those services. Other approaches ask patients to choose a primary care provider and share this information with the payer. Stakeholders consulted through the PCM design process said existing attribution methodologies were imperfect. However, requiring that payers adopt a new methodology would be challenging for payers that use a nationally standardized approach, it may run counter to other payer specific innovations, and it is unlikely to generate sufficient program value to offset these consequences. They also suggested that it would be more worthwhile to revisit attribution in a few years when experience with PCM could inform the discussion (e.g., frequency and nature of interactions with primary care providers and other care team members).

The PRC envisioned payers would use their current attribution methodologies, with the following modifications requested.

- Prioritize Patient Choice: Stakeholders informing PCM design felt it was important that patients should be able, though not required, to choose their own provider. They recommended that payers develop ways for patient designation of provider to be recognized above all other attribution methods. Patients who chose not to designate a primary care provider would be assigned to one based on the payer's current attribution policy. Stakeholders said it was important that patients be notified when they were attributed to a provider in the program and that those communications should utilize clear, easily understood templates developed by the state.
- Utilize Prospective Attribution: The model envisioned patients would be linked to a primary care provider at the beginning of the performance period. Ensuring that providers know upfront the group of people they are responsible for improves their ability to coordinate high-quality care and

connections to community resources. It also reduces any incentive to drop difficult patients or those whose costs are more difficult to control.

- Only to Primary Care Providers Participating in Payment Innovations: The PCM model defined primary care providers as physicians with a primary care specialty or nurse practitioners and physician assistants with a supervising physician with a primary care specialty. The rationale was that advance funding to support care transformation works best when providers receive a significant portion of their revenue through this type of payment. Recognizing payer methodologies would still attribute patients to subspecialists, the PCM model envisioned those providers would maintain these relationships but would continue to be paid fee for service.
- Revisit Attribution Methods in the Future: Over time, attribution methodologies should be updated to reflect PCP interactions via non-office-based visits and care delivered by other team members.

The PCM model design envisioned that patients could continue to see any provider in their payer's network according to the terms of their benefit design. Providers would continue to be paid fee for service for care provided to any patient not attributed to them, even if they have a primary care specialty.

Framework for Accountability

The PRC discussed the importance of accountability from many perspectives including access, fulfillment of the capabilities, quality, patient experience and cost. An overview of these discussions is below.

Monitoring Progress

The PCM model design envisioned that OHS and payers would evaluate progress toward achieving the capabilities and performance criteria related to access, quality, patient experience, utilization and total cost of care. Data would be aggregated across payers on a standardized set of metrics. Performance data would be derived from the state's Health Information Exchange (HIE), Core Data Analytics Solution (CDAS), All-Payer Claims Database (APCD) and other sources including surveys of patient experience and Access Tracking reports. In addition to routine data sharing with PCM participants, OHS also would utilize this data to develop an annual public report on the performance on PCM participants.

Access: Under the PCM model design, ANs/FQHCs would track all clinical patient encounters and contacts including face-to-face (e.g. office visit) and virtual contacts (e.g. phone, text, email and video visits) with all clinical staff (e.g. physician, nurse practitioner, dietitian, pharmacist or other licensed professional) and with non-clinical staff (e.g. care coordinator). These encounters and contacts would include interactions discussing patients' care plans, but not simply reminders of an appointment. ANs/FQHCs would utilize the approach outlined below or an alternative approach with OHS approval. Additional hypothetical approaches for AN/FQHCs were considered and can be found here.

Stakeholder Input: Whenever providers are not paid for each service performed, there is a risk they will not perform necessary services.
Model Impact: ANs/FQHCs will report all clinical patient encounters with all members of the care team including those that occur through phone, text, email and video visits.

All personnel would record clinical patient encounters in the electronic health record. Documentation would include patient and provider IDs, purpose of the encounter, and services rendered. PCM model design envisioned that Connecticut would build a state-wide mobile

compliant website in which ANs/FQHCs could download or import these encounters from the HIE or CDAS to support their care activities and include in their EHRs. The use case for developing the website would need to be presented and accepted by the CT HIT planning and development process. This approach was developed to minimize burden on practices, while still providing a record of patient interactions to support accountability.

The PCM model design envisioned that data gathered from either process could be used to easily create standardized reports. Report content and format would be determined through a stakeholder process involving OHS, OHIT, participating providers, consumers and other stakeholders. This stakeholder process also would determine the best way to share information on access with the public. An example report is shown in Figure 16. The model design envisioned that OHS and payers would utilize the Access Tracking Report to inform decisions about whether each AN/FQHC could continue participation or be subject to a corrective action plan.

FIGURE 16: Example Access Tracking Report

Access Tracking Report
ABC Healthcare
April 1, 2018-March 31, 2019 (rolling 12 months)

Practices included: Acton, Bridgefield, Essex, Marston and Overbrook

Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).

Attributed Patients		PCP				
Total Number of Patients Attributed		Office Visits	Telemedicine Visits	Home Visits	Phone/Text/E-mail contacts	Total Clinical Encounters
RAW TOTALS	6,149	7,230	2,987	1,172	10,001	21,390
RAW AVERAGES (PER ENROLLEE PER YEAR)		1.18	0.49	0.19	1.63	3.48
RISK ADJUSTED AVERAGES		1.13	0.47	0.18	1.56	3.34

GENERATING THE REPORT

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in their daily work flow similar to other visit types
- AN/FQHC runs a quarterly summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers.
- Summary report includes contacts/patient by type of coverage (Medicare, Medicaid and commercial)

In addition to the Access Tracking Reports, the PRC recommended payers use claims data to identify significant changes in care patterns that might reflect underservice, referrals aimed at maximizing revenue, or unexpected needs for care. For example, payers could track how often attributed patients visit providers at other practices. The process was intended to identify practices with substantial increases and decreases in the office visits delivered by these other practices. If visits to other practices increased substantially, the payer would have the ability to recover some payments to the attributed PCP. If visits to other practices decreased substantially, the payer would have the ability to increase payments to the attributed PCP.

This process was also intended to offer additional protection against payers spending more than expected, ensuring providers receive fair compensation and removing the incentive to deliver in care in a way that captures bundled payments and then refers patients to other providers for additional care delivery.

In addition to the Access Tracking Reports, the model design envisioned OHS would establish a Consumer Feedback Loop in collaboration with its multi-stakeholder advisory bodies to answer questions and investigate complaints. Payers also may implement mystery shoppers to confirm equitable access.

Quality: OHS recently released the state's first healthcare quality scorecard, known as the CT Scorecard on HeatlhscoreCT.com. It assesses the performance of ANs/FQHCs in Connecticut on a set of measures utilizing two data sources: health insurance claims reported to the APCD and Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys administered by contractors for Yale University (commercial beneficiaries) and the CT Department of Social Services (Medicaid

beneficiaries). The CT Scorecard measures were recommended by the SIM Quality Council and encompass a wide range of health care quality domains such as prevention, chronic disease management and behavioral health management. The PCM model design envisioned measures included in the CT Scorecard would serve as a foundation for the quality performance metrics used to assess AN/FQHC performance in PCM. AN/FQHCs would be responsible for sharing these measures with participating primary care practices and developing improvement plans, where necessary. The list could have been expanded over time to better reflect current PCM priorities and when possible, incorporate outcome measures such as whether patients with diabetes kept their blood glucose levels in control or patients maintained a healthy blood pressure.

Stakeholder Input: Many quality measures exist already.
Model Impact: Reporting is built upon previously discussed metrics. PCM will add measures as needed but also aims to better align existing measures across payers and focus all stakeholders on a smaller set of more meaningful measures.

Patient Experience: As noted above, the CT Scorecard includes some measures of patient experience. Under the PCM model, surveys would oversample populations most at risk for 1) disparities, 2) underservice, which occurs when a provider does not provide adequate access to or quality of needed care, and 3) patient selection, which occurs when a provider aims to eliminate less profitable patients from its practice.

Utilization: Utilization metrics would serve two purposes in PCM monitoring. First, the metrics would support the AN/FQHC, payers and OHS in better understanding whether primary care providers' efforts to transform care were leading to reductions in avoidable visits to subspecialists, the emergency department and the hospital. Second, utilization data also would be used to identify significant changes in care patterns that might reflect underservice, referrals aimed at maximizing revenue or unexpected needs for care. For example, increases in visits to urgent care, emergency departments and subspecialists could have signaled a reduction in primary care access.

FIGURE 17: Provisional PCM Impact Goals

HEALTH OUTCOMES IMPROVE

- Improve diabetes and blood pressure in control rates
- Improve rates of preventive screening (colonoscopy)
- Reduce health inequities (e.g. race, ethnicity, income)
- Reduce percent of residents with risk factors (e.g. weight, tobacco use)
- Improve CAHPS scores
- Increase in physician satisfaction, recruitment and retention (PCPs per 100,000)
- Reduce ED costs by 20%; hospital costs by 10%; Medicare skilled nursing facility use by 16%;
- Reduce commercial outpatient hospital costs by 6%
- Reduce specialty care spend by 3.6% in commercial and 6% in Medicare

AFFORDABILITY IMPROVES

- 2% net reduction in total cost;
- 4.7% of Medicare, 4% of commercial spend redeployed to primary care

Total Cost of Care: The PRC and other stakeholders felt it was important to tie additional primary care investments to a total cost of care accountability program as a way to counteract the potential inflationary effect of incremental increases in primary care payments. This framework would offer additional accountability to payers who were reluctant to increase payments to providers without a clear return on their investment. All payments to providers, including the supplemental bundle, would be included in calculations of total medical expense. Those dollars would be included when payers determined if the provider organization was eligible for shared savings or responsible for shared losses. Therefore, stakeholders envisioned that AN/FQHCs participating in PCM would also need to participate in total cost of care accountability programs such as the MSSP Pathways

model and similar programs offered by commercial payers and the state's Medicaid program (CMS, 2018).

While each payer would be responsible for monitoring the return on investment it received from dollars invested in PCM, OHS would utilize APCD data and payer reporting on supplemental payments to better understand the impact of PCM on total cost of care. In Oregon, this data has been used to demonstrate the success of the program and identify opportunities for improvement (OHA, 2019).

The PRC recommended that participating payers and providers agree that the basic and supplemental bundles are intended to support primary care that is not funded by another mechanism. AN/FQHCs would report on use of funds in aggregate (across all payers) and would attest that funds were used for primary care providers and primary care activities and that there was no duplication of funding (payers will not pay for the same service twice). AN/FQHCs would engage a third-party accounting firm of their choosing to issue the report and would be required to share the auditor's findings in their entirety.

The PRC recommended that unused funds could be rolled forward not more than one year and then returned to payer on a prorated basis. In addition, payers would reserve the right to inspect books and records relating to use of funds.

Provider Compensation: In its discussions, the PRC recognized that ANs and FQHCs compensation structures needed to fit within existing contracts, employment arrangements, organizational culture and priorities. Members discussed the need to balance two important considerations in their recommendations.

1) The ability to compensate providers for providing high-quality, efficient care, which often has the impact of lowering total cost of care.
2) The unintended consequence of providers feeling pressure to restrict access to services, not recommend care that would be helpful, or provider selection healthier patients (i.e. cherry picking).

Therefore, the PRC envisioned ANs and FQHCs would continue to determine the internal compensation structure within their organizations. However, they said the model should prohibit participating ANs and FQHCs from tying individual provider compensation directly to a provider's contribution to total cost of care in a manner that incents underservice or patient selection (i.e. cherry picking).

Based on the PRC's discussions, OHS created a provisional approach to support AN/FQHCs in applying for and maintaining participation in PCM. This approach is outlined below.

Initial Application: The PCM model envisioned ANs and FQHCs interested in participating in PCM would complete an initial, provisional application, developed by OHS. In this application, the AN or FQHC would outline its current organizational structure and health information technology infrastructure, its experience to date with primary care transformation and how it would approach achieving the capabilities.

OHS would use this initial application to assess readiness and evaluate the reasonableness of the AN/FQHCs plan to achieve the capabilities over five years, the first phase of the 10-year demonstration. While each participating AN and FQHC will have significant latitude to develop an implementation plan that reflects its patient needs and the organization's infrastructure and culture, all participating ANs/FQHCs will need to achieve all required capabilities by the end of the period.

After reviewing its initial application, OHS would provisionally recommend whether the AN or FQHC was eligible to participate in PCM. The model envisioned Medicare would rely on OHS' determination. At their discretion, Medicaid and private payers could have excluded OHS-approved entities from participation in their PCM programs.

ANs and FQHCs would not have been required to participate in all payers' programs but would be required to meet a minimum threshold (e.g. percent of patients enrolled in PCM or percent of revenue from patients enrolled in PCM) to maintain PCM eligibility.

The model envisioned ANs and FQHCs would build the implementation plans included in their initial applications based on estimates of multi-payer funding. ANs/FQHCs would have the ability to amend their applications if a payer excluded them from its program. All ANs/FQHCs would be subject to another round of review before receiving final OHS approval.

PCM was not designed to introduce significant downside risk to providers. Downside risk occurs when providers share financial responsibility for increases in medical costs with payers. Therefore, PCM would not have assessed ANs or FQHCs solvency.

Ongoing Participation: Following each year of the program, OHS would offer a recommendation to commercial payers and Medicaid as to whether the AN/FQHC would remain in the program, be subject to a corrective action plan or be terminated from the program. The AN application and renewal process and associated supplemental bundle payments were envisioned to run on a synchronized calendar across payers. For the purposes of Medicare, OHS would recommend whether the AN/FQHC would advance along the supplemental bundle glidepath. The model design anticipated payers would continue to consult their own data as part of their internal decision-making processes. Commercial payers and Medicaid would keep autonomy to terminate participation, institute corrective action plans and not advance ANs/FQHCs along the glidepath for their own PCM programs.

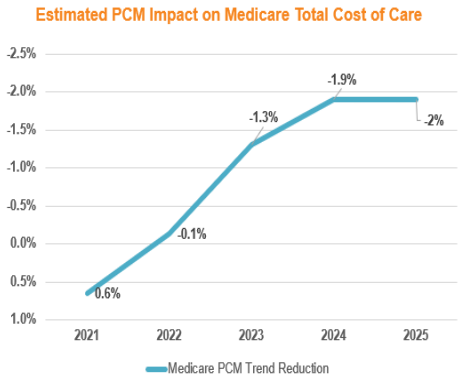
Estimating Savings from New Primary Care Investments

Supplemental bundle targets discussed in this report were developed based on the estimated cost of implementing the capabilities and the estimated savings that could be gained from achieving them.

Pricing Capabilities: To develop the cost estimates, Care Team and Network requirements outlined by capability in the compendium were priced. Connecticut-specific costs were used when available. Multiple scenarios were modeled recognizing each AN and FQHC will incur different expenses, depending on investments made to date and the needs of their patients. All scenarios found the supplemental bundle targets provided adequate funding to achieve the required capabilities and some funds left over to pursue elective capabilities, make investments in health information technology or support patients in addressing social needs.

Estimating Savings: Estimates of the potential savings that could be gained by implementing PCM capabilities were based on an extensive review of the literature and refined by the experience of local and national experts. Reductions in utilization found in the literature were then applied to the historical cost and utilization experience of Connecticut patients through analyses of de-identified Medicare and commercial claims data. Savings calculations recognize multiple capabilities working in concert may contribute to the prevention of a particular cost (e.g. admission, emergency department visit). Care was taken to ensure savings were not duplicated across categories.

FIGURE 18: Estimated PCM Impact on Medicare Total Cost of Care



PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year two
- 2 percent annual reduction in total cost of care by year five
- Less spending on low value services and more spending on high value services
- Approximately 4.7 percent spend redeployed to primary care

Most savings were attributed to the diverse care teams capability. Savings projections were based on work by PWC Health Research Institute which found more than $1.2 million could be saved per 10,000 patients by dramatically broadening primary care teams, relying less on primary care physicians and designing programs to truly serve consumer desires and needs. By leveraging a diversified primary care team, PWC estimated primary care providers could reduce overall emergency department costs by 20 percent and overall costs for hospital admissions by 10 percent. These reductions equaled $36 per beneficiary, per month, which was reduced to $32 per beneficiary per month to reflect the potential that a portion of these savings might inadvertently be counted in another category. A table showing estimated savings by required adult capability for Medicare is shown in Figure 19. A similar table produced for commercial payers can be found here. Commercial savings estimates also anticipated reductions per service costs, similar to those achieved in the successful Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC) program (Song, et. al., 2011). AQC significantly reduced costs over four years, largely by moving care to less expensive sites of service, such as from a hospital imaging department center to an independent imaging facility.

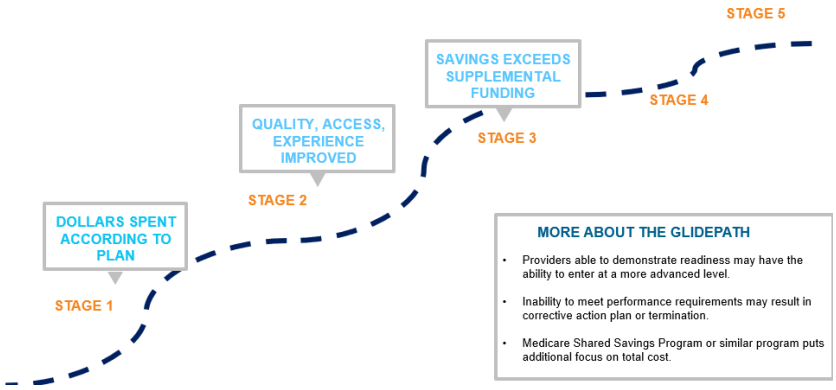
FIGURE 19: Savings Estimates from Capabilities for Medicare Patients

Capability	Estimated Savings for Medicare Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%, inpatient costs decrease 10%. *(PWC 2016)*	$32.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$4.03
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.70
Specialized Practices: Pain Management/MAT	Total medical expense decreases 45%. *(Duke 2017)*	$2.10
Specialized Practices: Older Adults with Complex Needs	Skilled nursing facility utilization decreases 16%. *(Gross 2017)*	$15.03
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$2.34
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

Savings estimates are based on the expected impact of the capabilities when fully implemented. Gradually increasing supplemental bundle payments over time, sometimes referred to as through a "glidepath," supports a range of organizations in achieving the capabilities, at their own pace, over the five-year period. More information on implementation can be found here. PCM would only increase supplemental payments for ANs and FQHCs able to meet certain performance requirements (e.g. access, quality, utilization, patient experience and financial). More information on these requirements and the review process can be found here. The supplemental bundle glidepath recognizes advancements in

primary care demand time, an evolving workforce and shifts in culture. Managing change is a complex endeavor that requires investments in clinical workflow re-engineering and training, as well as connections to technical assistance and peer learning opportunities. PCM is designed to support these investments while maintaining shared accountability for total cost of care.

FIGURE 20: Supplemental Bundle Glidepath



Strawman Model Refinements Based on Stakeholder Feedback

As discussed in the Stakeholder Engagement section of this report, PRC recommendations on the strawman model were shared during a second round of stakeholder engagement. This section discusses the feedback received, recommendations based on the feedback and next steps taken to support stakeholders, particularly providers, payers and purchasers, in better understanding the potential impact of PCM on their operations.

Suggested Modifications Related to the Capabilities

- Health Information Technology:
    - Payers find it important for ANs to be on a single electronic health record platform for reporting.
    - Ideally, ANs should be on the same or a compatible platform to be able to integrate information from external care team members and partner practices.
    - Change in EHR platform is resource intensive for small practices.
    - It takes time to change platforms once a new practice is acquired or affiliated with a network.

Recommended Modification: At least 80% of practices within ANs/FQHCs should be on the same or a compatible electronic health record platform. Newly acquired or affiliated practices should harmonize within two years of acquisition of affiliation.

- Diverse Care Teams:
    - ANs need the ability to develop care teams to meet the specific needs of their patients
    - Some ANs already have relationships with other providers or community-based organizations to augment their care teams. This should be able to continue.

- There is a need for guidance and training on how to structure teams and manage workflow change.

Recommended Modification: Each AN/FQJC will develop and submit for approval an implementation strategy that recognizes its patients' needs and ensures capability requirements are met by year 5. While there should be regular communication between the care team and the practice, team members will be able to be on-site at the practice, in the community or patient homes, and/or at a central hub in the network. Care team members can be established through consulting or subcontracting agreements from partner organizations as needed, provided there are sufficient pathways for communication and data sharing. ANs/FQHCs will be able to spend supplemental bundle dollars on technical assistance for care team development or other needs. In addition, OHS will offer more a Peer Learning Collaborative.

- Behavioral Health Integration:
  - Integration should focus on early identification of BH needs (e.g. screening, assessment) to address issues timely.
  - Co-location of behavioral health services is preferred, but not always possible
  - BHI is difficult to implement and some ANs may need technical assistance
  - PCM should allow practices to contract with partner organizations as needed

  Recommended Modification: Screening and assessment of behavioral health conditions are important requirements of the capability. When feasible, BH team members should be co-located in the practice. Alternatively, they can be at a central hub in the network. Care team members can be leveraged from partner organizations as needed, provided there are sufficient pathways for communication and data sharing. ANs/FQHCs will be able to spend supplemental bundle dollars on technical assistance for BHI or other needs. In addition, OHS will offer a Peer Learning Collaborative.

- eConsults and Co-management:
  - Estimates of the number of eConsults a provider would conduct in a week seem too high.
  - There are many ways to approach eConsults and some are more effective than others.

  Recommended Modification: Savings projections were revised to assume about 3 eConsults per week and 31% of patients still requiring face to face visits. Through its Learning Collaborative, OHS will provide research on evidence-based approaches to implementing eConsults and facilitate peer-to-peer sharing of successes and lessons learned.

- Remote Patient Monitoring:
  - This type of monitoring occurs in both primary and specialty care based on the unique circumstances of a patient's care.
  - There need to be guidelines about who should collect, share, and act on the data

  Recommended Modification: The network will develop policies and procedures guidelines with respect to whether remote patient monitoring requirements should be fulfilled by the primary care team or specialist. Informed by these guidelines, the PCP will decide which members of the care team collect, share, and act on the data.

- Specialized Practices:

- Some ANs said they already had relationships with providers specializing in the care of these populations and would prefer to fulfill the requirements through contracts with those providers.
- Some ANs said it would be difficult to have all three types of specialized practices (Care for Older Adults with Complex Needs, Pain Management and Medication-Assisted Treatment, and People with Disabilities)

Recommended Modification: The AN will determine whether the requirements would be best met through practice specialization or collaborative partnerships with organizations capable of implementing the requirements. All ANs will need to have specialized practices dedicated to each population listed above.

- Universal Home Visits for Newborns:
  - Stakeholders shared a range of perspectives on who should conduct the home visits, how soon after the family returns home, and how to best connect the families to the home visiting team.

  Recommended Modification: ANs will develop practice-level strategies that achieve the home visit guidelines, previously requirements outlining newborn home visit care team composition, timing and how families will be connected with the program and provide consent

Basic Bundle for Interested Providers

As part of Stakeholder Engagement Round 2, participants were asked to provide input on the benefits, challenges and feasibility of transitioning some reimbursement to a basic bundle.

Primary care providers already receiving a bundled or capitated payment for services, such as those working for the Veterans' Administration, noted its transformative ability to allow a full redesign of care delivery including optimizing virtual visits, offering longer, more comprehensive visits with complex patients and supporting a meaningful expansion of the care team. While also recognizing the benefits, many providers working in fee-for-service environments noted the challenges that would likely come from such a transition. These challenges included difficulty tracking access and incenting productivity, the risk of loss of income to primary care providers and a lack of sufficient trust between payers and ANs/FQHCs to administer a new type of payment methodology. Stakeholders also noted the need for changes in provider technology, staffing and workflows to best support this new payment method. And, while some payers said they were already in the process of building payment adjudication systems to support this type of payment, others were not. Payers also mentioned operational challenges in administering a potential single primary care capitation, that could include basic and supplemental bundle services. Generally, stakeholders felt it would be best for some providers and payers to pilot a bundled or capitated payment for primary care before requiring it. One suggestion was allowing ANs and FQHCs participating in PCM to choose one of two payment tracks depending on the organization's infrastructure, culture and patients' needs.

Recommended Modification: Medicaid would not offer the basic bundle; other payers would offer the basic bundle by year 2. Through the two-track approach, ANs/FQHCs could then choose whether they wanted to receive a basic bundle or continue to receive fee-for-service payments. More information on each track can be found below.

Basic Bundle Track: The basic bundle track, Track One, would reimburse primary care providers for certain office visits through an advanced payment, known as a basic bundle. Other care would be paid for fee for

service**.** Payers would be required to offer Track One by the second year of the program. Track Two would continue to reimburse primary care providers through fee-for-service payments. Providers in Track Two would leverage additional codes to support achieving the capabilities. This would be the primary difference between the two tracks. Participants in both tracks would receive an additional advance payment, called a supplemental bundle. This additional payment would also support the cost of new investments necessary to achieve the capabilities.

As discussed below, during the PCM design process CMS announced it intended to add several new codes. PRC members envisioned commercial payers and Medicaid would be required to add or harmonize with those codes as a condition of participation in PCM.

Fee for Service Track: Providers choosing the fee-for-service track would continue to bill for primary care services the same way they do today. New CMS codes and fees to support more virtual care delivery could support a more incremental approach to care transformation. The model design envisioned that PCM would require other payers participating in the program to align with the new CMS codes and fees.

Stakeholder Input: Not all providers may be ready to replace fee-for-service payments for primary care office visits with an advance payment.
Model Impact: Track Two does not include a basic bundle and maintains fee-for-service payments for office visits.

Through the addition of these new codes and fees, CMS wanted to make it easier for providers to offer certain high value services including eConsult and remote patient monitoring. CMS also wanted a way to reimburse providers for brief virtual check-ins such as phone calls, text messages and emails. These new virtual check in codes are not intended to support a broad scale transition to virtual care. Rather, they offer limited compensation for time already being spent addressing patients' minor needs and questions. Providers receive approximately $14 for a virtual check in versus $95 for most office visits if the same patient came in for an office visit. If the virtual communication determines the patient needs an office visit, the provider can no longer be reimbursed for the virtual communication.

Even with the additional codes and fees, Medicare fee-for-service does not currently offer a broad pathway for most providers to bill for a video visit in lieu of an in-person visit. CMS restricts reimbursement for these types of visits to providers serving certain rural areas or treating a set of limited diagnoses. Beginning in January 2020, CMS will remove these geographic restrictions for providers that participate in its total cost of care accountability programs and are at risk for losses. Payment policies for video visits vary across commercial payers.

Evaluating Impact of New CMMI Programs

During the model design process, the Center for Medicare and Medicaid Innovation (CMMI), a key stakeholder in the PCM model design process, introduced two new programs, MSSP Pathways and Direct Contracting, aimed at replacing its existing MSSP program. This was an important development as PCM was envisioned as a multi-payer initiative grounded in a state-specific demonstration project with CMMI. The Pathways model and the Direct Contracting model, both of which move participating providers to downside risk more quickly than previous programs. An overview of these programs can be found here. With this transition in the background, ANs were evaluating whether they would participate in either of the models and if so, where they would enter. Both models offer provider organizations multiple options based on their readiness for risk, and in the case of Direct Contracting, their interest in a capitated payment for primary care or for all care delivery.

Since participation in MSSP Pathways or potentially Direct Contracting was envisioned to be a requirement of participation in PCM, these questions complicated ANs decisions regarding PCM participation.

As a part of their evaluation process, ANs utilized an OHS modeling tool to better understand how the advance supplemental bundle payments provided through PCM would support their care delivery redesign efforts and their success in the MSSP Pathways program. Another OHS tool supported ANs in better understanding how increased primary care investment may change referral patterns, specialty revenue, and how primary care revenue was spent and generated.

Throughout these conversations, ANs were focused on three key questions:

1) Would they be able to spend supplemental bundle dollars in a way that effectively reduced total cost of care and thus improve their chances of success in Pathways?
2) Or, would the supplemental bundle increase total cost of care and thus make success in Pathways more difficult?
3) Could they gain sufficient internal buy-in to transform care delivery quickly enough to succeed in a program that moved more quickly to downside risk? Essentially, as one AN leader said could they go from "heads in beds to the right heads in beds?"

Meanwhile, CMMI was focused on ensuring any program would generate savings. CMMI also noted the additional investment that would be required to adjust its payment systems. Therefore, it was looking for a certain level of guaranteed or near guaranteed savings.

As ANs struggled with whether they could succeed in Pathways "as is," CMMI considered whether it would require a faster progression to downside risk or other terms that offset the advantage gained through the supplemental bundle.

Recommended Modification: Participating ACOs would be required to participate in the MSSP Pathways program. ACOs that begin participation at higher Pathways levels will be eligible for higher supplemental funding. All participating ACOs will be enrolled in a Pathways Level that qualifies them as an AAPM by year three. Other terms and conditions of the Pathways program would apply.

Implications for Other Payers: Commercial payers and Medicaid would determine the terms of the total cost of care accountability program, including if and how they incorporated downside risk. Commercial payers noted PCM may have provided an important leverage in moving ANs to total cost of care accountability arrangements with downside risk. And, they noted this would be important to helping ensure additional primary care investment was not inflationary. The DC model offers a primary care capitation based on a percent of the total cost of care, a model which payers in CT are considering for their Medicare Advantage lines of business and should be revisited. In addition to each payer developing its standard approach, stakeholders envisioned that Medicare and Medicaid may have determined adjustments were necessary to support the unique needs of dual-eligible beneficiaries, whose care is paid for by both payers and who have among the most complex medical, behavioral and social needs.

Stakeholder Input: Some AN/FQHCs may not be ready to be responsible for higher than expected costs for a population of patients.
Model Impact: PCM does not change the terms of total cost of care accountability programs. Payers and providers will determine when they and if they move from sharing in savings to sharing in savings and losses.

Ensuring Sufficient Participation from the State's Payers

Stakeholders noted that without significant and proportionate primary care investment from most of the state's payers, ACOs will not transform and/or a "free rider" problem may develop. They suggested primary care investment should be monitored by the state using the APCD and, as needed, supplemental reporting from participating payers and ANs/FQHCs.

Recommended Modification: As the state agency responsible for facilitating multi-stakeholder payment, care delivery and payment reforms and as steward of all-payer claims and clinical healthcare data, OHS is well positioned to assume these roles. OHS will develop thresholds for payer participation and implement a process for measuring primary care spending as a percentage of total cost of care using data from the APCD and supplemental reporting. Information from this analysis will be used for program monitoring and enforcement. It will be shared with CMS and, also published annually. A provisional approach to payer accountability is outlined below.

Provisional Approach to Payer Accountability

- Adopt an incremental primary care investment strategy that aims to double or nearly double primary care investment over the next five years.
- Require ANs/FQHCs participating in PCM to achieve the recommended capabilities by the end of the demonstration.
- Offer additional codes and fees, harmonized with the Medicare fee schedule, to support the new PCP patient care activities.
- Provider supplemental bundles: standardized, risk-adjusted, incremental, advance payments to offset other investments necessary to achieve the capabilities.
- By Year 2, offer PCM AN/FQHCs the opportunity to participate in PCM Track 1. This track offers a basic bundle, or an advance, bundled payment based on historical revenue. This advance payment would replace, at a minimum, fee-for-service payments for sick office visits for adults and fee-for-service sick and preventive visits for pediatrics. Payers would develop the specific methodologies and adjust their own basic bundles, building off the equation provided in this report. Payers would also include an approach for primary care practices within ANs/FQHCs that may not have sufficient numbers of patients to develop custom actuarial estimates.
- Require that ANs/FQHCs periodically report and be evaluated based on certain performance data, including patient contacts/encounters, as a requirement of participation.
- Require providers participating in PCM also participate in a total cost of care accountability program.

PCM and the Health Enhancement Communities Initiative

Throughout recommendation development the PTTF and PRC recognized that primary care offers a common, trusted touchpoint for patients and their families. Primary care teams are well positioned to prevent, identify and treat disease. They often have a clear view into social and environmental contributors to health. Primary care teams can help bridge the gap between clinical medicine and population health (Galea & Kruk, 2019). As discussed in this report, PCM capabilities and payment model options were designed to support primary care teams in expanding their work in health promotion and address systemic barriers to health while continuing to focus on the specific needs of their patients.

PCM was contemplated as one component of a comprehensive approach to make Connecticut the healthiest state in the nation and slow its healthcare spending. The Health Enhancement Communities

(HEC) Initiative, a companion initiative, focuses on creating sustainable, multi-sector collaboratives across the state that implement health, health equity, and prevention strategies in the communities they serve. Primary care plays a vital role in the health of communities and would play a vital role in the work of HECs. Meanwhile HECs would offer PCM primary care teams the benefit of coordinated, aligned community focus on a shared vision for health improvement.

Together, HEC and PCM proposed a community-based approach to health that included an empowered primary care team ready to support patients in achieving their best health, identify and address systemic barriers to health, and partner with clinical and community resources to cocoon patients facing the most complex medical, behavioral and social needs.

Stakeholders envisioned that primary care teams could serve as important community partners in HECs. The initiative has identified two early aims:

1) Improve Child Well-Being in Connecticut Pre-Birth to Age 8 Years
2) Increase Healthy Weight and Physical Fitness for All Connecticut Residents

To illustrate how PCM and HEC were envisioned to complement each other's efforts, the following hypothetical narrative suggests how a lactation consultant could be integrated into a pediatric primary care practice and simultaneously support HEC aims.

Lactation Consultants Partnering with Families, Primary Care Teams and Communities

Breastfeeding offers many benefits. Skin-to-skin contact and touch supports the mother and child learning to communicate with each other and builds a sense of security within their relationship. Strong parent-child relationships contribute to brain development, can increase child well- being by reducing the occurrence of adverse childhood events and serves as a protective factor that enables children to cope with adverse events when they occur—both of which are at the heart of the HEC health priority of improving child well-being. Breastfeeding also increases health benefits for children and mothers. It has been linked to lower risks of acute illnesses and lower risks of chronic illnesses such as obesity, which supports the HEC health priority of healthy weight and physical fitness.

Through direct patient care and community collaboration, a layered network of support would assist mothers in establishing and lengthening the breastfeeding relationship with their child.

Direct Patient Care: Through visits at the primary care office, in a group setting or in the family's home, a lactation consultant would advise, direct, and support breastfeeding and potential breastfeeding families through education and counseling. In addition, the lactation consultant could be available through phone, text, email and by video to answer questions as they arise.

Community Collaboration: Lactation consultants and other members of the pediatric team could collaborate with HECs and community members to design and launch a community-wide campaign to promote breastfeeding. In addition, lactation consultants could share knowledge gained from supporting families to contribute important insights to HECs multi-sector work. These insights could be used to inform the collection of data to identify populations most at risk for facing barriers to breastfeeding. The primary care team, HEC and its multi-sector partners could then work jointly to examine problems community members are facing and devise potential solutions. Continuing with that collaborative approach, they could engage all partners in developing and implementing new policies, systems, or programs in both clinical and community settings. Together, they could continuously monitor and improve the policies, systems, and programs to ensure that they are effective in addressing the needs of populations.

Actuarial Analysis of Capabilities Investment

After stakeholder discussions on the strawman model, an actuary was hired to further develop the cost and savings assumptions. As part of this process, OHS revisited and adjusted the assumptions around price of capabilities and estimated savings. This section details pricing and savings for Medicare, Commercial and Medicaid respectively.

Over five years, healthcare spending for Connecticut Medicare beneficiaries could decrease more than $505 million net of expenses over five years if all had improved access to an expanded and diversified primary care team and other capabilities, an analysis of healthcare spending and utilization data found. The state's employee benefits plan could save nearly $89 million over five years if its members had the same access. The analysis found increasing primary care spending by 1.3% to 6.8% of total medical expense could lead to an annual net reduction in total cost of care of 0.3% to 3.6% by year five, for 10 of

the 11 populations studied (See Figure 21). The final population, Medicaid's Husky B, also known as Children's Health Insurance Program, was not expected to generate savings.

FIGURE 21: Projected Reduction in Total Medical Expense After New Primary Care Investment*

Payer	Population	Cost of Implementing the Capabilities Through Increased Primary Care Investment	Annual Net Reduction in Total Medical Expense 2025* (% TME)	Net Reduction in Total Medical Expense 2021-2025* (% TME)
Commercial	Adult	2.0%	2.1%	0.7%
	Child	2.1%	3.5%	1.4%
	Early Retiree Adult	2.3%	2.7%	1.0%
	Retiree	3.4%	2.5%	0.7%
Medicaid	Husky A Adult	3.9%	1.4%	0.0%
	Husky A Child	4.0%	1.9%	0.2%
	Husky B Child	6.6%	-5.0%	-3.5%
	Husky C Adult	5.1%	3.2%	0.7%
	Husky D Adult	6.8%	0.3%	-1.0%
	Husky D Child	1.3%	0.9%	0.2%
Medicare	Fee for Service	3.4%	3.5%	1.2%

** Calculations of total medical expense do not include pharmacy costs to be consistent across payers as Medicare Part D spending data was not available. Commercial projections were developed using data from the Office of the State Comptroller employee benefits plan. Medicaid projections were developed using data from the Department of Social Services. Medicare projections were developed using data available from the Centers for Medicare and Medicaid Services on the Connecticut Medicare population and data from the Office of State Comptroller on individuals with retiree coverage. Commercial Early Retiree Child and Medicaid Husky B Adult and Husky C Child populations are not shown due to very limited membership. Savings for these populations are included in overall savings projections.*

The challenge of achieving short-term savings for children, particularly those with high behavioral health and social needs, is multi-faceted. Higher rates of children with complex medical needs, behavioral health needs and experiencing adverse childhood events drive higher estimated care team costs. However, since many of those health and social needs do not manifest as costs until later, it is difficult to show savings within five years. Further, the impact of unaddressed behavioral health and social needs of children go beyond medical costs.

Methodology

The analysis included two steps 1) determine the cost of implementing a series of primary care capabilities 2) estimate the potential savings of implementing those same capabilities.

Determine the Cost of the Capabilities: The capabilities included in the analysis were recommended by the state's Practice Transformation Task Force (PTTF) as part of a multi-stakeholder process to improve primary care in the state. The PTTF guided stakeholders through an evaluation of primary care capabilities and possible payment model options to support those capabilities. Their goal was to determine whether incremental, flexible investments in primary care through evidence-based improvement strategies for primary care would support convenient care centered on the needs of patients and families and delivered effectively and efficiently. The PTTF recommendations included nine adult, core capabilities and three

elective or optional capabilities. The PTTF also recommended eight required or core pediatric capabilities and two optional pediatric capabilities. This analysis only estimated the impact of required, core capabilities for adults and pediatrics. More information on the capabilities including requirements to fulfill each capability, examples of how the patient experience would change and other expected impacts can be found in the PCM Capabilities Compendium (CT OHS, 2019).

The greatest cost associated with each capability was the additional staff necessary to carry out the associated tasks. The PTTF and multi-stakeholder design groups identified the care team members necessary to optimize the primary care experience for patients and families. For adult populations, full-time equivalent staffing levels for each provider type were developed using the PWC Health Research Institute's care team composition framework (PWC Health Research Institute, 2016). For pediatrics, care team composition and staffing levels were developed with Connecticut child health advocates and pediatricians.

For adults and pediatrics, staffing estimates were priced to align with Connecticut salary and benefit costs. Estimates were reviewed for reasonableness by representatives of Connecticut provider organizations, payers and foundations and refined as necessary. The model assumes participating provider organizations would have some foundational health information technology and infrastructure to support virtual care delivery and care coordination. It includes additional funds to support infrastructure, training, health information technology and other overhead costs associated with the expanded care teams.

Some provider organizations may find different care team compositions or additional investments in health information technology and infrastructure are necessary to meet the needs of their patients. Others may have existing infrastructure that reduces the incremental cost contemplated in this analysis. For each population, assumptions were made regarding the level of optimal care team use. To help ensure enough resources would be available, these estimates were developed with a conservative lens. Fewer care team members may be adequate, which would increase net savings.

Estimate Savings from Capabilities Implementation: Savings assumptions were developed based on a literature review of published evidence on the effectiveness of the PTTF core capabilities. The estimates were then reviewed for reasonableness by representatives of Connecticut provider organizations, payers, OSC and actuaries representing OSC and OHS and refined as necessary. Recognizing researchers may be less likely to publish disappointing results, most savings assumptions from the literature were reduced, as well as the size of the population most likely to benefit from the capability. Additionally, the analysis assigned savings to a single capability even if more than one capability contributed to the care improvement. For example, if a hospitalization was avoided because a nurse care manager answered a phone call from a patient, the savings from the hospitalization were assigned only to the Diverse Care Teams capability and not included in estimates for the Phone, Text, Email, Telemedicine capability. Savings found in the literature were then applied to the utilization and cost data provided by OSC and Medicaid. In some cases, publicly available data were used to supplement data provided by the plan. The Medicare population's estimated savings are based on savings assumptions used for the OSC Medicare Retiree population.

RESULTS

Capabilities Cost Analysis: For each population, data from the payer and publicly available information was used to identify a "target group" or a percent of the population that could benefit from the

capabilities. For Commercial and Medicare, this percentage was informed by data from the Rand Corporation on the percent of adults with multiple chronic conditions by age and gender. For Medicaid, this analysis was informed by "Prevalence and Medical Costs of Chronic Diseases Among Adult Medicaid Beneficiaries," a 2017 meta-analysis of research examining the incidence of chronic conditions among adult Medicaid beneficiaries published in the American Journal of Preventive Medicine (Chapel et al., 2017). Recognizing some patients manage their conditions well without additional support and others may decline to participate, this percentage was reduced by 49% based on Milliman research that used predictive modeling software to estimate the percent of individuals most likely to benefit from services similar to those outlined in the capabilities (Whittall and Caldwell, 2018). The number of individuals in the target group was then inserted into the PWC framework to determine the appropriate number of care team FTEs. The cost per target group member is estimated at $1,008. When those costs were spread across the population, the additional PMPM cost was approximately $12 PMPM for commercial adults, $18 for early retirees, and $35 for the Connecticut employee benefits plan retiree program. The Medicare fee-for-service population were assigned the same $35 cost. The PMPM cost for adult Medicaid beneficiaries ranged from approximately $11 to $28 depending on the program. As in the PWC model, those figures include an additional $1 PMPM was added for health information technology, training and other overhead associated with deploying new care team members and achieving the capabilities.

The pediatric care team would offer support to all children and families, with an emphasis on reaching the following subpopulations: 1) children with chronic conditions such as asthma, 2) children with complex medical needs 3) children at risk for adverse childhood events and 4) families with newborns. The estimated cost of the expanded pediatric care team was approximately $5 PMPM for commercial and nearly $10 PMPM for Medicaid. Differences in the proportion of children in each of the focused subpopulations drove the variation in care team costs. As noted above, some care teams may be able to achieve improved outcomes with less intensive resources, which would decrease the cost of program and provide more opportunity for short-term savings. Similar to the adult model, the pediatric cost estimates include $1 PMPM added to cover additional costs associated with implementing the capabilities.

Capabilities Savings Analysis: Figure 22 below shows the 2018 PMPM reduction in total cost of care by population for each of the required capabilities for which savings were calculated. Savings assumptions were adjusted to avoid duplicating savings across capabilities. In addition, note that the estimates are PMPM savings spread across the entire population, including among individuals not impacted by capability. Savings assumptions are higher for the subset of individuals who would be directly impacted by the capability. Also note that Medicare Part D pharmacy data was not available for Medicare and therefore pharmacy was not included in the denominator for these analyses.

Figure 22: Estimated Savings PMPM by Capability Category

Payer	Population	Diverse Care Teams	Phone Text Email Telemedicine	Econsults and Co-management	Behavioral Health Integration	Specialized Practices Pain Mgmt/SUD	Newborn Universal Home Visits	Specialized Practices Older Adults	Remote Patient Monitoring	Community Integration	ALL	
											PMPM	% Savings
Commercial*	Adult	$13.59	$2.65	$0.51	$6.69	$1.60	$0.00	$0.00	$0.15	$0.00	$25.18	4%
	Child	$4.36	$1.25	$0.35	$2.78	$0.00	$5.86	$0.00	$0.00	$0.00	$14.59	6%
	Early Retiree Adult	$25.30	$2.44	$0.61	$8.18	$2.09	$0.00	$0.00	$0.20	$0.00	$38.81	5%
	Retiree	$33.79	$2.35	$0.48	$9.78	$3.29	$0.00	$10.52	$0.18	$0.00	$60.38	6%
Medicaid	Husky A Adult	$9.06	$0.00	$0.14	$2.01	$2.09	$0.00	$0.02	$1.46	$0.69	$15.47	5%
	Husky A Child	$2.21	$0.00	$0.17	$1.68	$0.00	$10.34	$0.00	$0.00	$0.13	$14.53	6%
	Husky B Child	$1.19	$0.00	$0.09	$0.93	$0.00	$0.00	$0.00	$0.01	$0.13	$2.35	2%
	Husky C Adult	$11.37	$0.00	$0.07	$4.96	$6.56	$0.00	$14.66	$7.90	$0.69	$46.21	9%
	Husky D Adult	$16.10	$0.00	$0.14	$3.58	$4.96	$0.00	$0.57	$2.97	$0.69	$29.00	7%
	Husky D Child	$9.75	$0.00	$0.25	$6.78	$0.00	$0.00	$0.00	$0.00	$0.13	$16.91	2%
Medicare	Fee-for-Service	$39.94	$2.53	$0.48	$9.78	$3.29	$0.00	$15.03	$0.18	$1.28	$72.51	7%

Commercial Early Retiree Child and Medicaid Husky B Adult and Husky C Child populations are not shown due to very limited membership. Savings for these populations are included in overall savings projections.

Most savings were attributed to the Diversified Care Teams capability. This capability is defined as the expansion and diversification of care teams to make primary care more comprehensive and accessible, better meet the needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction. Two rationales for this attribution of the savings were that 1) effective care team members were the most critical component to the success of any capability and 2) most costs for achieving the capabilities were attributed to the associated salary and benefit costs. The PWC framework estimates that a diversified care team could result in a 20% reduction in emergency department costs and a 10% reduction in inpatient costs. The PWC results were based on a multi-payer, all ages patient population. With this in mind, the model reduces these percentages for commercial active adults and all children. For active adults, emergency department savings were reduced from 20% to 18% and inpatient savings were reduced from 10% to 8%. For children, pediatric emergency department savings were reduced from 20% to 10% and pediatric inpatient savings were reduced from 10% to 6%. The full PWC savings assumptions were applied to the Medicare. Savings for the Medicaid population were adjusted downward to avoid duplicative savings across the behavioral health and remote patient monitoring capabilities and to reflect potential higher barriers to primary care access and use even after implementing the program.

Behavioral Health Integration (BHI), defined as a team-based, primary care approach to identifying and managing common behavioral health conditions, co-occurring health conditions, and lifestyle behaviors that affect health, also drove savings across the populations. A Milliman research report on potential economic impact of integration of medical-behavioral healthcare review of models demonstrated a cost savings estimate range from 5% to 10% of total healthcare costs over 2 to 4 years. This research informed savings estimates that were developed for each population and applied to prevalence and cost data from the payer for commercial (state employee plan) and Medicaid. Medicare estimates were based on retiree data from the state employee plan. As with all the capabilities, it was assumed only a portion of those who might benefit would engage.

Specialized Practices for Older Adults with Complex Medical Needs is defined as enhanced primary care from a practice specially designed to improve outcomes for patients age 75+ with multiple chronic conditions, functional challenges, trouble traveling to in-office visits, and more likely to have potentially avoidable emergency department visits and require nursing home placement. The American Journal of Accountable Care reported a improved care coordination strategy and a skilled nursing facility strategy for older adults that resulted in a 19% decrease in skilled nursing facility days. This model reduced the impact to a 16% reduction and tried to isolate the impact to acute skilled nursing facility care, which would be most responsive to improved primary care. Medicaid was unable to isolate this type of skilled nursing facility care. The model assumes 10%.

Universal Home Visits for Newborns offered savings for pediatric populations despite the cost of offering this service. This capability would offer families a home visit with a nurse and a community health worker, if desired. Visits would aim to offer new parents important tips about infant health and development including strategies for eating, sleeping and play. The visit would aim to begin building a relationship between the primary care team and the family. Visits could identify families in need of social support or parents facing behavioral health conditions including post-partum depression and anxiety. A successful program in North Carolina informed savings assumptions for this capability. Durham Connects was a program to assess family needs and connect parents with community resources to improve infant health and well-being. All 4777 resident births in Durham, North Carolina, between July 1, 2009, and December 31, 2010, were randomly assigned to intervention and control conditions. Hospital discharge records found Durham Connects families had 85% fewer hospital overnights and 18% fewer emergency visits.

These assumptions were applied to utilization data for children under 1 provided by Medicaid and the state employee plan to develop commercial savings estimates.

Savings were not assigned to the Health Equity Improvement capability, which includes development of a clear, documented policy and procedure to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities. The data collection and analysis contemplated in this capability would be helpful in ensuring gains in care quality and outcomes are equitably distributed. However, since savings already applied to inpatient and ED for all patients, additional savings may be duplicative. Savings for the Specialized Practices for Individuals with Disabilities was not calculated as each practice will likely require a specific model with its own services and input costs to offer the best support to its patients.

Current Primary Care Investment in Connecticut

Another takeaway from the Primary Care Modernization process was the need to better understand current primary care investment.

Primary care spending varied by less than $5 per member, per month across Connecticut residents with health coverage through the state's employee benefit plan, Medicaid, or Medicare, according to an analysis of 2018 primary care spending in the state. The Connecticut Office of Health Strategy (OHS) performed the analysis on Connecticut primary care spending to better understand the opportunities for investment in primary care and the improvement of healthcare delivery in the state. See Figure 23 for PMPMs and percent primary care spend by payer and population.

Primary care spending was 5% of total medical expense including pharmacy for all individuals enrolled in the state employee benefit plan, which served as the commercial population for the analysis. Primary care spending among Medicaid beneficiaries was 6% of total medical expense including pharmacy using the same technical specifications as the commercial analysis.

However, Medicaid offers many services and supports to help beneficiaries achieve their best health that are often utilized far less frequently by or are outside the covered benefits of commercial plan members. These services include long-term stays in skilled nursing facilities and other facilities, transportation to provider appointments, home care and personal care services. While some of these services were excluded for this report, others remained, including skilled nursing care. Skilled nursing facility spend across the commercial population was approximately $1 PMPM. In the Medicaid population, it was more than $124 PMPM. This difference impacts the percent primary care result. Without skilled nursing facility spend, the 6% Medicaid primary care spend figure would have been 8%. Better understanding these and other differences in utilization across payers will be important as policymakers consider primary care spending targets. A list of the services and provider types excluded in the Medicaid total medical expense denominator is provided in the methodology.

Commercial projections were developed using data from the Office of the State Comptroller (OSC) employee benefits plan. Medicaid projections were developed using data from the Department of Social Services. Medicaid and OSC payers used a primary care spend definition developed in partnership with the New England States Consortium Systems Organization that is very similar to the Definition 4 described in Standardizing the Measurement of Commercial Health Plan Primary Care Spending, a 2017 report published by the Milbank Fund (Bailit, Friedberg, & Houy, 2017).

Spending on primary care services for Connecticut Medicare beneficiaries was 2 percent of total medical expense including pharmacy. Due to data limitations, a different definition and methodology was used to calculate this percentage. Medicare projections were developed using the percent primary care spend from the Connecticut Medicare "Narrow" definition result included in the Primary Care Collaborative report "Investing in Primary Care A State-Level Analysis" (Jabbapour, et al., 2019). This percentage was then applied to data available from the Centers for Medicare and Medicaid Services on the Connecticut Medicare population. To calculate the percent Medicare primary care spend including pharmacy, assumptions regarding Connecticut Medicare pharmacy spend were made based on data for retirees enrolled in the state employee benefit plan. Medical spend data for the two populations were nearly identical.

FIGURE 23: 2018 Connecticut Primary Care Spending by Payer

Payer	Population	Primary Care PMPM	% Total Medical Expense w/o Rx	% Total Medical Expense w/ Rx
Commercial	Adult	$34.23	5%	4%
	Child	$33.26	13%	11%
	All	$34.01	6%	5%
Medicaid	Adult	$30.55	6%	4%
	Child	$34.96	16%	13%
	All	$32.63	9%	9%
Medicare	All	$33.62	3%	2%

Methodology: The commercial primary care spending analysis utilized 2017 data from the Office of State Comptroller (OSC) employee benefit plan and was performed by High Line Health. Community Health Connecticut Inc (CHNCT) performed the Medicaid primary care spending analysis on 2018 data. Both entities are under contract with the respective payers to perform analytic work. Both payers used a definition developed in partnership with the New England States Consortium Systems Organization (NESCSO) that is very similar to the Definition 4 described in Standardizing the Measurement of Commercial Health Plan Primary Care Spending, a 2017 report published by the Milbank Fund outlining opportunities to standardize measurement of primary care spending. Primary care spending estimates for adults and children were calculated. Spending for OSC Medicare-eligible retirees is not included in this analysis. Calculations were based on the total allowed amount for the CPT codes included when performed by providers with one of the included taxonomy codes. The taxonomy code list was consistent with the taxonomy code set used by the Connecticut OHS Quality Council. For Commercial and Medicare, the analysis did not include care management fees or other non-claims-based payments. The analysis includes these payments for Medicaid. As mentioned above, Medicaid provides services that are unique to their population and therefore the claims reflected in Figure 23 were removed from the Medicaid total medical expenses. As noted in the Summary of Findings, skilled nursing facility use was not removed from the denominator for this analysis due a lack of granularity regarding what percentage of that utilization related to acute rather than long-term care.

Figure 23: Medicaid Claims Excluded from Total Medical Expense

Exclusion Type	Type/Specialty

Claim Types	• Medicare Crossover • Dental • Vision • FQHC – Dental • Durable Medical Equipment
Provider Types	• Autism waiver • Mental health waiver • Mental health waiver performing provider
Provider Specialties	• DDSD/ICFMR waiver • Waiver group home • MFP-IFS/Comp waiver biller • Employment and day supports waiver billing provider • Autism waiver • Mental health waiver • Mental health waiver service provider • Mental health waiver performing provider

Medicare: Due to a lack of sufficiently granular data on Medicare spending, this analysis leveraged a Medicare primary care spending percentage reported by the Primary Care Collaborative, "Investing in Primary Care: A State Level Analysis" report and applied it the CMS data on Connecticut Medicare beneficiaries. The percentage shown here is the "Narrow Definition" referenced in the PCC report, which was most consistent to the definition used for this analysis by Commercial and Medicaid payers. However, comparing Commercial and Medicaid results in this report to the Private (Commercial) and Medicaid results published in the PCC report suggest the Connecticut Medicare primary care spending percentage may have been higher if the same definitions and methodologies used for Commercial and Medicaid in these analyses were also applied to Medicare for this analysis.

Wrap Up

In the process of sharing the strawman model with stakeholders, we could not move forward with the design process as initially planned for several reasons.

CMMI noted that its requirements for new programs were evolving and the agency put forward several requirements for the PCM model, many of which OHS felt would be difficult, if not impossible, to meet. For example, CMMI was looking for opportunities to long-term commitments from provider organizations. Meanwhile, the Connecticut provider landscape was changing quickly, both of which made it difficult for provider groups to make such a guarantee. CMMI also sought a guarantee of a minimum level of net savings, a condition OHS worried might not lead to the best outcome for Connecticut providers or patients.

In parallel, ANs were trying to determine their own paths forward in a quickly changing environment. As noted earlier, CMS had completely revamped its MSSP program and added Direct Contracting, both of which pushed ANs to take on downside risk more quickly. More risk for losses made ANs more reluctant to take on the incremental advance payments offered by PCM out of fear they would not be able to successfully generate a return on those investments. Direct Contracting also introduced a percent of

premium opportunity, which offered the flexibility envisioned by PCM with few requirements on how the advance payments would be used.

Ongoing collaboration with DSS, DPH and OSC will continue on the best path to ensure the goals of better primary care and increased spending on primary care will be achieved.

Appendices

Appendix 1: Acronyms and Definitions

Acronym	Definition	Acronym	Definition
AN	Advanced Network	HIT	Health Information Technology
APCD	All-Payer Claims Database	LCSW	Licensed Clinical Social Worker
APRN	Advanced Practice Registered Nurse	MSSP	Medicare Shared Savings Program
BH	Behavioral Health	NAMI	National Alliance on Mental Illness
BHI	Behavioral Health Integration	NP	Nurse Practitioner
CAB	Consumer Advisory Board	OEC	Office of Early Childhood
CAHPS	Consumer Assessment of Health Advisors and Systems	OHIT	Office of Health Information Technology
CBO	Community Based Organization	OHS	Office of Health Strategy
CCIP	Community and Clinical Integration Program	OMB	Office of Management and Budget
CCM	Chronic Care Management	OSC	Office of the State Comptroller
CDAS	Core Data Analytics Solution	OWC	Office of Workforce Competitiveness
CHF	Congestive Heart Failure	PA	Physician's Assistant
CHW	Community Health Worker	PCM	Primary Care Modernization
CMS	Centers for Medicare and Medicaid Services	PCMH+	Person-Centered Medical Homes Plus
CoCM	Collaborative Care Model	PCP	Primary Care Provider
CPC+	Comprehensive Primary Care Plus	PCPCH	Patient-Centered Primary Care Home
CPT	Current Procedural Terminology	PHQ	Patient Health Questionnaire
CT	Connecticut	PMPM	Per Member Per Month
DPH	Department of Public Health	PRC	Payment Reform Council
DOB	Date of Birth	PSI	Prevention Service Initiative
DSS	Department of Social Services	PTTF	Practice Transformation Task Force
ED	Emergency Department	PWC	PricewaterhouseCoopers
EHR	Electronic Health Record	RHC	Rural Health Clinic
E/M	Evaluation and management	RN	Registered Nurse
FFS	Fee for Service	SDOH	Social Determinates of Health
FQHC	Federally-Qualified Health Center	SIM	State Innovation Model
HCPCS	Healthcare Common Procedure Coding System	VBID	Value-Based Insurance Design
HEC	Health Enhancement Communities	WHO	World Health Organization
HIE	Health Information Exchange		

Advanced Network (AN): A provider organization or group of provider organizations that includes primary care providers within one or more practices with PCMH status or PCMH accreditation.	**Health Information Technology (HIT):** The electronic systems health care professionals and patients use to store, share, and analyze health information.
All-Payer Claims Database (APCD): Collects, assesses and reports health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care.	**Licensed Clinical Social Worker (LCSW):** A social worker who has been licensed by his or her state of residence to provide clinical social work services to patients.
Advanced Practice Registered Nurse (APRN): A nurse who has a master's, post-master's certificate, or practice-focused doctor-of-nursing practice degree in one of four specific roles.	**Medicare Shared Savings Program (MSSP):** Encourages coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.
Behavioral Health (BH): The scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self.	**National Alliance on Mental Illness (NAMI):** The nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.
Behavioral Health Integration (BHI): High-quality, coordinated health care between behavioral health and medical providers.	**Nurse Practitioner (NP):** A nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor.
Consumer Advisory Board (CAB): Advocates for consumers and provides for strong public and consumer input in healthcare reform policies in Connecticut.	**CT Office of Early Childhood (OEC):** Established in 2013 to coordinate and improve the various early childhood programs and components in the state to create a cohesive high-quality early childhood system.
Consumer Assessment of Health Advisors and Systems (CAHPS): Advances our scientific understanding of patient experience with health care.	**Office of Health Information Technology (OHIT):** Uses health information technology to support quality improvement to achieve the state's aims of healthier people, better healthcare, smarter spending, and health equity.
Community Based Organization (CBO): A public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs.	**Office of Health Strategy (OHS):** Develops health policy that improves health outcomes and limits health care cost growth across all sectors, whether private or public, including hospitals, physicians and clinical services and prescription drugs.

Community and Clinical Integration Program (CCIP): Comprised of a set of care delivery standards and technical assistance that is intended to enable Advanced Networks and Federally Qualified Health Centers (FQHCs) to deliver care that results in better health outcomes at lower costs for Medicare, Medicaid, and commercial plan enrollees.	**Office of Management and Budget (OMB):** Oversees the performance of federal agencies and administers the federal budget.
Chronic Care Management (CCM): The oversight and education activities conducted by health care professionals to help patients with chronic diseases and health conditions such as diabetes, high blood pressure, lupus, multiple sclerosis and sleep apnea learn to understand their condition and live successfully with it.	**Office of the State Comptroller (OSC):** To provide accounting and financial services, to administer employee and retiree benefits, to develop accounting policy and exercise accounting oversight, and to prepare financial reports for state, federal and municipal governments and the public.
Core Data Analytics Solution (CDAS): Enables in-depth data analytics, including electronic Clinical Quality Measures (eCQMs) to support payment and practice reforms.	**Office of Workforce Competitiveness (OWC):** Assists the Labor Commissioner as one of the Governor's workforce development policy advisors with the goal of ensuring Connecticut has sufficient talent to support its economic growth.
Congestive Heart Failure (CHF): A chronic condition that affects the pumping power of the heart muscles.	**Physician's Assistant (PA):** A health care practitioner who practices medicine in collaboration with or under the supervision of a physician, depending on state laws.
Community Health Worker (CHW): Members of a community who are chosen by community members or organizations to provide basic health and medical care to their community capable of providing preventive, promotional and rehabilitation care to these communities.	**Primary Care Modernization (PCM):** Includes developing a new model for primary care in Connecticut that supports providers in expanding their care teams and offers new ways for patients to access care outside of a traditional office visit. PCM also will propose a more flexible payment model that supports these improvements in care delivery.
Centers for Medicare and Medicaid Services (CMS): Federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health	**Person-Centered Medical Homes Plus (PCMH+):** Provides person-centered, comprehensive and coordinated care to HUSKY (Connecticut Medicaid) members.

Insurance Program, and health insurance portability standards.	
Collaborative Care Model (CoCM): A model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team.	**Primary Care Provider (PCP):** Health care professional who practices general medicine.
Comprehensive Primary Care Plus (CPC+): A national advanced primary care medical home model that aims to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation.	**Patient-Centered Primary Care Home (PCPCH):** A primary care system that emphasizes care coordination and communication and focuses on patients' needs, providing higher quality care at lower costs.
Current Procedural Terminology (CPT): A system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.	**Patient Health Questionnaire (PHQ):** An instrument for screening for potential behavioral health needs.
Connecticut (CT): The state of Connecticut.	**Per Member Per Month (PMPM):** Refers to the dollar amount paid to a provider (hospital or healthcare worker) each month for each person for whom the provider is responsible for providing services.
Department of Public Health (DPH): The state's leader in public health policy and advocacy.	**Payment Reform Council (PRC):** A stakeholder group under PCM working to develop payment model options for Medicare Fee-for-Service that increase flexibility to make primary care more convenient, community-based and responsive to the needs of patients and ensure a return on investment.
Date of Birth (DOB): The exact date on which you were born, including the year.	**Prevention Service Initiative (PSI):** Part of Connecticut's comprehensive SIM strategy to promote healthier people, better care, smarter spending, and health equity.

Department of Social Services (DSS): Delivers and funds a wide range of programs and services as Connecticut's multi-faceted health and human services agency.	**Practice Transformation Task Force (PTTF):** A stakeholder group working to recommend advanced medical home standards; provide advice on practice transformation processes; foster alignment with other care delivery models in the state (e.g., DMHAS behavioral health homes); and provide ongoing advice during implementation.
Emergency Department (ED): A medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance.	**PricewaterhouseCoopers (PWC):** A multinational professional services network.
Electronic Health Record (EHR): The systematized collection of patient and population electronically stored health information in a digital format.	**Rural Health Clinic (RHC):** A clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs.
Evaluation and management (E/M): A medical coding process in support of medical billing.	**Registered Nurse (RN):** A nurse who has graduated from a nursing program and met the requirements outlined by a country, state, province or similar licensing body to obtain a nursing license.
Fee for Service (FFS): A payment model in which doctors, hospitals, and medical practices charge separately for each service they perform.	**Social Determinates of Health (SDOH):** Factors and resources essential to the health of communities and individuals. These include income, shelter, education, access to nutritious food, services, community norms and cohesion, and social justice.
Federally Qualified Health Center (FQHC): Outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid.	**State Innovation Model (SIM):** Working to improve Connecticut's healthcare system for the majority of residents by establishing a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality and care experience, empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

Healthcare Common Procedure Coding System (HCPCS): A collection of standardized codes that represent medical procedures, supplies, products and services used to facilitate the processing of health insurance claims by Medicare and other insurers.	**Value-Based Insurance Design (VBID):** A strategy that minimizes or eliminates out-of-pocket costs for high-value services in defined patient populations.
Health Enhancement Communities (HEC): Supports the health and well-being of individuals and families in communities across the state by improving community health and healthy equity and preventing poor health.	**World Health Organization (WHO):** A specialized agency of the United Nations that is concerned with international public health.
Health Information Exchange (HIE): The mobilization of health care information electronically across organizations within a region, community or hospital system	

Appendix 2: Practice Transformation Task Force (PTTF) Members

Susan Adams Masonicare	**Kate McEvoy** Department of Social Services
Lesley Bennett Consumer Representative, Stamford, CT	**Douglas Olson** Fair Haven Community Health Center
Supriyo Chatterjee Consumer Representative, West Hartford, CT	**Juan David Ospina** Community Health Center Inc.
Beth Cheney Hartford HealthCare	**Donna Perlee** Harvard Pilgrim Health Care
Grace Damio Hispanic Health Council	**Rowena Rosenblum-Bergmans** Western Connecticut Health Network
Leigh Dubnicka United Healthcare	**H. Andrew Selinger** ProHealth Physicians
Heather Gates Community Health Resources	**Anita Soutier** Cigna
Shirley Girouard Consumer Representative, Branford, CT	**Elsa Stone (Executive Team)** Pediatrics Plus
Anne Klee VA Connecticut Healthcare System	**Randy Trowbridge** Team Rehab
Alta Lash United Connecticut Action for Neighborhoods	**Mark Vanacore** Dept. of Mental Health & Addiction Services
Daniel Lawrence Anthem	**Jesse White-Frese** Consumer Representative, North Haven, CT

Appendix 3: Incorporating Feedback in Payment Model Options

Consumer PCM Priorities

What are consumers looking for in PCM model options?

- Providers have experience with population health management, know attributed patients in advance and are well-positioned for success
- Patients choose their providers
- Reduced cost-sharing
- Improved access, longer visits for complex needs, more convenient options
- Protections against underservice and patient selection (i.e., cherry picking)
- Transportation barriers addressed
- Improved health outcomes and equity for underserved populations
- Care teams that understand and respond to patient's different needs based on culture and ethnicity
- Additional support for patients with unmet medical, behavioral and social needs

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Addressing Consumer PCM Priorities

Providers are well-positioned for success and outreach to patients
- Provider qualifications require experience in population health management and shared savings
- Prospective attribution

Patients choose their providers
- Patient choice of providers maintained
- Attribution prioritizes when patient affirmatively chooses provider

Reduced cost-sharing
- Value-based insurance design likely to be recommended with waiver of cost share for the PCP to whom you're attributed

Improved access
- Phone, text, email, telemedicine offer fast access for minor needs and frees up PCPs to spend more time on complex medical needs
- Expanded care teams offer additional support between visits
- e-Consult offers quicker access to a specialist's opinion of a treatment plan and whether a visit is needed
- Pressure on total cost of care puts focus on keeping patients well and out of the hospital
- Home visits, telemedicine and remote patient monitoring support patients with transportation needs

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Addressing Consumer PCM Priorities (continued)

Protections against underservice (i.e., seeing patients less than they need or in different ways than they prefer)

- ***Require that providers submit periodic reports that demonstrate how new funds are being invested (e.g., CPC+)***
- ***Measure volume of patient contacts by the PCP and by members of the Care Team***
  - ***Include office and telemedicine visits; phone, text, email interactions;***
  - ***Urgent care and ED visits; hospitalizations***
- ***Measure Care Experience (specific questions/items to be considered) and link care experience performance to financial rewards***
- Ensure that patients are given the option of an in-office visit when appointments are scheduled
- Ensure that patients are given information about who they can contact if they feel they are not getting needed services

Protections against patient selection (i.e. avoiding patients that are more challenging to serve

- Adjusting the basic and supplemental bundle based on clinical need or complexity (risk adjustment)
- Potentially adjusting the supplemental bundle to include social determinant risks
- ***Mystery shopper function, which is currently used in PCMH+ to test whether practices are not attempting to avoid some patients over others***

Bolded, italicized items related to performance measurement and monitoring

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Addressing Consumer PCM Priorities (continued)

Improved health outcomes and equity for underserved populations

- Increased primary care expertise to care for vulnerable populations (older adults with complex needs, people with disabilities, populations with SDOH needs)
- Social determinants of health screening
- Care team members coordinate with community services and ensure follow up
- Home visits for patients who are unable to get to office visits

Care teams responsive to differences in patients' needs based on culture and ethnicity

- Training in cultural sensitivity and awareness
- Increased access to community health workers, who should represent the communities they serve.
- Medical interpretation services always available.

Additional support for patients with unmet medical, behavioral and social needs

- Integrated behavioral health care team member on site or available via telehealth
- Integration with community placed services, including coordination
- Screening for social determinant of health needs and linkage to services
- Care coordination functions to connect to SDOH community supports

Bolded, italicized items related to performance measurement and monitoring

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Appendix 4: Design Groups

Adult

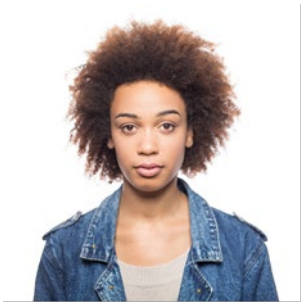
1. Adult Diverse Care Teams
2. Adult Federally Qualified Health Center (FQHC)
3. Adult Behavioral Health Integration
4. Adult Community Integration
5. Adult Older Adults with Complex Needs
6. Adult Pain Management
7. Adult People with Disabilities

Pediatric

1. Pediatrics
2. Pediatrics Behavioral Health Integration
3. Pediatrics Subgroup

Appendix 5: Patient Stories

Case Study: Chris



Chris was diagnosed with Crohn's disease in her teens. Now, she's 34, recently married and works full-time. Recently, Chris' disease has been flaring up more often. She's had several emergency department visits and missed work three times.

Chris feels worried and depressed. She visits Dr. Neil, her primary care provider. With the additional funding offered by PCM, Dr. Neil's practice recently added a part-time, licensed clinical social worker to its care team. The social worker meets with Chris to screen her for depression and connect her with a therapist and peer support group.

With the more flexible payment model options offered by PCM, Dr. Neil has time to talk with Chris' gastroenterologist, the specialist helping Chris manage her Crohn's disease. With Chris' input, they develop a new medication plan. Through eConsult, Dr. Neil quickly receives input from a dermatologist about a rash on Chris' arm. Dr. Neil arranges for a nutritionist to meet with Chris too. When Dr. Neil and Chris check in periodically over the next few months, they talk by phone and Chris avoids missing work.

Chris' Needs

- Help managing her Crohn's disease
- Support for her depression
- More coordinated care to achieve better results
- Fewer days of missed work and fewer trips to the emergency room

Dr. Neil's Practice Solutions with PCM

- Part-time licensed clinical social worker identifies behavioral health needs, makes referrals, and provides monthly support
- Coordinated care across Chris' care team
- eConsult addresses new skin problem
- Nutritionist counsels Chris on changes to her diet such as limiting fiber and dairy

Case Study: Mr. Jones

Mr. Jones has a complex medical history including heart failure, diabetes, and kidney disease. He's had two recent hospital stays. During an office visit, Dr. Neil, his primary care provider, noticed Mr. Jones' severe breathing issues and swelled feet made it difficult for him to walk.

Dr. Neil arranges for a part-time pharmacist to visit Mr. Jones at home to discuss his medications. The pharmacist finds Mr. Jones did not understand when to take his medications or even which ones he should be taking. She explains which medications to take and when. Then, she explains an easy system for Mr. Jones and his wife to keep track of the medications.

Dr. Neil offers Mr. Jones a device to help her team and his cardiologist monitor his condition remotely. Mr. Jones mentioned he likes to Skype with his grandchildren, so she arranges for regular video check-ins using a secure system. With the remote monitoring device and frequent check-ins, Dr. Neil hopes to keep Mr. Jones out of the hospital.

Mr. Jones' Needs

- Help managing prescriptions for diabetes, congestive heart failure, kidney disease
- More frequent and closer monitoring of changes in condition
- Fewer avoidable trips to the doctor due to mobility challenges related to a stroke

Dr. Neil's Practice Solutions with PCM

- Home visit by part-time pharmacist
- Video check-ins with PCP and/or RN care manager
- Remote patient monitoring for congestive heart failure
- Frequent communication with care team through phone and email

Case Study: Isaac and Gina

Isaac, age 6, has asthma that's hard to control. He and his mom, Gina, have made several long bus trips to his pediatrician, Dr. Bell. Each time, Isaac misses school and Gina misses work.

Dr. Bell asks a community health worker to arrange non-emergency medical transportation for Gina and Isaac's appointments. The CHW also connects them to Putting on Airs, a community-based program that helps kids with asthma. During a home visit, the program finds Isaac's apartment had mold that is making his asthma worse. Putting on Airs works with the landlord to remove the mold. In three months, Isaac's asthma improves.

Dr. Bell also starts to check in with Gina and Isaac by phone after school to cut back on Gina's time off work and Isaac's time away from school.

Isaac and Gina's Needs

- Help managing asthma
- Transportation to office visits
- Less time away from work and school
- Healthier home environment

Dr. Neil's Practice Solutions with PCM

- Transportation service
- Home assessment and mold removal
- Phone check ins with PCP and/or RN care manager
- Frequent communication with care team through phone

Case Study: Jesse

During a recent well-visit, Jesse, age 15, completes a confidential, validated screening known as a Pediatric Symptom Checklist-17. This checklist helps providers, patients and families identify issues including anxiety, depression, attention deficit disorder and other behavioral health conditions in children. The screening finds Jesse is showing signs of depression or anxiety. A follow-up assessment, known as a Patient Health Questionniare-9 or PHQ-9, suggests she has moderate to severe depression.

Jesse's Needs

- Help identifying and managing her depression
- Coping strategies to improve self-management of her condition
- Convenient, confidential counseling

Dr. Neil's Practice Solutions with PCM

- Confidential, validated screening
- Access to a licensed clinical social worker
- Coordinated care with school-based health center

Jesse tells her primary care provider, Dr. Bell, that she is feeling sad and stressed. Dr. Bell asks a licensed clinical social worker that is part of the pediatric care team to meet with Jesse. They meet for a brief series of sessions to talk about sleep and exercise. With Jesse's approval, the social worker at Dr. Bell's office connects with the therapist at Jesse's school-based health center. This therapist takes over counseling sessions Jesse and keeps her care team informed through regular updates in Jesse's electronic health record.

At a six-month check up with Dr. Bell, Jesse receives the assessment which finds her depression symptoms have improved. Jesse agrees and decides to continue seeing her therapist.

Appendix 6: PCM Capabilities Compendium

Adult

1. Diverse Care Teams
2. Behavioral Health Integration
3. Phone, Text, Email, Telemedicine
4. eConsults and Co-Management
5. Remote Patient Management
6. Older Adults
7. Pain Management
8. Adult Community Purchasing Partnerships
9. Oral Health Integration
10. Shared Medical Appointments
11. Health Equity Improvement
12. Community Integration for Social Determinants
13. People with Disabilities

Pediatrics

1. Diverse Care Teams
2. Behavioral Health Integration
3. Alternative Ways to Engage Patients
4. Universal Home Visits for Newborns
5. eConsults and Co-management
6. Community Purchasing Partnerships

PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Expand and diversify care teams to make primary care more comprehensive and accessible, better meet the needs of patients and families, and improve care coordination, efficiency, effectiveness and increase patient and provider satisfaction.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Recieve ongoing support from a primary care team that understands how to help you in the doctor's office, at home, and at work
- Spend more time with your primary care provider (PCP) when you need it
- Access behavioral health services right away at your primary care office
- Get help with your eating and exercise from a health coach or nutritionist to prevent or better manage chronic health problems
- Get help with your medications from a pharmacist
- Get help preparing for medical visits or following your care plan from a navigator or care coordinator
  - Get help with transportation, food, housing, and other needs from a community health worker

PRIMARY CARE TEAMS CAN...

- Enable PCPs to spend more time with patients and less time on activities that could be supported by other care team members
- Better assist with lifestyle changes to prevent or manage chronic illness and achieve health goals
- Expand your ability to help patients schedule specialist appointments, prepare for visits, ensure timely follow-up, manage medication problems, and reduce barriers to care
- Use new team members to better manage patients with complex conditions
  - Improve access to language assistance and community supports to address problems like housing, transportation, and food security.
  - Improve practice efficiency and care team satisfaction

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Martín is a 66-year-oldwith lung disease, poorly controlled high blood pressure and obesity. He is often homeless and without a car. Martín reluctantly agrees to come in for an office visit recommended to him by the network quality improvement team.

Martín prefers speaking Spanish and needs assistance with transportation. Before the appointment, the patient navigator and a Spanish interpreter call him to arrange transportation. Once there, his primary care provider conducts an exam with help from a medical interpreter.

With the help of the interpreter Martín creates an action plan by meeting with a nutritionist to eat healthier and the pharmacist to select the best value medications to treat his high blood pressure and lung disease.

Martín meets with a community health worker who speaks Spanish to apply for financial help for medications, food, housing, and utilities. The care team huddles together weekly to review Martín's care recorded in the EHR.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Hire care team members to provide acute, preventive and chronic care; comprehensive care management; care coordination; patient navigation; behavioral health integration; health promotion and chronic illness self-management and medication prescribing and management (see definitions of functions, activities and credentials)
- Provide population health analytic resources to develop, implement and refine operations and to support continuous health promotion and quality improvement
- Determine care team compositions, location of team members, and staffing ratios based on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, and team member role
- Deploy care team members on-site at the practice, in the community or patient homes, and/or at a central hub in the network or health center; partner with other organizations as necessary to provide appropriate services and care team capacity
- Ensure care team members apply their skills to the top of their training, but do not exceed their qualifications
- Train team members to deliver effective team-based care (see Principles for Team-based Care) including workflows and communications.
- **OPTIONAL** Hire care team members to provide evidence-based integrative medicine treatments for specific conditions through supplemental bundle funds

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- EHR and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR supports population and registry management and care management
- EHR includes a comprehensive care plan with role-based care team access
- Direct connection to support coordination with community-based services, including behavioral health

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, care team communication and coordination, access to BH care, provider support, discussing stress, and overall satisfaction with provider

★ Quality

- Improved preventive care (e.g., cancer screening, immunizations), especially for individuals with complex illnesses or disabilities
- Improved chronic illness outcomes (e.g., diabetes control)
- Improved care plan adherence by through medication reconciliation
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Lower out of pocket costs for patients when receiving services in primary care and by non-billable care team members
- Reduced ED and hospital utilization, and sub-specialty care

Access

- Easier access to services in the practice, home, and community

IMPROVING HEALTH EQUITY

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Diverse care teams help by:

- ✓ **Having community health workers** who reflect the patient's community and culture and medical interpreters who address language barriers.
- ✓ **Linking patients to housing, food, transportation** and other community resources.
- ✓ **Navigating billing and insurance issues** for people who have financial barriers to care

LEARN MORE!

ADULT DIVERSE CARE TEAMS

PRIMARY CARE MODERNIZATION

Adult Behavioral Health Integration

CORE CAPABILITY

A team-based, primary care approach to identifying and managing common behavioral health conditions, co-occurring health conditions, and lifestyle behaviors that affect health.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and worry can affect your physical health and how chronic illness can affect your emotional health and wellbeing
- Meet with a care coordinator to connect you to community-based support and additional behavioral health treatment services
- Have primary care and behavioral health clinicians who share information before your visits

PRIMARY CARE TEAMS CAN...

- Offer behavioral health assessment and brief treatment services (e.g. motivational interviewing)
- Offer cognitive and behavioral strategies to manage stress, anxiety, sleep problems and pain, and make lifestyle changes to support chronic illness management
- Access practice-based behavioral health expertise to improve the care of patients with behavioral health conditions and co-occurring medical conditions
- Access psychiatric consultation to support primary care prescribing and behavioral health management
- Coordinate access to behavioral health, medical and community-based services
- Access behavioral health care information on your Electronic Health Record (EHR)

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Nate is 62 years old and lives alone after his divorce. He has diabetes and is overweight. He tries to eat healthy but hates cooking. He tries to take walks on weekends when his son visits, but he's mostly alone.

When Nate goes to his primary care office for his diabetes check-up, the nurse administers the PHQ9 (Depression Screening Tool). His score indicates a possible moderate depression. He says that he just wants to watch TV all the time.

He agrees to see the licensed clinical social worker in the practice. His doctor walks him down the hall to introduce them. They make an appointment for him to come see her when he comes back for blood work in a few weeks.

When Nate returns, the social worker introduces him to the practice's behavioral health care coordinator. She connects Nate to a local support group for divorced men and a walking club and records this in his medical record.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Standardized screenings to identify depression, substance use, anxiety, and social determinants of health
- Dedicated behavioral health clinician, on-site or via telemedicine, responsible for assessment, brief interventions, and care team consultation
- Protocol for "warm-hand off" to and telemedicine visits with behavioral health clinician
- Care coordinator with behavioral health expertise
- Referral assistance and tracking to support access to community behavioral health specialists, higher level behavioral health services, behavioral supports (e.g., peer support) and community resources (e.g., housing, legal assistance)
- eConsult arrangement with community-based psychiatrist or psychiatric APRN
- Memorandum of Understanding with at least one behavioral health clinic if behavioral health specialty services are not available within the network.
- Bi-directional communication as needed between primary care team and community-based behavioral health specialists and community supports.
- Care team training on behavioral health teaming, chronic illness, and care coordination.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for primary medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR configuration and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR configuration to support outcomes measurement
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Bi-directional communication solution to support coordination with community-based BH specialists
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care (practice-based and/or community), provider support, discussing stress, and overall satisfaction with provider
- Less time off from work, improved functioning at work

★ Quality

- Earlier identification and treatment of behavioral health conditions
- Improved behavioral health outcomes (e.g., depression remission rates)
- Improved chronic illness outcomes (e.g., A1C control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Lower out of pocket costs for patients when treated in primary care
- Reduced avoidable physical health utilization related to unmet BH needs
- Reduced ED and hospital utilization

✓ Access

- Easier access to BH services and reduced wait time for treatment
- Assistance with referral and linkages to community-based behavioral health specialty services and community supports

IMPROVING HEALTH EQUITY

Patients with behavioral health needs face obstacles in getting care. To reduce this disparity, primary care will change in the following ways:

✓ **Improved access for populations** who might be less inclined to seek behavioral health treatment in other settings due to stigma.

✓ **Expanded connections** with culturally appropriate behavioral health services and coordination to address social determinant barriers.

✓ **Care coordinators and medical interpreters** improve communication between primary care and behavioral health providers.

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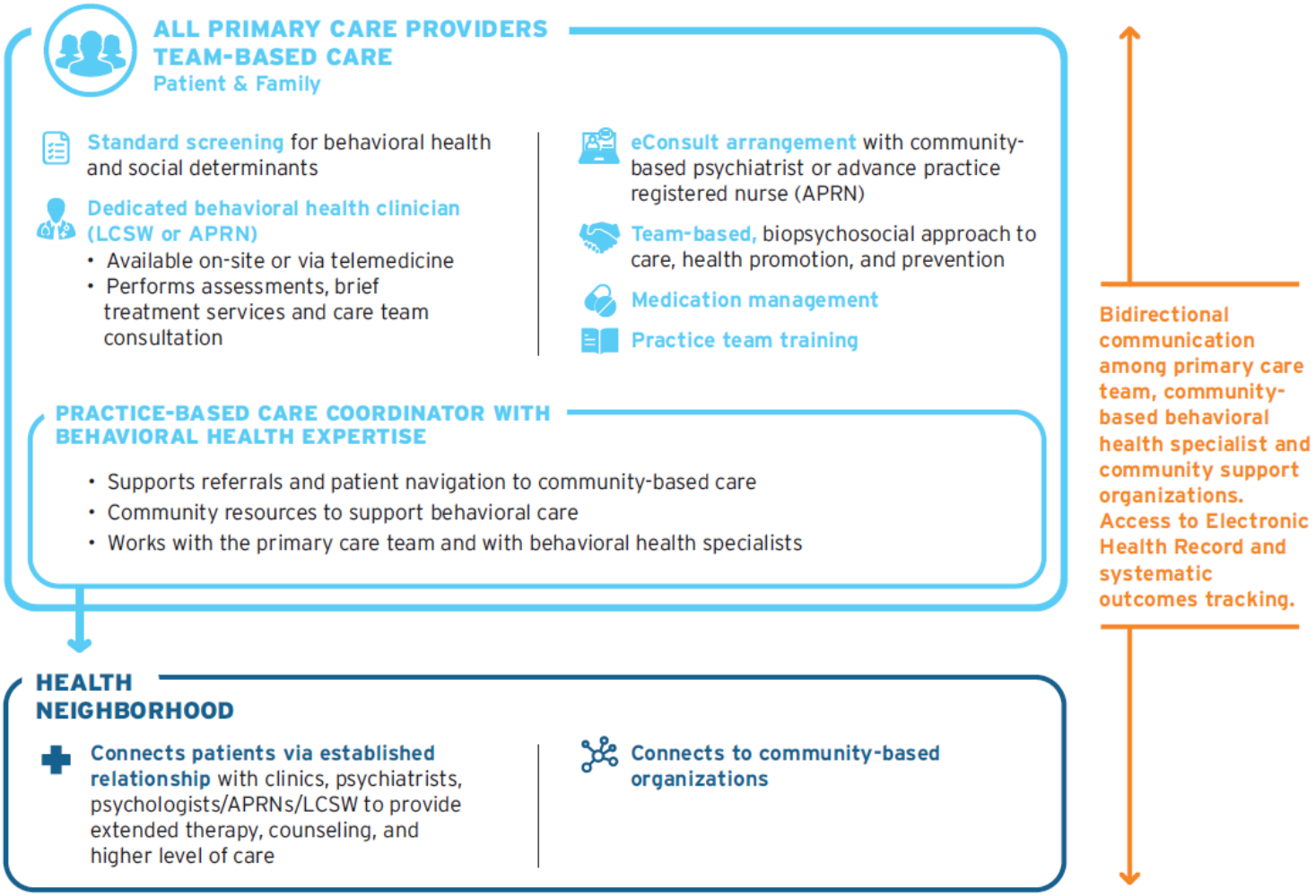
ADULT BEHAVIORAL HEALTH INTEGRATION



PRIMARY CARE MODERNIZATION

Phone, Text, Email and Telemedicine

CORE CAPABILITY

Telemedicine visits, phone calls, text messages, and emails expand patient access to primary care team for diagnosis, treatment, advice, check-ins and coaching.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Connect with your primary care team remotely, at your choice of time and device, more easily than traveling to the doctor's office
- Have a telemedicine visit with your primary care provider (PCP) for diagnosis and treatment, medical advice, or to determine whether you need to be seen in person
- Check in with your primary care team to get your questions answered and stay on track with your care plan and medications
- Save money compared to most office visits
- Avoid a costly emergency department or urgent care visit when it's not a medical emergency
- Take less time off work while reducing stress and worry about your health

PRIMARY CARE TEAMS CAN...

- Expand capacity for routine and urgent care via telemedicine, improve convenience and help reduce avoidable emergency department visits and hospital admissions
- Offer timely advice to patients about following care plans, adjusting medications, addressing medication problems, and determining the need for an office visit
- Connect patients with care team members such as health coaches, nutritionists and behavioral health clinicians
- Remind patients about immunizations, tests, follow-up visits, and self-management via text and email
- Enable more efficient and flexible patient support while ensuring stable practice revenue

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Jeannie is newly diagnosed with asthma. Her PCP sends her home with two inhalers and instructions on how and when to use them. Jeannie can call, email or text her PCP or her health coach if she has any questions.

After a few days, Jeannie still isn't feeling better. She's not sure she's using the inhalers properly. Jeannie calls her health coach and they arrange to have a video chat at a convenient time.

During the video chat, the health coach reviews the use of the inhalers and asks Jeannie to demonstrate. Afterwards, the health coach sends Jeannie encouraging texts and reminders to call her right away if Jeannie starts to feel worse.

The health coach and Jeannie continue to exchange texts to check in on Jeannie's progress. After a few days, Jeannie reports that she is feeling better.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Establish secure platforms for phone, text, email and telemedicine visits; provide technical support resources
- Design office workflows to ensure timely responses to patient questions
- Train primary care team on workflows, handoffs and escalation processes to decrease after-hours workload for primary care clinician
- Update and maintain patient contact and language preferences and, for telemedicine, confirm access to high-speed internet and technology
- Ensure that communications are in the patient's preferred language
- Ensure that all contacts are documented in the electronic health record (EHR)

Health Information Technology Requirements

- Access to common EHR platform
- Secure web-based platform (patient portal) where sensitive patient information can be exchanged between the patient and his or her care team.
- EHR or complementary platform to support secure email and text communications
- EHR protocols to ensure all interactions between patient and care team members through phone, text, email and telemedicine are documented
- EHR to support outcomes measurement and performance accountability by logging and reporting all contacts and results

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care, provider support, and overall satisfaction with provider
- Less time off work

★ Quality

- Improved engagement in chronic illness self-management
- Improved timely response to new symptoms or change in condition
- Reduced admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned readmissions

$ Cost

- Reduced costs associated with avoidable ED visits and hospital admissions
- Reduced out-of-pocket costs associated with in-person visits, ED and hospitals visits, and time off from work, childcare and travel

✓ Access

- Faster, more convenient connections to culturally competent health resources
- Improved access to primary care with reduced need for travel

IMPROVING HEALTH EQUITY

Patients with lower wage jobs, limited access to childcare, disability or frailty-related mobility challenges, or living in underserved communities may find it harder to take time off from work, arrange childcare, leave the home, or get transportation to a doctor's office. To reduce this disparity, primary care will change in the following ways:

- ✓ **Offer more ways to receive care** without physically going to the office
- ✓ **For patients with internet access, use text, email and telemedicine** to build a stronger relationship with the primary care team
- ✓ **Provide more timely response** to questions and access to care for routine needs management in primary care.

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PRIMARY CARE MODERNIZATION

eConsults and Co-management

CORE CAPABILITY

Primary care provider electronically consults with specialists[1] for non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit. When appropriate co-management can support continued collaboration between the PCP and the specialist.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Begin treatment sooner in primary care for some health problems rather than waiting for an appointment with a specialist
- Get the benefits of a specialist's expertise without having to see a specialist
- Have a primary care team that effectively manages more of your healthcare needs
- Pay less out of pocket by having more of your needs met in primary care

PRIMARY CARE TEAMS CAN...

- Access specialist consultations to support evaluation and treatment in primary care and improve quality of care
- Manage a wider range of health problems and changes in condition without referring to a specialist
- Enable patients to avoid unnecessary specialist visits, testing and procedures
- Enable patients to start treatment for some problems more quickly by avoiding the delays associated with scheduling specialty visits and barriers to accessing specialty care (e.g., transportation, time off work, childcare)
- Offer expanded capacity to treat patients with co-occurring conditions that might otherwise require different specialties

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Donna has congestive heart failure and is feeling tired. She can't drive and her cardiologist's office moved to a big medical center far from her home. Donna does not like the side effects of her diuretics. Donna likes her primary care team and keeps her appointments.

The primary care clinician examines Donna. They discuss how she's been feeling recently. Together, they review her latest EKG, a test that records the electrical activity of the heart, and her bloodwork.

With Donna's permission, the primary care provider requests an eConsult with a cardiologist. The next day, after reviewing the patient's medical information, the cardiologist suggests increasing the patient's medication and following up with blood work in four weeks.

A nurse from her primary care office calls Donna to explain the treatment plan, including how to handle medication side effects. Donna is relieved. She doesn't have to figure out how to get to the big medical center. She follows the new medication plan and feels better.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Determine which specialties would be best suited to participate in an eConsult program based on evidence and knowledge about the Network's patients and providers
- Develop arrangements with specialists in relevant disciplines
- Create protocols that maintain clinician autonomy and support identifying appropriate patients, receiving patient consent, scheduling, receipt and review by the specialist, communication of the outcome back to the primary care team and follow up with patients
- Create protocols to guide co-management of patients following an eConsult, when appropriate.
- Train primary care team staff in using secure portals and technology
- Engage clinician champions to promote use and answer questions
- OPTIONAL Offer a "fast track" system for patients who have received an eConsult and need a face-to-face visit with a specialist.

Health Information Technology Requirements

- Access to common, secure technology platform such as an Electronic Health Record (EHR) to share information between primary care providers and specialists, including test results and imaging, as appropriate **- OR -**
- Network engages a vendor providing eConsult services to support deployment of the program and meeting HIT requirements
- EHR configuration and protocols to capture eConsult recommendations and treatment plan as presented by specialists
- EHR system able to supply data for measurement and accountability
- Appropriate consent and confidentiality protections

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with shorter wait times
- Reduced presenteeism and time away from work
- Increased satisfaction with provider

★ Quality

- Earlier diagnosis and treatment for some health problems
- Improved chronic illness outcomes
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Lower out of pocket costs for patients treated in primary care
- Reduced duplicative or unnecessary testing
- Reduced avoidable ED visits and hospitalizations

Access

- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist
- Eliminates access barriers for visits avoided (e.g., transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Many patients lack adequate access to specialty care due to geography and lack of specialist availability. To reduce this disparity, primary care will change in the following ways:

✓ **Allow access to timely, high-quality specialty care** through primary care consultation with specialists.

✓ **Reduce patients' access barriers** including provider scarcity and maldistribution, transportation, time off work and childcare.

[i] "Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.

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PRIMARY CARE MODERNIZATION

Remote Patient Monitoring

CORE CAPABILITY

Remote patient monitoring uses connected digital devices and technology to move patient health information from one location, such as at a person's home, to a healthcare provider in another location for assessment and recommendations, usually at a different time. It is most helpful for patients with certain conditions including congestive heart failure, often called CHF.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have certain health conditions monitored from home by the primary care team without the need for transportation, child care and time off work
- Benefit from early detection of changes in their health conditions and timely adjustments to the care plan
- Be assured that their care team has information about how their conditions are responding to treatment
- Transition to home from the hospital with more help from primary care teams
- Avoid some emergency department visits and hospital stays through better management of health conditions

PRIMARY CARE TEAMS CAN...

- Better support patients with more complex needs between visits and after hospital stays for improved clinical outcomes
- Have real-time information about changes in condition and response to treatment in order to inform care plan adjustments
- Have the data necessary to inform patient coaching (e.g. medication compliance, lifestyle changes) without the need for an office visit
- Enable patients to avoid unnecessary emergency department visits and hospital admission

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Diane is a grandmother who takes care of her daughter's two children full time. She has congestive heart failure (CHF), but caring for the children, she doesn't have much time to go to the doctor's office.

Recently, she was having chest pain and shortness of breath and was admitted to the hospital for four days. After being discharged, a nurse care manager from her primary care practice made a home visit.

The nurse set her up with a remote patient monitoring system to check her weight, blood pressure and other vital signs daily. The nurse showed her how to use it and how it automatically sends information to her primary care team.

Diane's weight went up quickly, a sign she was retaining water and needed to change her medication. Her nurse saw the change in data and called to talk about adjustments to Diane's diet and medications.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Use evidence to develop protocols to determine which conditions, in addition to congestive heart failure (e.g., chronic obstructive pulmonary disorder) and which patients with those conditions will receive remote patient monitoring based on level of risk
- Establish systems and staff workflows for transmission of health data from the patient to the provider
- Establish systems to enable care team members to receive and monitor data
- Ensure patients or their caregivers have the necessary tools and instruction to participate in remote patient monitoring and transmit data through a secure platform
- Nurse care managers or other qualified team members monitor the data and consult with a primary care clinician about treatment plan
- Facilitate trainings for designated members of the care team with respect to use of technology and related clinical protocols work flows
- Process actionable, clinically-relevant data with trends identified for use in routine clinical practice
- Determine legal liability for response protocols

Health Information Technology Requirements

- Remote monitoring devices with mechanism to transmit data to healthcare provider
- Data transmission method incorporates data into EHR and clinical workflow
- Platform has ability to alert care team when data values exceed thresholds
- Data is received on platform compatible with practice's electronic health record (without a separate login)

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, provider support, care outside of office hours, and overall satisfaction with provider

★ Quality

- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions
- Lower out of pocket costs for patients able to avoid unnecessary services

Access

- Reduced wait time to address changes in condition and response to treatment
- Eliminates access barriers by allowing visits to be avoided (e.g., cost-share, transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Many patients with chronic conditions experience health disparities. These disparities may result from less engagement with care teams and social determinant barriers such as transportation, child care, or out of pocket costs. Remote patient monitoring can reduce chronic illness disparities in the following ways:

✓ **Offer ways for care teams to monitor patients** without requiring an office visit.

✓ **In conjunction with telemedicine and diverse care teams** it will improve engagement of under-served patients experiencing barriers to care and health disparities with respect to chronic illness outcomes.

LEARN MORE!
rebrand.ly/dropb110f1

[1] Health Resources and Services Administration (September 2017). Telemedicine and Telehealth. Retrieved from: https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth

PRIMARY CARE MODERNIZATION

Care for Older Adults with Complex Needs

CORE CAPABILITY

Enhanced primary care from a practice specially designed to improve outcomes for patients age 75+ with multiple chronic conditions, functional challenges, trouble traveling to in-office visits, and more likely to have potentially avoidable emergency department (ED) visits and require nursing home placement.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have a primary care team that understands how to care for older patients with complex health needs
- Get care at home to help you follow your care plan or when you have difficulty leaving your home
- Use phone, text, email, and telemedicine to get more convenient care, coaching, medication adjustment and support
- Avoid unnecessary trips to the emergency department or hospital
- Get help from a care coordinator or community health worker to connect with community-based resources or medical providers
- Get help when you go home after staying in a hospital, nursing facility or rehabilitation center

PRIMARY CARE TEAMS CAN...

- Include an array of staff with special expertise and training in caring for older adults with complex health needs
- Tune your practice workflows and accommodations to better address the problems commonly encountered by older adults such as hearing and cognitive issues, including dementia
- Offer home visits, telemedicine, and remote patient monitoring to support patient engagement, improve self-management, optimize the living environment to improve chronic illness outcomes and reduce risk (e.g., falls prevention)
- Improve Advanced Care Planning and access to palliative care
- Improve care coordination and patient navigation across systems and care settings

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Dan is an 85-year-old patient with high blood pressure and diabetes. Recently, his wife has noticed he gets confused sometimes. He visits his primary care provider, who specializes in geriatrics care, after an unexpected hospital stay.

During the visit, his doctor reviews his medical record and notices three emergency department visits in the past six months. One time he fell. Another time his blood sugar got too high. The third visit was for a urinary tract infection.

During a risk assessment, Dan and his wife say he forgets about appointments and his medications. Also, they don't drive anymore, so office visits require planning. Dan agrees to a home-based primary care plan written by his physician and a nurse home care provider.

A nurse visits Dan's home weekly to support him in taking his medication properly. A community health worker shows Dan how to have a video visit with his doctor and arranges transportation for office appointments. She connects Dan's wife to a caregivers' support group.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

A subset of primary care providers specialize in advanced primary care for older adults with complex conditions:

- Hire and train an expanded, diversified care team with expertise in geriatric care
- Provide home-based primary care services
- Coordinate access to subspecialists and community-based supports, link to community-based services
- Develop practice workflows and accommodations to better address the problems commonly encountered by older adults such as functional impairments, including durable medical equipment needs, hearing and cognitive issues, problems associated with multiple medications and age-related medication considerations, and common mental health issues such as depression and loneliness
- Provide access via phone, text and email and telemedicine when appropriate
- Prioritize practice locations that are accessible for the communities they serve
- Establish remote patient monitoring for patients with Congestive Heart Failure for post-acute care and eConsults with subspecialists as needed
- Provide specialized care for patients with dementia
- Receive advanced training in and offer palliative care and end of life services to minimize discomfort, provide referrals to and coordination with hospice care
- Establish clinical links to institutional care settings, rounding by primary care providers to transition patients back to home setting and coordinated aftercare
- Subset of providers supported by Project Echo guided practice and technical assistance for Advanced Care Planning

Health Information Technology Requirements

- Electronic Health Record (EHR) that is accessible by all care team members and on mobile devices outside the office
- Health Information Exchange (HIE) to communicate with all members of the patient's care team
- Scheduling system accessible to all members of the patient's care team.
- Remote patient monitoring technology as needed for patients

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience regarding timely care, communication, coordination, specialists, provider support and overall satisfaction with provider
- More convenient patient access to care

★ Quality

- Earlier diagnosis and treatment for some conditions
- Improved preventive care (e.g. influenza immunization)
- Improved chronic illness outcomes
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions
- Improved care plan adherence
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced avoidable visits, tests and procedures
- Reduced urgent care, ED, nursing facility and hospital utilization
- Lower out of pocket costs for services in primary care and by non-billable care team members

Access

- Easier access to high quality support from primary care team outside of traditional office visits
- Reduced wait time for diagnosis and treatment for some health problems

IMPROVING HEALTH EQUITY

Early life stressors increase risk of dementia and other health conditions, which puts patients with greater social needs at higher risk of nursing home placement and uncoordinated care. To reduce these disparities, primary care will change in the following ways:

✓ **Text, phone, email, telemedicine care avoids barriers** to in-office visits like transportation.

✓ **Reduced out-of-pocket expenses,** which can be a barrier to care for fixed income patients.

✓ **Primary care provided at home or in the community** helps older adults with complex needs receive needed care and stay in their homes.

✓ **Practices specialized in geriatrics care** improve coordination between providers and community services.

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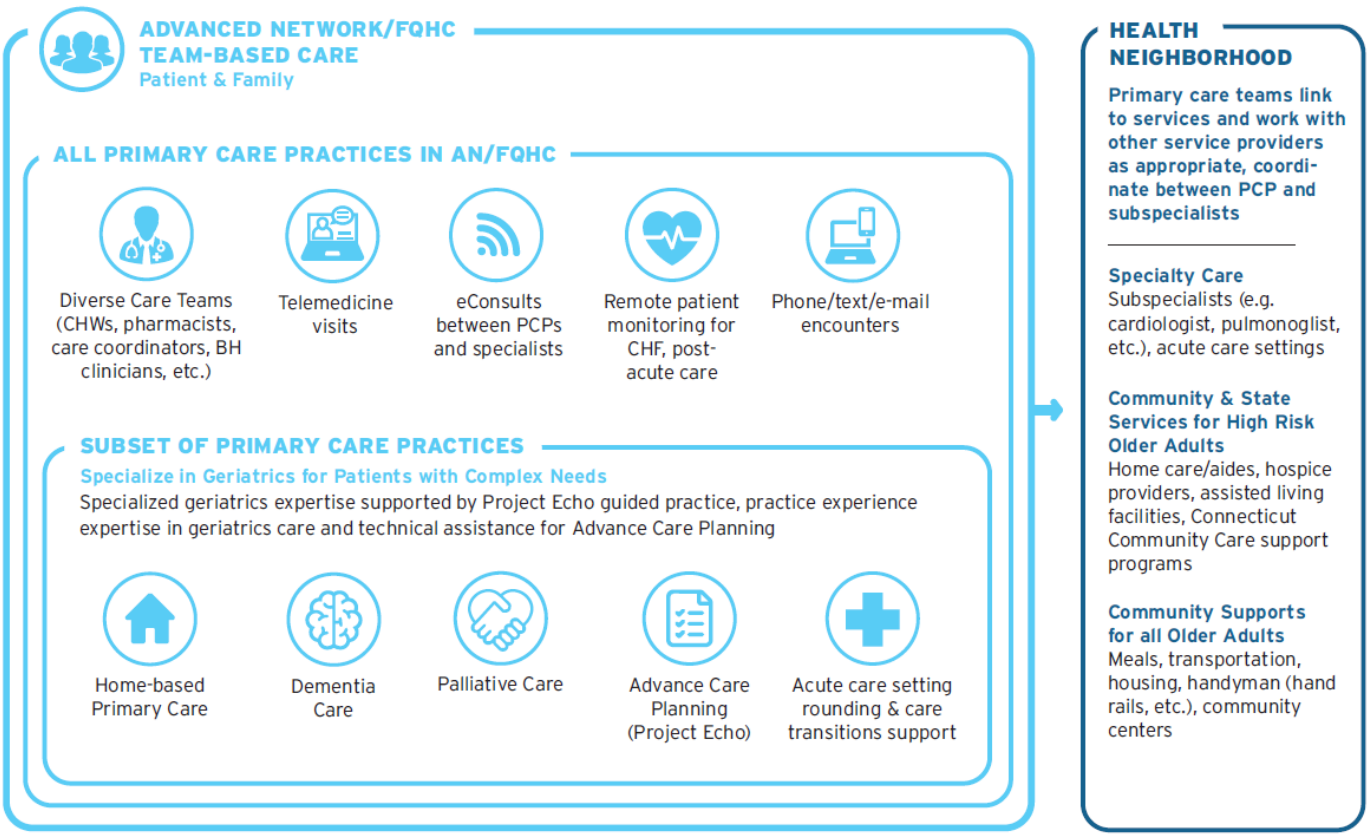
SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities



PRIMARY CARE MODERNIZATION

Pain Management and Medication Assisted Treatment

CORE CAPABILITY

Preventive, routine and advanced pain management in primary care. All practices have basic competence in pain management while a subset have specialized expertise, supported by Centers of Excellence in pain management. Some practices specialize in Medication Assisted Treatment for opioid addiction.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Learn how to manage acute and chronic pain as part of regular primary care
- Work with your primary care team to reduce your pain and address its causes
- Avoid opioids with access to traditional and alternative therapies for pain, including affordable medications
- Meet with a behavioral health clinician in the primary care office to address emotional contributors to pain and learn new pain management strategies
- Receive Medication Assisted Treatment (MAT) for opioid addiction or see a specialist for treatment

PRIMARY CARE TEAMS CAN...

- Develop expertise in evidence-based pain prevention and the routine management of chronic pain with reduced reliance on opioids
- Use decision support and analytics to identify patients who have severe chronic pain or are at risk of opioid addiction
- Apply a team-based approach that may combine physical medicine, behavioral health and alternative therapies
- Offer options for pain management to practices with pain management expertise in your primary care network or to a Center of Excellence

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Michelle's shoulder and back still hurt months after falling on the ice. The pain is so intense that she can't go to work, sleep or get anything done. Her prescription for pain relievers ran out and no one will refill it.

Michelle goes to see a new primary care team who she heard specializes in pain management. She hopes they offer her a stronger dose. The primary care provider takes a detailed history and screens Michelle for risk of addiction.

The primary care provider follows FDA opioid prescribing guidelines. After consulting with the pharmacist, her primary care provider offers Michelle an effective but less addictive pain medication.

The primary care provider also suggests that Michelle try other therapies. The care coordinator assists with making appointments for cognitive behavioral health therapy, physical therapy, and acupuncture.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

All primary care practices

- Offer routine care for patients with acute and chronic pain in the primary care practice, including patient education on pain management
- Train teams on bio-psycho-social approach to pain management that promotes patient activation and self-management and appropriate prescribing for pain, especially when starting or continuing opioid therapy
- Establish protocols for referrals and hand offs to primary care practice with specialized pain management expertise
- Provide access to clinical decision support tools at the point of care and provide web- and phone-based self-management resources for patients
- Referral assistance and tracking to support access to primary care providers that specialize in advanced primary care pain management and those who provide MAT for opioid addiction.
- Formal pain management training arrangement with Centers of Excellence
- Two-way communication between primary care team and MAT clinicians

Subset of primary care providers specialize in advanced primary care pain management and or MAT

- Receive advanced training through Project Echo/Centers of Excellence
- eConsults with pain management experts for complex cases and ongoing knowledge development
- Connect patients with complementary community-based therapies
- Provide re-assessments of patients with chronic pain and refer back to routine primary care provider

Health Information Technology Requirements

- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR process to ensure capture of all interactions between patient and care team members, including non-office-based care
- Analytic tools to identify patients with chronic pain and those at risk for opioid abuse
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to care team's caring and concern, communication, provider support and overall satisfaction with provider
- Less time off from work; improved functioning at work

★ Quality

- Reduced use of opioid painkillers and less opioid addiction
- Earlier recognition of risk for opioid addiction
- Improved opioid use disorder treatment outcomes

$ Cost

- Reduced avoidable visits and treatments for chronic pain
- Reduced emergency department visits
- Reduced costs associated with time off work due to acute pain

Access

- Easier access to high quality pain management support from primary care team
- Improved access to medication assisted treatment resulting from increased in-network capacity and improved identification of patients who would benefit

IMPROVING HEALTH EQUITY

People of color and other historically underserved communities face disparities in pain assessment and treatment. To reduce this disparity, primary care will change in the following ways:

✓ **Networks track pain prevalence and treatment** across populations to identify disparities and overprescribing in vulnerable populations.

✓ **Community health workers available** to help find transportation and childcare for appointments.

✓ **Provide options** for more affordable medications, behavioral health services, and alternative treatments through integrated pain management in primary care.

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INCREASE EXPERTISE IN PAIN MANAGEMENT

All Primary Care Providers

PREVENTIVE CARE TO AVOID ACUTE TO CHRONIC PAIN PROGRESSION

- Basic assessments, diagnosis and care planning
- Self care, e.g. nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

ROUTINE CARE FOR ACUTE AND CHRONIC PAIN

- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Subset of Primary Care Providers

with specialized expertise in pain management or MAT. Manage complex patients and provide reassessment services and consultative support to all network PCPs

ADVANCED PRIMARY CARE CHRONIC PAIN MANAGEMENT

- Chronic pain management and re-assessment
- Specialized expertise in alternative therapies, e.g. behavioral health, acupuncture, self-management, etc.

MEDICATION ASSISTED TREATMENT (MAT)

- Treatment for opioid addiction

Primary Care Referrals

to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

CENTERS OF EXCELLENCE IN PAIN MANAGEMENT

- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

ADVANCED NETWORK / FQHC

PATIENT EDUCATION AND ENGAGEMENT AT ALL LEVELS OF CARE

INCREASING PAIN ACUITY AND TREATMENT COMPLEXITY →

CENTERS OF EXCELLENCE PROVIDE	**All PCPs**: Training and technical assistance in pain assessment and management	**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management

PRIMARY CARE MODERNIZATION

Community Purchasing Partnerships

ELECTIVE CAPABILITY

Primary care practices contract for home and community-placed services that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Get help from your doctor's office to find community resources to help you meet your health goals
- Get help adopting a healthy lifestyle from organizations in your town or neighborhood
- Get help managing your chronic illness in your home or your community, possibly with others who have similar health problems
- Connect to services such as early intervention or community care programs that are important to getting and staying healthy

PRIMARY CARE TEAMS CAN...

- Engage community resources such as community centers, churches, barbershops, and schools to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with complex care needs by partnering with community care teams or community paramedicine providers
  - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Constance is eighty years old and has struggled with her health since complications from a hip replacement two years ago. She manages living alone at home but is not very mobile and driving is uncomfortable.

Constance wakes up one night in extreme pain. She has felt like she has to go the bathroom all the time for a few days. Not wanting to go to the Emergency Room, she calls her primary care's hotline to speak to a nurse on call.

The nurse dispatches a community paramedic, contracted with the practice, to her house. The paramedic takes a urine sample and tests it with a portable kit. He calls the nurse to confer on results and treatment.

After conferring with the nurse, the paramedic gives Constance an injection of antibiotics to treat a urinary tract infection and a pill to relieve her symptoms. The next day, Constance's primary care provider calls to check on her.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Identify service gaps and needs for community-placed services
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex needs
  - Segment evaluation based on population characteristics such as race, ethnicity, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and secondary prevention, chronic illness self-management, care management for patients with complex health needs, and in-home support for patients as needed
- Clinical protocols and analytics to support identification of patients that require these services
- Referral management protocols including determining whether individuals were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient experience, healthcare outcomes and cost

Health Information Technology Requirements

- Electronic health record (EHR) that captures population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your health"

★ Quality

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions
- Averted or reduced length of stay in skilled nursing facilities with coordination of home-based supports

Access

- Faster, more convenient connection to local, culturally competent health resources

IMPROVING HEALTH EQUITY

Patients experience barriers to care that result in health disparities. Access to culturally appropriate community-placed care can reduce these disparities in the following ways:

✓ **Community-placed providers can address health and preventive care needs** in the home or in a convenient, culturally appropriate and trusted community setting.

✓ **Community-placed providers can better address social and environmental risks,** language preference and health literacy gaps.

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ADULT COMMUNITY PURCHASING PARTNERSHIPS

CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services
[See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness Self-management Services	Complex Care Coordination for High Risk Patients, Often with SDOH Needs	Support for Patients with Acute or Chronic Medical Risk at Home
EXAMPLES OF MODELS	Health Leads or Project Access	Community Meeting Place Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/Community Paramedicine

PRIMARY CARE MODERNIZATION

Oral Health Integration

ELECTIVE CAPABILITY

Provide dental prevention services in a primary care doctor's office during regular checkups, including screenings, fluoride varnish, oral hygiene education, and when necessary, referrals to oral health providers.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have a care team that understands how problems with your teeth and mouth affect your overall health and well being
- Be screened for oral health problems as part of a general physical exam
- Learn how health behaviors can affect or improve oral health
- Learn how to take care of your teeth and mouth, especially when you have other chronic medical conditions.
- Receive fluoride therapy or fluoride varnish treatment to prevent more serious problems

PRIMARY CARE TEAMS CAN...

- Train care team in oral health risk assessment, exams and prevention
- Screen individuals for oral health risk factors and symptoms of oral disease
- Educate patients about the importance of good oral health and practices to maintain oral health
- Provide information and education that recognizes culture, language and perceived oral health barriers.
- Provide fluoride varnish or fluoride therapy, as needed
  - Assess patient's medications for risk of negative effect on teeth and gums, and make changes if needed
- Facilitate patient navigation to oral healthcare services with referrals and track outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Marianne checks in for a diabetes wellness appointment. As part of her medical record update, Marianne says that she does not have a regular dentist and hasn't had a check-up in a long time.

During the physical exam, Marianne's primary care provider notes signs of oral disease. The provider explains that researchers have found people with diabetes are more likely to have oral health problems and these problems can make it harder to control diabetes.

Marianne and her provider discuss Marianne's options. Marianne agrees to meet with the team's trained dental health educator. They discuss brushing, flossing and the damaging effects of sugar and carbohydrates on her teeth.

Marianne mentions that she can't afford dental care because she doesn't have dental insurance. The health educator connects Marianne to the team's care coordinator who helps her make an appointment at a dental clinic with lower fees for uninsured patients.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Conduct patient-specific oral health risk assessments that ask about symptoms or risk factors to screen for oral disease
- Conduct oral health exams that look for signs indicating poor oral health and active problems
- mplement preventive oral health strategies which may include prescribing or changing medications that protect teeth and gums, fluoride therapy, application of fluoride varnish, dietary counseling, and in-house or co-located dental cleanings
- Develop targeted patient education about the importance of good oral health and practices to maintain it, particularly for communities disproportionately affected by dental problems
- Develop a process and protocols to make, manage and close out referrals including connecting patients without dental coverage to safety providers of dental services
- Primary care providers exchange patient information and coordinate care with dental providers, track referrals and oral health outcomes

Health Information Technology Requirements

- Electronic health record includes modules to capture answers to oral health questions, document information regarding the patient's mouth, build an in-house risk assessment, order referrals, and track patient outcomes over time.
- Patient portal provides educational materials and after visit summaries

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, coordination, access to dental care, provider support, and overall satisfaction with provider

★ Quality

- Improved preventive oral health care
- Reduced restorative treatments

$ Cost

- Lower out of pocket costs for patients when receiving services in primary care
- Reduced preventable ED visits and hospital admissions for severe dental conditions

Access

- Easier access to preventive dental care services
- Assistance getting access to comprehensive dental care through primary care referrals as needed

IMPROVING HEALTH EQUITY

Rural and underserved communities are disproportionately affected by dental problems and have limited access to dental care in the community. To reduce this disparity, primary care will change in the following ways:

✓ **Dental and oral health services provided** in primary care offices increase access to dental care.

✓ **Integration of primary care and dental care** improve care coordination.

✓ **Reduce need for additional appointments** to receive certain basic dental services.

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PRIMARY CARE MODERNIZATION

Shared Medical Appointments

ELECTIVE CAPABILITY

Shared Medical Appointments are a form of group visit for patients with similar medical conditions during which a clinical team provides physical exams and education about ways patients can help manage their own conditions such as lifestyle changes and how to use community resources to reduce barriers to care.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have routine, condition-specific check-ins at a convenient location and time of day
- Get support and coaching to help change health behaviors
- Talk regularly with others who have a similar medical condition and socio-economic backgrounds and learn from their experience
- Improve your knowledge about your medical condition
- Receive guidance in a preferred language
- Have a primary care team that helps with "real life," day-to-day challenges about a medical condition

PRIMARY CARE TEAMS CAN...

- Help patients improve self-management through coaching, discussion, and peer-to-peer interactions
- Offer more convenient meeting times and locations compared to conventional appointments and potentially improve compliance for patients who do not otherwise keep appointments
- Offer supports and strategies to help patients overcome cultural barriers, health literacy challenges, and social isolation, which may hinder self-management.
- Build relationships with patients and help support engagement and commitment to lifestyle changes
- Improve provider experience and practice efficiency by using expanded care team members prevention or condition related shared visits

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Lenny arrived for a routine appointment to check his diabetes, weight and high blood pressure. He's busy and has had trouble keeping on track with exercise and diet. He has also missed some primary care check-ups.

Lenny's primary care provider suggested he try a shared visit at a community center near his home. Unsure whether he wanted to talk to others about his health, Lenny was reassured by the confidentiality agreements everyone signed.

At the evening meeting, after work and before kids' homework started, a medical assistant recorded Lenny's blood pressure and other vital signs in a private area. A health coach gave a short talk about building more exercise into daily routines.

Lenny and others in the group met to share suggestions and ideas that Lenny thought might work. When it was time for questions, Lenny asked for tips on how to eat at a family barbeque. After this meeting, Lenny attended regularly and with the group's support, achieved his goals.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Develop protocols and analytic methods to identify patients who might benefit from peer group coaching and support
- Designate and train care team staff to perform initial health checks, collect and record information, provide health instruction and facilitate discussion.
- Designate and train support staff to recruit and confirm participants, coordinate transportation, provide materials, set up the room and organize supplies and equipment, if needed
- Establish policies regarding privacy and confidentiality for patient participants
- Develop or identify an appropriate curriculum and provide training for staff in education, teaming, and facilitation
- Establish a regular meeting time at a conveniently located, accessible private meeting place

Health Information Technology Requirements

- Electronic Health Record configured to record patient vitals, notes and group-based encounters
- Accurate and up-to-date patient contact information to send invitations and meeting reminders

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, provider support, discussing stress, and overall satisfaction with provider

★ Quality

- Improved preventive care compliance (e.g., colonoscopy screening)
- Improved chronic illness outcomes (e.g., diabetes control)
- Improved care plan adherence
- Reduced preventable hospital admissions for ambulatory care sensitive conditions

$ Cost

- Potential reduction in out-of-pocket costs
- Reduced emergency department, urgent care and hospital utilization

Access

- Easier access to primary care support and peer resources

IMPROVING HEALTH EQUITY

Patients with complex medical conditions feel brief office visits don't allow enough time to answer questions and support self-management. Patients may face social isolation, low health literacy, and cultural barriers that affect their ability to effectively access care and manage conditions. To reduce this disparity, primary care will change in the following ways:

✓ **Interactions with peers from own community** may reduce stigma, address cultural barriers, enable peer support and reduce social isolation

✓ **Care team supports** may include medical translators or others with cultural insight, such as community health workers

✓ **May reduce health literacy barriers** through discussion with questions and answers (rather than lectures)

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PRIMARY CARE MODERNIZATION

Health Equity Improvement

CORE CAPABILITY

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

85%

of the practices in your network have fully implemented the policy and procedure.

GOALS

Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Process Measures

1. Increased collection of all specified data documented in the EHR
2. Completed analyses that identify at least three disparities
3. Completed interventions to address the three disparities

KEY ELEMENTS OF HEALTH EQUITY IMPROVEMENT

COLLECT AND ANALYZE

- Expand collection, reporting, & analysis of demographic data
- Identify and prioritize opportunities to reduce healthcare disparities

IMPLEMENT

- Implement intervention to address identified disparity

EVALUATE

- Evaluate the intervention

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Expand the collection, reporting, and analysis of standardized demographic data stratified by sub-populations

1. Collect race and ethnicity categories for all patients that go beyond the broad OMB categories. The selection of additional categories must:
   a. Draw from the recognized "Race & Ethnicity–CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS) or a comparable alternative;
   b. Have the capacity to be aggregated to the broader OMB categories;
   c. Be representative of the population it serves based on (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members
2. Collect information regarding preferred language, sexual orientation and gender identity (SOGI), and disability status for all patients
3. Collect information regarding health literacy and social determinants of health
4. Identify valid clinical and care experience performance measures to compare clinical performance between sub-populations; such measures should meet generally applicable principles of reliability, validity, sampling and statistical methods
5. Analyze the identified clinical performance and care experience measures using variables identified in 1-3 above and geography/place of residence
6. Establish methods of comparison between sub-populations and in relation to the network's attributed population or a benchmark
7. Conduct a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population's linguistic and cultural needs, and implementing a plan to address workforce gaps

Identify and prioritize opportunities to reduce healthcare disparities

1. Document opportunities to reduce healthcare disparities identified through data analysis
2. Prioritize opportunities by engaging members of the sub-population.

Implement three interventions to address identified disparities

1. Conduct root cause analyses for the identified disparities and develop interventions. To conduct the analyses, utilize:
   a. Relevant clinical and patient data
   b. Input from the focus sub-population for whom a disparity was identified
2. Design pilot interventions that will meet the needs/barriers identified in the root cause analysis
3. Involve members of the sub-population who are experiencing the identified disparities in the intervention design
4. Implement the interventions in at least five practices

Evaluate intervention

1. Demonstrate that the interventions are reducing the healthcare disparities identified by:
   a. Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed
   b. Achieving improved performance on measures
   c. Sharing evaluation findings with the focus sub-population
2. Identify opportunities for quality and process improvement design

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PRIMARY CARE MODERNIZATION

Community Integration to Address Social Determinants

CORE CAPABILITY

Identify social determinants of health and other barriers that may affect patient's healthcare outcomes and address those barriers by connecting patients to community resources.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Talk to your care team about life circumstances that make it hard to get preventive care or to manage a chronic illness
- Get help finding solutions from a community health worker or care coordinator
- Get connected to community organizations that can help with housing, access to healthy food, financial support, legal services, transportation, heat for your home and other needs.

PRIMARY CARE TEAMS CAN...

- Better understand the social determinants of health that make it hard for your patients to participate in preventive care or manage their chronic conditions.
- Incorporate social determinants of health into the care plan such as connections to food, housing, clothing and fitness programs
- Improve the quality of care by addressing common problems that may contribute to poor outcomes
- Reduce burden on primary care team members by providing support in addressing problems that affect patient engagement

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Eva is a single mother of two. She does not make enough money to buy enough food for her family and she struggles to pay other bills. She also prefers speaking and reading Spanish to English. Eva goes to her primary care provider's office for a regular checkup.

While waiting to see the doctor, Eva answers some questions about her housing, food and other health factors, called a social determinants of health (SDOH) screening tool. A community health worker trained in SDOH assessments and community linkages reviews her SDOH risk and enters it into her electronic health medical record.

After Eva meets with her doctor, the community health worker meets with her to talk about her needs. She connects her with a local food pantry. They also talk about her diabetes and her struggles to eat healthy and measure her glucose levels daily.

The community health worker refers her to a program at the local community center that holds diabetes self-management courses in Spanish. The community health worker calls Eva the following week to confirm she was able to enroll in the diabetes self-management course.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Implement a standardized process for screening patients for social determinants of health using a screening tool that is linguistically and culturally appropriate and that addresses food insecurity, housing instability, utility needs, financial resource strain, transportation, exposure to violence and other areas such as childcare, education, employment, health behaviors, and social isolation/engagement
- Establish protocols for documenting in the care plan the social determinant barriers and the plan to address them
- Designate a care team member (such as a Community Health Worker) with training in social determinants of health, cultural sensitivities, and community services to address the identified social determinant barriers
- Create referral relationships with those community organizations whose services are most frequently utilized
- Establish a process for accessing an up-to-date resource directory (such as 211)
- Establish referral management protocols that include determining whether individuals were successfully linked to and served by community resources
- Track outcomes including assessment of the impact of community resources on patient experience, healthcare outcomes and cost.

Health Information Technology Requirements

- Access for all team members to electronic health record (EHR) or interoperable software that enables the capture of coded social determinants of health risk assessment results
- Analytics that enable the analysis of performance with respect to social determinants of health
- EHR configuration or software to support referral management with respect to community resources
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider satisfaction ratings with respect to medical home support such as "asked you if there were things that make it hard for you to take care of your health"

★ Quality

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions

Access

- Improved access to community resources to address social determinant barriers

IMPROVING HEALTH EQUITY

Patients experience social determinant barriers to care that result in health disparities. These disparities disproportionately affect individuals who are lower income and of certain race/ethnic groups. Improving the identification of social determinant barriers and linkage to community resources that help resolve these barriers will reduce disparities. Patients that experience disparities will be better able to engage in preventive health and management of chronic conditions.

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PRIMARY CARE MODERNIZATION

People With Disabilities

CORE CAPABILITY

Enhanced primary care for people with disabilities including experienced primary care teams, access to preventive screenings and care, accessible services, and home- and community-based services and care teams.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Access to primary care teams who are experienced in supporting individuals with unique physical, cognitive, and communication needs
- Get more convenient care via phone, text, email, and video visits
- Get support transitioning from the hospital or skilled nursing facility to home
- Have accessible equipment like table lifts and communications devices
- Have the primary care team coordinate with specialists and other providers to keep up to date on their well-being and preferences
- Connect to support services for food, housing, and transportation with help from the care team

PRIMARY CARE TEAMS CAN...

- More effectively address disability related health disparities including chronic illness outcomes and preventive screening
- Spend more time addressing patients' clinical needs and supporting their non-clinical needs
- Get training and support to improve care and the experience of care for individuals with disabilities
- Engage patients in their preferred style with options for phone, text, email, and video visits, and home visits when circumstances require
- Collaborate with the Department of Developmental Services and long-term services and supports to help patients formulate care plans

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Fernanda has a physical disability due to a car accident that left her unable to speak. She uses a wheelchair and is often in pain due to her injuries. She goes with her husband to a primary care provider who specializes in care for people with disabilities.

Fernanda appreciates that staff make eye contact and speak directly to her. The team has paid special attention to ensuring that she receives preventive care including routine colon and breast cancer screenings.

The provider has information about Fernanda's physical disability and communication preferences in her electronic medical record and offers a tablet so that she can answer questions. The exam table has a lift so that Fernanda can more easily get on and off.

To help her manage her pain, a care coordinator connects Fernanda with physical and occupational therapists who conduct home visits and coordinate with DDS regarding other services and supports that Fernanda receives.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

All primary care practices

- Expanded care team (care coordinator, nurse care manager, community health worker, pharmacist, etc.) is required
- Establish system and staff workflow for eConsults between subspecialists and primary care providers
- Enable phone, text and email encounters and telemedicine visits
- EHR contains information about the person's disability, preferred communication style and long-term services and supports
- Coordinate with Department of Developmental Services (DDS) waiver services, other agencies responsible for supporting individuals with disabling conditions, community supports and advanced specialty care
- Receive training in person-centered preventive care for people with disabilities

Subset of primary care providers specialize in care for people with disabilities

- Establish system and staff workflow for home-based primary care
- Enhanced accessibility solutions for exam equipment and communication support
- Establish clinical links to hospitals and skilled nursing facilities, rounding by primary care providers when possible and support from the primary care team for care transitions
- Provide a specialized care team (coordinator with expertise in durable medical equipment and long-term services and supports, physical/occupational therapist)
- Ensure care team training, expertise and experience in providing care to individuals with disabilities
- Situate practices in locations accessible via public transportation

Health Information Technology Requirements

- Access to electronic health record for all care team members, and from remote locations
- Scheduling system accessible to all members of the patient's care team
- Analytic capabilities to support identification of disability-related health disparities
- Accessibility technology in exam rooms such as table and toilet lifts
- Communication devices for patients with speech impairments or who are non-verbal
- Remote patient monitoring technology as needed

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to care team's caring, concern and respect, communication, BH services, shared decisions, provider support and overall satisfaction with provider
- Improved experience through more convenient, timely, coordinated, and accessible care

★ Quality

- Improved preventive care (e.g. immunizations, screenings)
- Improved chronic illness outcomes
- Earlier diagnosis and treatment for some conditions
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Reduced urgent care, ED, nursing facility and hospital utilization
- Lower out of pocket costs for services in primary care and by non-billable team members

Access

- Easier to find a PCP that will accept a new patient with disabilities
- Access to practices with appropriate experience, expertise and resources
- Easier access to expertise of a specialist

IMPROVING HEALTH EQUITY

People with disabilities tend to receive necessary preventive care less often than people without disabilities. To reduce this disparity, primary care will change in the following ways:

✓ **Options for phone, text, email, and video** will improve patient engagement and associated preventive and chronic care outcomes.

✓ **More accessible equipment and communication devices** will help individuals with disabilities receive care and share their concerns and preferences.

✓ **Additional training, support and experience** will improve care teams' ability to address the needs of individuals with disabilities such as chronic pain.

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Joy is a young teenager with Down Syndrome. She has congenital heart disease and frequent upper respiratory illnesses. Recently she seems tired all the time.

Concerned about Joy's recent weight gain, Joy's parents bring her to a primary care practice with special expertise in treating people with disabilities.

At the visit, the clinician talks with Joy about how she's feeling. Joy gets a full physical and they talk about getting more exercise and handling stress at school.

Lab tests suggest that Joy is at risk of developing diabetes. The primary care team meets with Joy and her family to discuss a monitoring plan, healthy eating, exercise and what to expect during Joy's teenage years.

NETWORK/PRACTICE LEVEL REQUIREMENTS

ADVANCED NETWORK/FQHC

Patients & Caregivers

Network conducts population health analytics to identify disparities in care, healthcare outcomes and patient experience and empowerment

ALL PRIMARY CARE PRACTICES IN AN/FQHC

Providers and care teams trained in values-based care for people with disabilities

- Diverse Care Teams (CHW, behavioral health clinician, care coordinator)
- Person-centered care
- eConsults between PCPs and specialists
- Disability information sharing with patient consent
- Phone/text/e-mail encounters, telemedicine visits

SUBSET OF PRIMARY CARE PRACTICES

Patients and families/caregivers may choose practices and providers with additional expertise and experience in complex care for individuals with disabilities

- Home-based Primary Care
- Specialized care team (coordinator w/ expertise in DME, long-term services & supports, & physical therapists)
- Hospital, nursing facility rounding, discharge planning
- Accessible exams equipment and communication accommodations
- Project Echo and eConsults with centers of excellence in chronic pain management

SERVICES OUTSIDE THE PRACTICE

State Supports & DDS Services
Community Companion Homes
Case Management
Employment and Day Services
Long-term Services
Conneticut Community Care
Guardian Education and Support Programs
Peer Support Programs

Community Supports
Meals
Transportation
Housing
Handyman (handrails, etc.)
Community centers

Advanced Specialty Care
Center of Excellence specialized in chronic pain
Subspecialists with specialty in patients' condition(s)

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PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Create diverse care teams that are guided by the primary care provider in collaboration with the patient and family, integrate other professionals, coordinate with community supports, and promote the strengths of families and best health for all children.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Ongoing support from a primary care team that is accessible in the doctor's office, at home, and in your community
- More time with your pediatric primary care provider when needed
- Behavioral health services right away in the pediatric office
- Help with childcare, nutritious food, transportation and other needs from a community health worker
- Connected to early intervention services from a navigator or care coordinator
- Help with school or childcare center from a care coordinator who knows your child's health needs
- Fluoride treatment at the pediatric office to prevent cavities without having to go to a dentist

PEDIATRIC CARE TEAMS CAN...

- Enable PCPs to spend more time with patients and families and care teams to efficiently support the provider
- Expand capacity to support parenting, strengthen families and promote child well-being
- Improve coordination with schools, childcare centers, and other settings that playing a role in child health and development
- Expand PCPs' abilities to manage children with complex needs through tele-mentoring
- Improve access to language assistance and community supports to address family needs like housing, transportation and food security
- Improve practice efficiency, cultural effectiveness and care team satisfaction

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Jenny is almost three years old. Her parents are worried that she is not talking yet, and her daycare says she is being aggressive towards other kids. With full-time jobs and two more kids at home, her parents aren't sure how to help her.

Jenny's father takes time off work to take her to the doctor. They meet with her PCP, who recommends a developmental assessment and a home visit to understand Jenny's behavior. The visit is scheduled so that her parents don't miss work.

They meet with the social worker at the office who does a developmental screening. She refers them to a service near their house that supports children with developmental delays and has weekend hours.

The social worker visits Jenny's family at home to assess her behaviors. She visits her at daycare to learn more about her aggressive behaviors. She works with Jenny's primary care provider and her parents to develop a care plan.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Hire care team members to provide functions defined by the American Academy of Pediatrics, including: well visits and preventive care; acute and chronic care; care management; care coordination; patient navigation; behavioral health integration; oral health integration; and chronic illness self-management
- Deploy care team members in the practice, in the community or patient homes, and/or at a network central hub
- Coordinate with community services and other places where patients receive care (e.g. schools, childcare centers)
- Utilize Community Health Workers to link patients and families to culturally appropriate community resources, track follow-up, and provide support
- Ensure care team members apply their skills to the top of their training
- Train team members to deliver effective team-based care, including workflows and communications
- Provide access to tele-mentoring programs for care teams (e.g. Project ECHO) in collaboration with community-based organizations to expand ability to manage more complex cases

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- Analytic resources to identify populations at risk, develop, implement and refine operations and to support continuous health promotion and quality improvement
- EHR and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR supports population and registry management and care management
- EHR includes a comprehensive care plan with role-based care team access
- Data sharing systems between practices, community care settings (e.g. school health centers), and centralized care coordination resources when possible

MEASURING IMPACT

✓ Patient Experience

- Improved patient and family experience through more timely, culturally effective, coordinated, and family-centered care, including behavioral health care; increased community and provider support for stress and worries

★ Quality

- Increased screenings and follow-up (e.g. oral screenings, developmental assessments)
- Improved preventive and well-child care
- Improved health promotion outcomes (e.g. school readiness, healthy weight)
- Improved chronic illness outcomes (e.g. asthma, childhood obesity)
- Reduced risk for development of chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for services in primary care and by non-billable team members
- Reduced healthcare costs over lifetime by identifying and preventing risks in childhood

Access

- Easier access to services including behavioral and oral health, in the practice, home, or community
- Assistance accessing culturally appropriate medical services and community supports

IMPROVING HEALTH EQUITY

Health disparities, such as those faced by communities of color or non-English speakers, start early in life. They can be reduced in part by pediatric care that identifies and address health and social determinant risks early. Care teams can help by:

- ✓ **Having community health workers who reflect the family's community and culture** and medical interpreters who address language barriers.
- ✓ **Linking families to childcare, nutrition services, developmental supports** and other community resources.
- ✓ **Using peers to provide culturally appropriate support** to families, such as parenting support.

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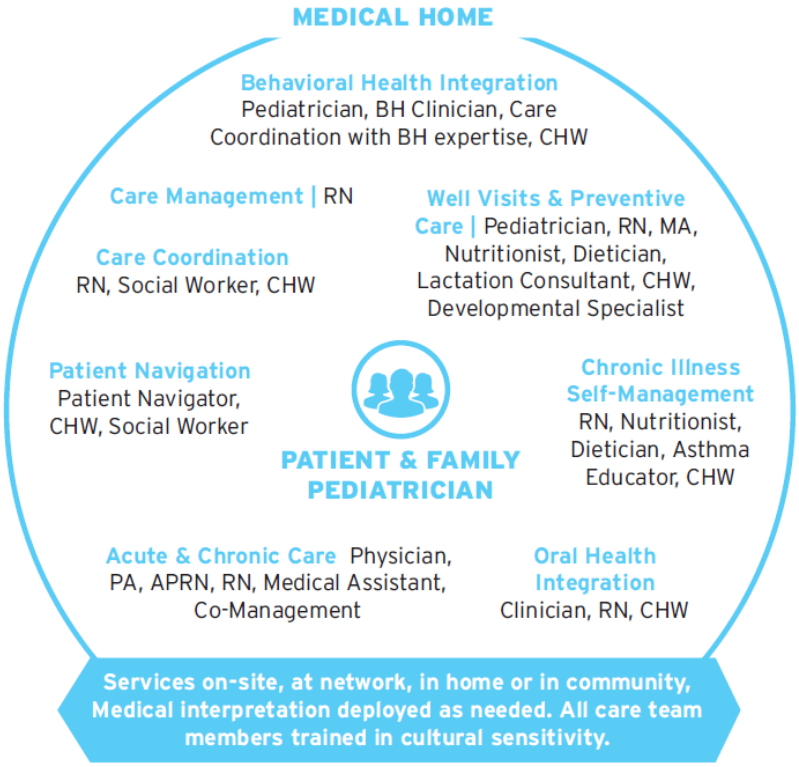
PEDIATRIC DIVERSE CARE TEAMS

Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care



PRIMARY CARE MODERNIZATION

Behavioral Health Integration

CORE CAPABILITY

A team-based approach to prevention, early identification and promotion of developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and trauma impact your child's development and health later in life
- Meet with a care coordinator to connect you to community-based supports and additional behavioral health and developmental services
- Get coaching on managing your child's behaviors
- Access the behavioral health clinician through video visits
- Get help communicating with your child's school or childcare center about development and behavior
- Have a single point of contact to coordinate all of your child's providers

PEDIATRIC CARE TEAMS CAN...

- Expand capacity to provide behavioral health screenings, brief interventions, and medication management
- Improve early identification and treatment of behavioral health and developmental issues, and ability to provide trauma informed care
- Coordinate with schools and childcare centers and facilitate access to behavioral health and related community services
- Better address the preventive and medical care needs of children with serious behavioral health conditions
- Access psychiatric consultation to support prescribing and management of behavioral health and health behaviors
- Access behavioral health care information on your EHR

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Andre is in sixth grade and having trouble concentrating in school. His teacher says he is disruptive in class and doing poorly on assignments. Andre's parents have noticed he is more active than his peers and distractible at home.

Andre and his mom Marie go to the pediatrician's office for an annual check-up. The PCP sends his mom home with the Vanderbilt ADHD Diagnostic Rating Scale to complete and return. With permission, the PCP sends the scale to Andre's teacher.

The practice's care coordinator follows up with Marie and Andre's school to get the completed scales and gives them to Andre's PCP at their weekly meeting. The PCP has an eConsult with a child psychiatrist about whether medication is indicated.

At a follow up visit, Andre's PCP introduces Andre and Marie to the psychologist at the office to determine if counseling is needed. The care coordinator reaches out to Andre's school regularly to keep the care team informed about his progress.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Dedicated behavioral health clinician (BHC) on-site or via telemedicine
- Dedicated care coordinator with expertise in coordinating access to services in support of BH and SDOH needs of children and parents, and who coordinates across all service systems (e.g., schools, Title V, child welfare)
- Administer universal screenings to assess developmental and socio-emotional health; behavioral health and health behaviors; and social and environmental factors
- Provide brief interventions for behavioral health and health behaviors and promote trauma-informed care
- Provide referrals to and coordinate with community BH specialists, higher level BH services and supports, developmental services and community resources (e.g., housing)
- Train primary care teams and BHCs in core competencies, effective teaming and cultural sensitivity
- Establish arrangements with community-based child psychiatrist or psychiatric APRN for telephonic and eConsults, such as through Access Mental Health CT
- Develop and track outcome measures assessing effectiveness of the practice in addressing BH needs; including health equity and disparities

Health Information Technology Requirements

- Access to common EHR platform for medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and eConsult
- EHR configuration and protocols to ensure capture of all interactions between patient/family and care team members, including nonoffice-based care
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with BH specialists and community-based organizations
- Bi-directional communication solution to support coordination with BH specialists and community care settings (e.g. school health centers)
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient/family experience with respect to timely care, communication, coordination, access to BH care, and provider support
- Single point of contact for services received at practice and community settings
- Less time off work or school for parents and children

★ Quality

- Earlier identification and intervention for behavioral health and developmental conditions
- Improved behavioral health outcomes (e.g., remission of disruptive behavior disorders)
- Improved school outcomes (e.g., school readiness, attendance)
- Improved family functioning (e.g. reduced exposure to adverse childhood events)
- Reduced risk of developing chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for patients and families when treated in primary care
- Reduced ED and hospital utilization

✓ Access

- Easier access to BH services and reduced wait time for treatment
- Assistance connecting to community-based BH specialty services and community supports

IMPROVING HEALTH EQUITY

Children and families who have BH needs face obstacles accessing care. Childhood BH conditions that go untreated can negatively impact health in adulthood. BH integration will:

- ✓ **Improve access for families** who, for reasons related to culture, stigma or SDOH barriers, may not access behavioral health treatment in other settings.
- ✓ **Expand connections with culturally appropriate community services** to address BH and SDOH needs for children and their parents.
- ✓ **Use care coordinators and medical interpreters** to improve communication between primary and behavioral health providers.

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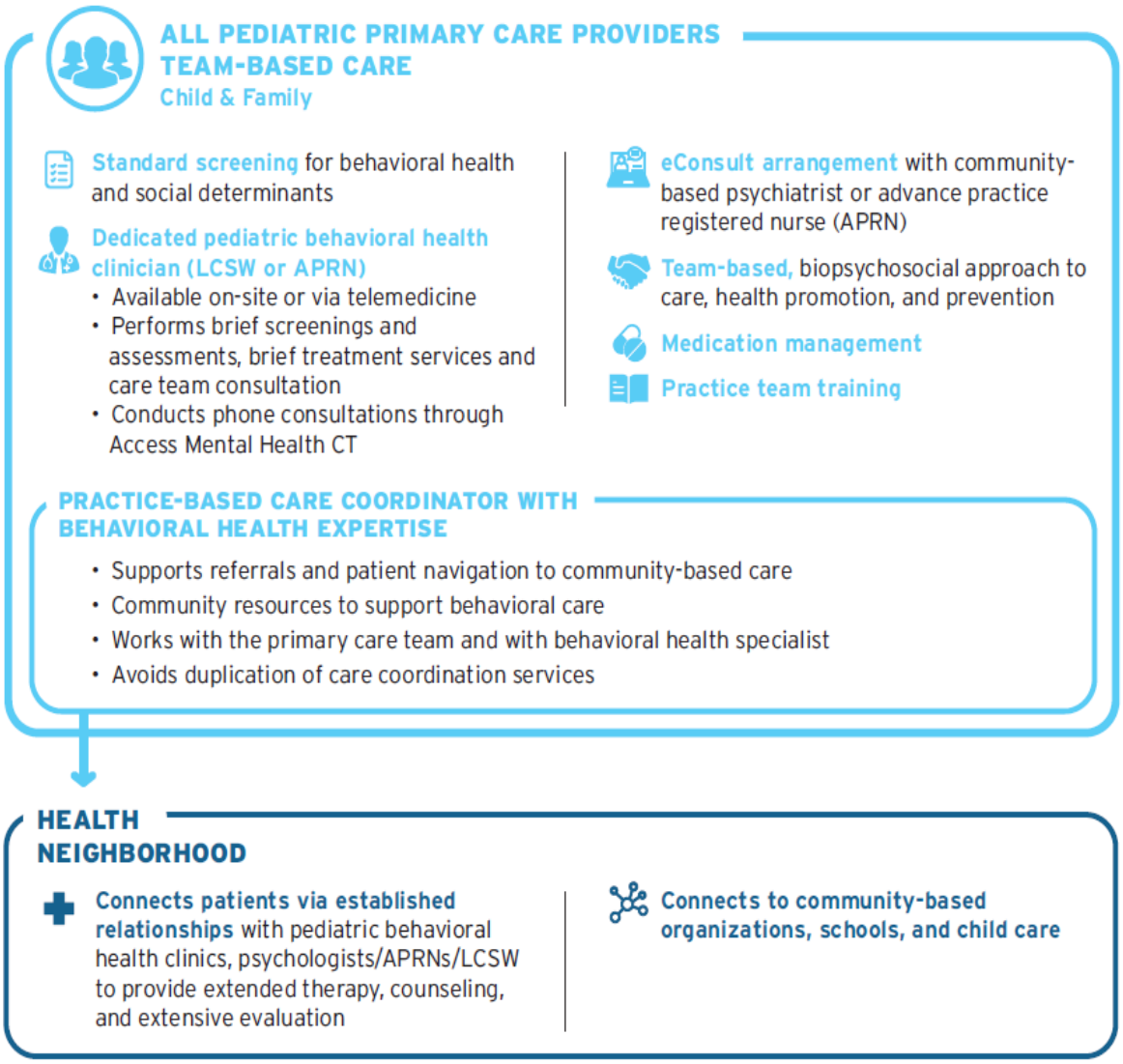
PEDIATRIC BEHAVIORAL HEALTH INTEGRATION



PRIMARY CARE MODERNIZATION

Alternative Ways to Engage Patients and Their Families

CORE CAPABILITY

Offer alternative ways for patients and families to engage with the pediatric medical home beyond individual office visits, such as telemedicine visits, phone calls, text messages, emails, and group visits.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Connect with your child's PCP or care team between in-office visits as needed
- Arrange a telemedicine visit with your child's PCP for diagnosis and treatment, medical advice, or to determine if an in-person exam is needed
- Get timely answers to parenting questions
- Save money with virtual visits compared to most in-office visits
- Avoid an emergency department or urgent care visit when it's not an emergency
- Take less time off work to bring your children to visits and reduce worry
- Get more time with care team and other families in group visits for wellness or managing a condition (e.g., asthma)

PEDIATRIC CARE TEAMS CAN...

- Have more time to offer advice to patients and families about care plans and parenting using phone, text or email
- Expand capacity for routine and urgent care via telemedicine to support more timely and convenient care and reduce avoidable emergency department visits and hospital admissions
- Enhance relationships with patients and families through more continuous care
- Remind patients and families about immunizations, well child visits, screening results and follow-ups, and self-management activities via text and email
- Enable practice efficiencies and flexible methods of support while ensuring stable practice revenue

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Darren is five years old and loves to play soccer. His father Marty, who works full-time and is a single parent, has noticed lately that Darren has been wheezing during soccer practice and complaining that his chest hurts.

Marty and Darren take time off work and school to go to Darren's pediatrician. His PCP asks about Darren's symptoms, and does a lung function test after having Darren do jumping jacks. She diagnoses him with exercise-induced asthma.

The PCP sends Marty and Darren home with an inhaler prescription and spirometer. She instructs Marty to have Darren blow into the spirometer before and after taking his inhaler and report readings and symptoms via secure email.

A week later, Marty and Darren have a video visit with the PCP to watch how Darren takes the inhaler. She gives Marty more instructions and sets up a time to have a phone call in two weeks to check-in on Darren's symptoms.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Establish protocols and workflows to support scheduling:
  - Telemedicine and phone visits with the PCP for routine and urgent care and the care team for coordination of care, navigation, coaching, screening and information
  - Groups visits with the PCP or care team (*optional*)
- Establish protocols and workflows to support:
  - Email, text, phone, and voicemail communications with PCPs and care team
  - Timely responses to patient inquiries and questions
- Train care team on new workflows; handoffs and escalation processes; when telemedicine is appropriate, i.e. for established patients and clinical scenarios
- Update and maintain patient contact, visit and language preferences and, for telemedicine, confirm access to high-speed internet and technology
- Ensure communications are in the patient's preferred language
- Ensure telemedicine visits are with patient's care team (not third-party providers)
- If group visits are adopted, establish:
  - procedures to recruit and group patients, document participation and schedule time for individual follow-up
  - private, convenient space for group visits
  - staff training on group visits and privacy and confidentiality protections

Health Information Technology Requirements

- Network provides secure web-based platform to support
  - telemedicine scheduling and encounters
  - the electronic exchange of sensitive patient information between the patient or family and care team
- Configuration of electronic health record (EHR) or web-based platform and protocols to ensure all patient and family contacts through telemedicine, phone, text, email, and group visits are automatically documented
- EHR supports outcomes measurement and performance accountability by logging and reporting all contacts, follow-up, and outcomes

MEASURING IMPACT

✓ Patient Experience

- Improved patient and family experience through more timely care, more accessible and family-centered care, coordination and communication; increased provider support
- Less time off work or time spent arranging for childcare or transportation
- More continuous engagement with the care team

★ Quality

- Improved engagement in preventive care and chronic illness self-management
- Improved timely response to new symptoms or change in condition
- Reduced preventable ED visits and admissions for ambulatory care sensitive conditions

$ Cost

- Reduced costs associated with avoidable ED and urgent care visits and hospital admissions
- Reduced out-of-pocket costs associated with in-person visits, ED, urgent care and hospitals visits

Access

- Faster, more convenient connections to culturally appropriate health resources
- Improved access to medical home with reduced need for travel, time off work or childcare

IMPROVING HEALTH EQUITY

Families with lower income, disability related mobility challenges, or living in underserved communities may find it harder to take time off from work, arrange childcare, leave the home, get transportation to a doctor's office, or pay for co-pays. Primary care can help by:

✓ **Offering more ways to receive care and get questions answered** without physically going to the office.

✓ **For patients and families with a smart phone, using text, email and telemedicine** to build a stronger relationship with the pediatric medical home.

✓ **Facilitating support from peers** from the same community in group well child visits.

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PRIMARY CARE MODERNIZATION

Universal Home Visits for Newborns

CORE CAPABILITY

Pediatric primary care practices offer home visits to all families of newborn children via a nurse and community health worker (CHW) team to promote family and infant health and well-being.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Get advice and support at home from your baby's pediatric practice within a week or two after leaving the hospital
- Ask questions and get answers about your baby without having to go to the doctor's office or wait for a phone call
- Learn about helping you and your newborn eat and sleep during early infancy
- Get lactation coaching on breast feeding from a lactation consultant
- Build your confidence in your parenting skills and in your relationship with your pediatrician's care team

PEDIATRIC CARE TEAMS CAN...

- Engage new parents early, during these important first days with a newborn
- Share information about when sick newborns and infants need to be seen in the office or at the emergency department
- Help new parents with hands-on advice, support, and reassurance
- Model and teach effective childcare techniques in less formal, more familiar home settings
- Improve the quality of care for newborns and young children by addressing common problems that may contribute to poor outcomess
- Build a foundation for a collaborative and supportive relationship with new parents
- Educate new parents about immunizations and well child visits

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Candace, age 20, has just given birth to Logan. Candace is exhausted after the delivery and doesn't have anyone to help her at home. Her husband was unable to get time off to help. She is anxious, a little overwhelmed and has many questions as a first-time mom.

When she arrives home, a nurse from her pediatrician's office calls to tell her about a free home visit program that offers coaching on infant care, self-care, breast feeding and what to expect with a newborn. Candace agrees to have a visit later in the week.

At the home visit, the nurse helps Candace with breast feeding, what to do when Logan gets sick, and how to handle her depression and anxiety. The community health worker connects Candace to local parenting and child care programs. The pediatric office receives visit notes.

One night, Logan cries for hours and hours. Instead of heading out to the emergency department, a worried Candace calls the pediatrician's office. She shares Logan's symptoms with the pediatrician and they decide she should bring Logan into the office in the morning.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Establish systems to identify families who are eligible to receive home visits (all families with newborns), including:
  - Policies and procedures for obtaining and documenting families' consent
  - Scheduling systems to connect with postpartum patients before discharge to arrange for a home visit as soon as possible after returning home.
  - Protocols to prioritize families with greater needs due to social determinant and other risk factors
- Establish home visiting teams that consist of a nurse and/or community health worker from the practice
- Use community health workers who are parents for peer-to-peer support whenever possible
- Conduct at least one home visit with all families of newborns whose parents consent to a visit within two weeks of the newborn going home; consider whether to introduce home visiting team to families in office prior to home visit
- Screen families to identify individual family needs
- Conduct brief interventions with extended education in specific areas based on parent needs
- Connect families to community programs, resources and supports as needed

Health Information Technology Requirements

- EHR configuration or software to support referral management with community-placed services and resources
- Portable device to support documentation of clinical and social needs during home visits
- Consent and confidentiality management solution
- Ideally, scheduling module that can accommodate and automate visit routing

MEASURING IMPACT

✓ Patient Experience

- Improved parent satisfaction with pediatric practice and perceived support by the primary care team during the early days of parenting a newborn
- Parental satisfaction with the home visiting program and team

★ Quality

- Improved parent/infant relationship and developmental health and behavior
- Improved positive parenting practices
- Improved maternal emotional health (i.e. anxiety and depression)
- Increased paternal involvement
- Improved family safety in the home and car; reduced avoidable injuries
- Increased community connections

$ Cost

- Reduced preventable emergency department visits and hospital stays

Access

- Increased access to parental support in the convenience of families' home and referrals to community resources

IMPROVING HEALTH EQUITY

Many new parents lack access to parenting support and community resources, especially those with social determinant needs, behavioral health problems, and those with infants at higher risk (e.g. low birth weight). Universal home visits for families with newborns will:

- ✓ **Provide parenting support and education** to improve parent/child relationship and positive parenting practices in the convenience of families' homes.
- ✓ **Connect families to community resources** that are culturally appropriate and specific to their needs.
- ✓ **Foster peer-to-peer support** through use of community health workers who are also parents.
- ✓ **Improve access to parenting support** by removing the stigma that may be associated when newborn visits are only offered to families identified as "at-risk."

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PRIMARY CARE MODERNIZATION

eConsults and Co-management

CORE CAPABILITY

Pediatric primary care providers partner with specialists[1] via electronic consults (eConsults) or collaborative care programs (co-management) for treating non-urgent conditions before or instead of referring a patient to a specialist for a face-to-face visit. When appropriate co-management can support continued collaboration between the PCP and the specialist.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Begin treatment sooner in primary care for some health problems rather than waiting for an appointment with a specialist
- Avoid the need for travel, time off work or school or childcare to see a specialist
- Get the benefit of a specialist's advice more quickly and easily, without having to schedule a separate visit
- Have a primary care team that effectively manages more of your healthcare needs
- Pay less out of pocket by having more of your needs met in primary care

PEDIATRIC CARE TEAMS CAN...

- Access specialist expertise to support evaluation and treatment in primary care and improve quality of care
- Manage a wider range of health problems and changes in condition without referring to a specialist
- Expand capacity for prescribing and management of behavioral health and health behaviors through specialist consultation and guidance
- Enable patients to avoid unnecessary specialist visits, testing and procedures
  - Enable patients to start treatment for some problems sooner by avoiding delays associated with scheduling specialty visits and other barriers to accessing specialty care (e.g., transportation, time off work, childcare)

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Erin is fifteen and has childhood onset Type II diabetes. She and her mom go to her pediatrician's office for a checkup. Her PCP is concerned that she is bordering on morbid obesity and her blood sugar remains uncontrolled.

Erin's PCP has talked with Erin and her family about diet and exercise many times. Erin's mother says the food at school that she gets for free is unhealthy but she can't afford to buy many fruits and vegetables. Erin hates sports.

Erin's PCP has an eConsult with a pediatric endocrinologist who recommends a medication regimen. Her PCP requests another eConsult for advice when Erin has initial side effects to the medication.

Guided by established co-management protocols, Erin's PCP and the pediatric endocrinologist continue working together to manage Erin's condition. Erin's blood sugar control improves with the medication and it is not necessary for her to visit the specialist.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Determine which specialties would be best suited to participate in an eConsult or co-management program based on evidence and knowledge about the Network's patients and providers
- Develop arrangements with specialists in relevant disciplines
- Create protocols that maintain clinician autonomy and support identifying appropriate patients, receiving patient consent, scheduling, receipt and review by the specialist, communication of the outcome back to the primary care team and follow up with patients
- Create protocols to guide co-management of patients following an eConsult, when appropriate.
- Train primary care team staff in using secure portals and technology
- Engage clinician champions to promote use and answer questions
- **OPTIONAL** Offer a "fast track" system for patients who have received an eConsult and need a face-to-face visit with a specialist.

Health Information Technology Requirements

- Access to common, secure technology platform such as an Electronic Health Record (EHR) to share information between primary care providers and specialists, including test results and imaging, as appropriate **- OR -**
- Network engages a vendor providing eConsult services to support deployment of the program and meeting HIT requirements
- EHR configuration and protocols to capture eConsult recommendations and treatment plan as presented by specialists
- EHR system able to supply data for measurement and accountability
- Appropriate consent and confidentiality protections

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with shorter wait times
- Reduced time away from work and/or school for parents (due to travel) and children
- Increased overall satisfaction with provider

★ Quality

- Earlier diagnosis and treatment for some health problems
- Improved outcomes for behavioral health and other conditions that typically require specialty care
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Lower out of pocket costs for patients and families treated in primary care
- Reduced unnecessary use of specialists and duplicative or unnecessary testing and procedures
- Reduced avoidable ED visits and hospitalizations

Access

- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist
- Eliminates access barriers for visits avoided (e.g., transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Some populations may experience health disparities due to barriers to accessing specialty care. The disparities may result from transportation or other social determinant risks as well as out-of-pocket costs and limited specialist capacity due in part to reimbursement rates. eConsults and co-management arrangements will:

✓ **Allow easier access to timely, high-quality specialty care** through electronic consultation with specialists.

✓ **Reduce patient and family access barriers** related to provider scarcity and maldistribution, transportation, time off work and childcare.

[1] "Specialist" refers to subspecialty physicians who do not have a primary care specialty, such as endocrinologists, cardiologists, and gastroenterologists. As specialist is the more common term, it is used instead of subspecialist.

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PRIMARY CARE MODERNIZATION

Community Purchasing Partnerships

ELECTIVE CAPABILITY

Advanced Networks or FQHCs facilitate arrangements for home and community-placed services on behalf of pediatric practices that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Get help from your pediatric provider's office to find community resources to help your family achieve your health goals
- Get help supporting your child's health from organizations in your town or neighborhood
- Get help parenting or managing your child's chronic illness in your home or your community, possibly with others who have similar issues
- Get help coordinating your child's care with services in your community
  - Connect to services such as early intervention, developmental supports and transitional services for adolescents that are important to strengthening your family and supporting your child's long-term health

PEDIATRIC CARE TEAMS CAN...

- Engage community resources such as schools, childcare centers, and recreation centers to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients and families experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with special health care needs by partnering with community care coordination resources and home visiting programs
  - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Nathan is twelve years old and was diagnosed with Dyslexia at age six. In elementary school, he worked with a reading specialist and tutor. Since transitioning to middle school this year, he has been acting out in class and getting poor grades.

Nathan's parents take him to his annual checkup at his pediatrician's office. They share that he is really struggling in school and doesn't seem to get enough support. Nathan starts crying because he says he "feels dumb" in class.

The pediatrician refers Nathan's family to the care coordinator, who connects them to a program that provides transition support services and works with their school system.

Nathan and his parents meet with the transition program's support specialist. She explains what services his middle school are required to provide and offers to meet with his parents and the school to develop a support plan for Nathan.

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HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

- Identify service gaps and needs for community-placed services:
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex health and SDOH needs
  - Segment the evaluation based on population characteristics such as race, ethnicity, country of origin, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and developmental services, chronic illness prevention and self-management services, complex care coordination for high-risk patients and families, parental support services, and transition services for adolescents
- Clinical protocols and analytics to support identification of patients and families that require these services
- Referral management protocols including determining whether families were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient/family experience, healthcare outcomes and cost

Health Information Technology Requirements

- Electronic health record (EHR) that captures above population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your child's health"

★ Quality

- Improved preventive and well-child care (e.g. immunizations, developmental and BH screenings)
- Improved chronic illness and behavioral health outcomes (e.g., asthma control)
- Reduced preventable hospital admissions for asthma

$ Cost

- Reduced emergency department visits and hospital admissions

Access

- Faster, more convenient connection to local, culturally effective health resources

IMPROVING HEALTH EQUITY

Patients and families experience barriers to care that result in health disparities. Health disparities start early and can be reduced through interventions in childhood. Access to culturally appropriate community-placed care can reduce disparities in the following ways:

✓ **Address health and preventive care needs in the home** or in a convenient, culturally appropriate and trusted community setting.

✓ **Better address social and environmental risks**, language preference and health literacy gaps.

✓ **Support pediatric practices** by filling gaps in services for patients and families experiencing barriers to care.

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PEDIATRIC COMMUNITY PURCHASING PARTNERSHIPS

MEDICAL HOME

Uses person-centered assessments (including culturally appropriate SDOH screening) and/or analytics to identify patients and families whose needs are best met through community placed services. [See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Developmental Services	Chronic Illness Prevention and Self-Management Services	Complex Care Coordination for High Risk Patients and Families, Often with SDOH Needs	Parental Support Services	Transition Services for Adolescents
EXAMPLES OF MODELS	Health Leads	The Village Model	DPH Putting on Airs (Prevention Services Initiative), Healthy Me	Clifford Beers ACCORD Model	MOMs Partnership, Minding the Baby	CPAC REACH for Transition

Appendix 5: Payment Reform Council Members

Robert Block Community Health Center, Inc.	**Kate McEvoy** CT Department of Social Services
Peter Bowers Anthem Blue Cross and Blue Shield	**Fiona J Mohring** Stanley Black & Decker
Robert Carr Western Connecticut Health Network	**Naomi Nomizu** Integrated Care Partners, HHC
Tiffany Donelson Connecticut Health Foundation	**Terry Nowakoski** The Partnership for Strong Communities
Eric Galvin ConnectiCare	**Joseph Quaranta** Community Medical Group
Peter Holowesko United Technologies Corporation	**Thomas Woodruff** Office of the State Comptroller
Jess Kupec Saint Francis Healthcare Partners	**Ken Lalime** Community Health Center Association of Connecticut

Appendix 7: Hypothetical Hybrid Bundle Case Study

Risk of Revenue Loss with Hybrid Method

Under a hybrid model, moving to non-FFS billable services will negatively impact revenue.

Fee for Service:
Dr. Smith and her team (2 MDs, 1 NP, 2 MAs) see about 80 patients a day in the office. They are paid an average of $75 per visit. Revenue for an average day $6,000. Dr. Smith returns patient phone calls and emails after hours. She is not paid for this time.

Bundle:
Using supplemental bundle revenue, Dr. Smith's practice adds a care coordinator and a social worker. It taps into community health workers, pharmacists and e-consult services from its AN. The practice moves about 25% of office visits to other care team members and/or phone, text or email. With the time saved, Dr. Smith participates in Project Echo, the practice begins pre-visit huddles and it accepts new patients again. Dr. Smith also gets her evenings back.

Full: The bundle payment is 100% of historical costs or $6,000.

50/50 Hybrid: The basic bundle payment is 50% historical costs or $3,000. Each office visit brings in half the historical FFS rate or $37.50 per visit. However, with only 60 office visits per day, FFS revenue drops to $2,250. Total revenue for an average day decreases to $5,250.

Payment Approach	FFS Revenue	Bundle Revenue	Total Revenue
FFS	$6,000 (80 office visits)	N/A	$6,000
Full Basic Bundle	N/A (60 office visits)	$6,000	$6,000
Hybrid Basic Bundle	$2,250 (60 office visits)	$3,000	$5,250

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Appendix 8: CMS Codes

Topic	Codes	Description	Expected Reimbursement
Remote Patient Monitoring	CPT 99453:	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.	$21
	CPT 99454:	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.	$69
	CPT 99457:	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.	$54
Virtual Check-Ins	HCPCS G2012:	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified healthcare professional who can report evaluation and management [E/M] services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.	$15
	HCPCS G2010:	Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. CMS clarified that follow-up may take place "via any mode of communication, including secure text messaging, phone call, or live/asynchronous video chat, so as not to restrict a clinician's interaction with patients."	$13
	HCPCS G0071	Virtual communication services furnished by a rural health clinic (RHC) or federally qualified health center (FQHC). Specifically, an RHC or FQHC may receive reimbursement for "at least 5 minutes of communication technology-based or remote evaluation services" furnished for a patient who has had an RHC or FQHC billable visit within the last year. This service is subject to the same limitations as HCPCS G2012 and G2010 with regard to prior and subsequent in-person visits.	Payment for HCPCS G0071 is set at the average of the national non-facility payment rates for HCPCS G2010 and G2012
Interprofessional Internet Consultation	CPT 99451:	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the	$34

		patient's treating/requesting physician or other qualified healthcare professional, 5 or more minutes of medical consultative time	
	CPT 99452:	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified healthcare professional, 30 minutes	$34
	CPT 99446-49, depending on time spent:	Interprofessional telephone/internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional;	$18-$73, depending on amount of time spent (5 min to 31 or more min)
Chronic Care Management	CPT 99490	CCM services, at least 20 minutes per month of clinical staff time	Average $42.84 adjusted based on geography
	CPT 99487	Complex CCM services, for patients who have five or more chronic conditions and who take eight or more medications, 60 minutes of clinical staff time per month.	Average 2018 reimbursement is $94.68.
	CPT 99489	Complex CCM services, each additional 30 minutes of clinical staff time per month (can only be billed with 99487)	Average 2018 reimbursement is $47.16
	HCPCS G0506	Care Planning for Chronic Care Management created to improve payment for the CCM initiating visit, accounts specifically for a billing practitioner's additional work in personally performing a face-to-face assessment of a beneficiary requiring CCM services, and personally performing CCM care planning that is not reflected in the initiating visit or in the monthly CCM service code.	Average 2018 reimbursement is $64.44.
	HCPCS G0511	Code for FQHCs and RHCs	Payment for G0511 in 2018 is $62.28. This rate is an average of the non-facility national payment amounts for CPT® 99490 (simple CCM), CPT® 99487 (complex CCM), and CPT® 99484 (general behavioral health integration) paid under the

			physician fee schedule.
	HCPCS G0512	FQHCs and RHCs may receive payment for providing 70 minutes or more of initial psychiatric CoCM services, or 60 minutes or more of subsequent psychiatric CoCM services by billing HCPCS code G0512, either alone or with an RHC or FQHC claim.	$145.08 The enhanced reimbursement rate is based on an average of the national non-facility PFS payment rate for CPT code 99492 and CPT code 99493.
	CPT 99358	Prolonged E/M service before and/or after direct patient care, first 60 minutes by physician or non-physician practitioner (NP, PA)	$113.76
	CPT 99359	Prolonged E/M service before and/or after direct patient care, each additional 30 minutes by physician or non-physician practitioner (NP, PA) (listed separately with 99358)	$54.72
Behavioral Health Integration	CPT 99492	First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider. Must include: Outreach and engagement of patients; Initial assessment, including administration of validated scales and resulting in a treatment plan; Review by psychiatric consultant and modifications, if recommended; Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant; and Provision of brief interventions using evidence-based treatments such as behavioral activation, problem solving treatment, and other focused treatment activities.	$161.28
	CPT 99493	First 60 minutes in a subsequent month for behavioral health care manager activities. Must include: Tracking patient follow-up and progress; Participation in weekly caseload review with psychiatric consultant; Ongoing collaboration and coordination with treating providers; Ongoing review by psychiatric consultant and modifications based on recommendations; Provision of brief interventions using evidence based treatments; Monitoring of patient outcomes using validated rating scales; and Relapse prevention planning and preparation for discharge from active treatment.	$128.88
	CPT 99494	Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above. Listed separately and used in conjunction with 99492 and 99493.	$66.60
	CPT 99484	Care management services for behavioral health conditions - At least 20 minutes of clinical staff time per calendar month. Must include: Initial assessment or follow-up monitoring,	$48.60

		including use of applicable validated rating scales; Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and Continuity of care with a designated member of the care team.	
Transitional Care Management	CPT 99495	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge Medical decision making of at least moderate complexity during the service period. Face-to-face visit within 14 calendar days of discharge.	$166.50
	CPT 99496	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge Medical decision making of high complexity during the service period. Face-to-face visit within seven calendar days of discharge	$234.97

Appendix 9: Original Savings Estimates from Capabilities for Commercial Patients

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

PMPM savings reflects the estimated per member, per month savings across the entire Commercial population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Commercial Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%; inpatient costs decrease 10%. *(PWC 2016)* Other outpatient facility costs decrease 12% *(NEJM, 2014)*	$19.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$1.27
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 3.6-6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.00
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$1.91

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Appendix 10: Access Tracking Options Considered

Option 1. (Preferred) Notes are entered in the practice's EHR (the practice gives all needed personnel access to their EHR). The practice would assume the costs for EHR seat licenses, if needed. The practice-associated personnel would record their patient encounters similarly to other visit types or communications. Documentation would include patient and provider IDs, purpose of the encounter (in English or using ICD-10 codes), and services rendered (in English or using CPT codes). Like other notes, these would be trackable in the EHR. Until the HIE has achieved the functionality and connectivity to capture these notes, the practice would create a periodic (monthly or quarterly) report of its clinical encounters and other clinical contacts, and upload this, in standard format, to the HIE's Landing Spot for ingestion and analysis by CDAS. The standard format is discussed below.

Option 2a. Practices unable to follow Option 1 may use standardized notes in electronic or paper format. Personnel performing non-traditional services would upload or fax a note to the Entity. OHS/OHIT would design and post a downloadable form with structured data entry fields (e.g., patient name and DOB, PCP name, date of encounter, name of staff performing visit, etc.). The form would be completed either on a device (i.e., using Adobe Acrobat) or filled by hand. The provider would include the purpose of the encounter (in English or using ICD-10 codes) and services rendered (in English or using CPT codes) for enhanced tracking. Upon receipt of the fax or file, the Entity would transform the information into a C-CDA. The C-CDA would be available in the Entity and could be pushed to or pulled by a practice's EHR into the patient's record. If the body of the note is entered using a device it will be stored as a computer-readable note in the patient's record, but if handwritten it will be stored as an image.

Option 2b. Practices unable to follow Option 1, and until the Entity is capable of supporting Option 2a, may use readily available (and admittedly low-tech) fax machines. Personnel performing non-traditional services would fax a note to the practice. Staff would use the same OHS/OHIT designed form as in Option 2a. Upon receipt of the fax, the practice would import it into their EHR, along with the structured data[1]. Once the fax is entered in this manner, it would be trackable in the EHR. Until the HIE has achieved the functionality and connectivity to capture these visits, the practice would create a periodic (monthly or quarterly) report of its patient touches, and upload this, in standard format, to the HIE's Landing Spot for ingestion and analysis by CDAS. The standard format is discussed below.

Option 3. Longer range in terms of timing, CT builds a state-wide mobile compliant website (or app)[2] with a form to allow entry and saving of encounter info, that would be saved to the HIE. The information entered includes those key data noted above. By the time this website is developed in 2020 or 2021, the HIE should have bidirectional connections to participating practices. The practices could download or import these encounters from the HIE or CDAS to support their care activities and include in their EHRs. The use case for developing the website would need to be presented and accepted by the CT HIT

[1] Accepting faxes is a routine function of EHRs, though keying in data would be an added burden on practice staff. A practice using Option 2 could use PDF files sent via secure email in lieu of ordinary fax, if preferred.
[2] Instead of a website, the state could build a mobile app. An app would require software development for at least two operating systems (iOS and Android), QA, revisions, support, upgrades, etc. A mobile-friendly website would be a better option and the back-end integration with CDAS and HIE would be easier.

planning and development process. Using the website minimizes burden on practices, and it eliminates the need to submit a periodic report of patient touches.

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