

July 1, 2010

To: SustiNet Board of Directors

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Re: SustiNet Patient Centered Medical Home Advisory Committee Report

Pursuant to PA 09-148, An Act Concerning the Establishment of the SustiNet Plan, we are proud to submit the report of the SustiNet Patient Centered Medical Home Advisory Committee. By this transmittal, we are fulfilling the requirement of the committee under Section 6 of that Act.

We want to thank all the members of the committee for their hard work in developing this report, the many generous experts who shared their wisdom with us, from within Connecticut and from other states, and to thank you for this opportunity. We also want to thank the able assistance of Anya Rader Wallack, Vicki Veltri, Michael Mitchell, Marilyn Rice, and David Krause without whose assistance this report would not have been possible.

We are available to answer questions or to re-convene the committee as needed to ensure that every Connecticut resident has access to coordinated, quality care through a patient-centered medical home.

Cc: House, Senate Clerks
CT Legislative Library
CT State Library

SustiNet Patient Centered Medical Home
Advisory Committee
Final Report

July 1, 2010

Respectfully submitted,
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Co-Chairs

Background

Access to care is a problem for too many Connecticut residents, particularly minorities and those with low incomes. Last year twelve percent of at-risk adults in Connecticut had not visited a doctor for a routine check up in the past two years; that rate is 33% higher for state residents living under twice the poverty level. About half of Connecticut adults over age 50 do not receive recommended care; that rate is 10% higher for Latino state residents and 15% higher for black Connecticut residents than for whites. Mortality amenable to health care for black state residents is 89% higher than for whites.ⁱ One third of Connecticut emergency department visits, 1,100 per day, are for non-urgent health issues. 64% of these visits occur between 8am and 6pmⁱⁱ suggesting that access to primary care, even during working hours, is a significant challenge for many Connecticut residents. In a recent survey, almost three out of four Americans report difficulty accessing care from their doctor. Half report poor coordination of care; especially among those who see more than one doctor. One in three Americans reports getting unnecessary care or duplicate tests. Ninety one percent believe it is important to have one place or doctor responsible for their primary care and coordinating care.ⁱⁱⁱ

There is no shortage of proposals to reform the health care system and no shortage of controversy over which proposals to implement. But one option that enjoys great support across interest groups is the patient-centered medical home (PCMH) concept. PCMHs are built on coordinating care in a patient-centered model. Proponents argue that PCMHs can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities.^{iv} A recent multi-database search of the research literature found 12,044 articles with the keyword patient-centered medical home.^v

PCMHs are not buildings or hospitals, but a different way of practicing medicine.

Upon entering a model PCMH in Flushing, New York, visitors are struck by the quiet – no scrambling, no rushing around. Patients spend little time in the waiting room but are moved quickly into an exam room. Then, as a practice manager described it, everything “swirls around the patient.” He doesn’t move; services and personnel come to him. The day before the visit, his team of providers, including a doctor, nurse and medical assistant, “huddled” to discuss his case, ensure that all his test results were ready and that all the services he needed would be available, and he got a reminder call. Most tests he needs are available on-site so his team can review the results and adjust his treatment while he waits. No getting back to him days later and trading phone messages. Each member of his PCMH team works at the top of their training; no control freaks allowed. You are as likely to see a medical assistant explaining how to do something to a doctor as the reverse. Not surprisingly, patients are very happy with the care they receive and providers find it a more organized and satisfying place to work. Staff turnover is not a problem and the practice is saving money.^{vi}

PCMHs offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce

duplicate tests and prevent errors in conflicting treatment when patients have several providers. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. The team may include a doctor, nurse, medical assistant, health educator and other professionals. PCMHs can make primary care practice more appealing to graduating physicians who are predicted to be in short supply as Connecticut's population ages.^{vii} There is ample evidence on the health benefits of access to a usual source of continuous care^{viii}, and initial evaluations of PCMH pilots are very encouraging.^{ix}

PCMH patients have to take responsibility for educating themselves and managing their care, with help from the PCMH team. They must learn about the best ways to maintain their health, communicate openly with their team of providers, and actively participate in decision making about their care. They must participate honestly in assessing their health risks and actively participate in the development of and commit to follow an individualized, feasible care plan designed to address their health issues. Treatment in PCMHs focuses on prevention and management of disease. Patients are not responsible for keeping track of the details of their care across all their providers such as test results or medication dosages; their PCMH coordinates those records. Patients don't have to wonder who they should call with a problem – they call their PCMH for help. The PCMH staff knows them and their family, their preferences, which treatments are most likely to help, and understands their cultural and language needs.

States and the federal government are recognizing the potential of the PCMH model. Eight states have defined the PCMH concept in law or regulation and seven states are developing processes and criteria to recognize PCMHs.^x In 2005 Ontario implemented the first wave of Family Health Teams, very similar to PCMHs, to reduce ER use and expand access to preventive care. There are now 150 Family Health Teams across the province in areas of need, with 50 more in planning.^{xi} Medicare recently released a solicitation for states to participate in multi-payer PCMH pilots.^{xii} The new federal health reform act includes significant incentives for PCMH implementation including grants for community resources, 90% Medicaid matching funds for care coordination services to patients with chronic conditions, and primary care workforce training incentives.^{xiii}

Despite the momentum, PCMH implementation faces some significant barriers. Coordinating care among providers, a cornerstone of the concept, is very difficult without electronic health records and structures to share health information among providers. Only 13% of US physicians have even a basic electronic medical record system^{xiv} but the recent federal stimulus package includes significant resources for providers to purchase health information systems. Care coordination also requires the cooperation of providers outside the PCMH team, who are not compensated for those activities. Patients have different responsibilities and rights within a PCMH including directing all care through their provider team; some may associate this with gatekeeping which was not popular in the 1990's and has largely been abandoned. Proposals to increase resources for primary care and PCMHs at the expense of other providers have met strong lobbying resistance.

A special concern for Connecticut is that between 50 and 62% of state physicians are in solo practices and between 70 and 88% work in groups of four or fewer providers.^{xv} Small practices face special challenges in implementing the PCMH model including weak infrastructure, inadequate capital investment, and less sophisticated management structure^{xvi}. Recommended supports for small practices transforming to the PCMH model include training and development for clinical and nonclinical staff on patient engagement skills, cultural competence, teamwork, and language needs. Tools and resources needed include patient education materials, clinical practice guidelines, quality improvement tools and shared services or staff to provide interpretation, patient education or care management, data analysis and health information technology.^{xvii}

Preliminary research on the PCMH model is promising, but also offers caution and guidance for success including patience, flexibility and support.^{xviii} Researchers have found that implementing the PCMH model requires a fundamental transformation of practice, which can be difficult for even willing practices, and is an on-going developmental process rather than a destination. New ways of practicing medicine, through teamwork, may pose the greatest challenge to PCMH adoption.^{xix} Recommendations for policymakers include assuring adequate financial resources, flexibility that respects the wide diversity of successful PCMHs, support for providers in transforming the way they practice, including training, new tools and other learning, and patience – successful practice transformation takes time. Recommendations for practices include establishing realistic timelines and gathering the resources needed, developing a technology plan, monitoring change fatigue, and developing a learning organization.

Current status of patient-centered medical homes in Connecticut

The National Committee for Quality Assurance (NCQA) has the only standardized, nationally recognized PCMH recognition program. Other national organizations are reportedly developing PCMH recognition programs. NCQA recognizes three levels of PCMHs.^{xx} There are no NCQA recognized PCMH practices in Connecticut, at any level; surrounding states have 31 (RI), 87 (MA) or 225 (NY).^{xxi} However, Connecticut does have two PCMH initiatives important to SustiNet populations – Primary Care Case Management in HUSKY and the state employee plan ProHealth pilot.

Primary Care Case Management (PCCM) was implemented as a pilot program beginning in February 2009 offering a PCMH alternative to HUSKY families living in the Waterbury and Willimantic areas. The program has since been expanded to the New Haven and Hartford areas.^{xxii} PCCM, named HUSKY Primary Care in Connecticut, has enrolled only 403 members as of June 1, 2010^{xxiii} and has suffered from inadequate resources for administration and marketing. However the program enjoys strong legislative support; a 2010 law expanding the program to two new communities passed both houses unanimously.^{xxiv} Providers participating in PCCM are paid on a fee-for-service basis for the medical services they provide (at the low Medicaid rates) but they are also compensated \$7.50 per member per month for care coordination and other PCMH functions. HMOs are not involved in PCCM.

In the December 2009 procurement for the state employee health plan, the Office of the State Comptroller (OSC) included a strong PCMH component. OSC, along with Anthem and United Healthcare the winning bidders, plan to partner with ProHealth, a large primary care practice in the state. ProHealth serves about 10% of Connecticut's population including at least 35,000 state employees. By early 2011, ProHealth intends to have completed transforming all their 74 sites with 225 primary care providers to Level II or III NCQA recognized PCMHs. Several other funding partners have agreed to support ProHealth's transformation through a wide variety of payment mechanisms including enhanced fee-for-service rates for some patients, per member per month fees for others, performance-based incentives for others, and some upfront investments.^{xxv}

A regional PCMH collaborative of at least nine states is developing; the collaborative includes all the New England states but Connecticut. The collaborative is working to share resources in developing state-specific multi-payer PCMH cooperatives. The collaborative also plans to cooperate on evaluation and data collection, a learning collaborative and share best practices.^{xxvi}

What we have learned

Through readings, presentations, webinars, discussions with PCMH innovators in other states, and our discussions, the committee has explored each aspect of the PCMH model and how it could work in Connecticut.

There is some confusion about the PCMH model in Connecticut, even among providers. Information about the model is expanding through the efforts of nonprofits and provider organizations, but much more needs to be done.

Practices will not undergo the hard work of PCMH transformation for only some patients. Providers are clear that they provide the best level of care to every patient.

As in other states, many primary care practices in Connecticut are financially fragile, working on very thin margins. Most are not in a position to invest in PCMH transformation without help with upfront costs.

Primary care providers and staff in Connecticut, especially in small practices, are very busy. Training must be as easy to access as possible and they should be compensated for their time.

PCMH development is intimately tied to payment reform. Connecticut providers are used to fee-for-service, pay-for-performance and flat care management fees. Bundled payments are common in some areas such as surgery and obstetrics, but not in primary care. Capitation is not popular. Most primary care practices are not financially able to accept risk, even performance risk, and are reluctant to accept risk for services over which they have no control, i.e. consumer behaviors and services provided by other providers or institutions.

There is strong support for including consumer incentives to follow care planning and separate funding for supports to care plans.

It is critical to ensure integration of behavioral health, oral health, nutritional, pharmacy medication management, and alternative medicine services into PCMHs.

One size does not fit all. Connecticut practices are fiercely independent and diverse. PCMH development in Connecticut must be flexible. Our diversity will be an advantage for Connecticut's health care system allowing natural experiments comparing various PCMH structures.

The work of the Committee

The Sustinet Patient Centered Medical Home Advisory Committee was convened in late 2009 and held its first meeting November 18th. The charge to the committee, created by PA 09-148, An Act Concerning the Establishment of the Sustinet Plan, is to "develop recommended internal procedures and proposed regulations governing the administration of patient-centered medical homes that provide health care services to Sustinet Plan members."

Throughout the rest of 2009 and into 2010, the task force held six in-person meetings and five meetings by webinar. A recommended reading list was provided to committee members and was publicly available. The committee heard presentations on patient centered medical homes by

- Queens long Island Medical Group Level III patient-centered medical home practice, Flushing office, slide show
- *American College of Physicians Medical Home Builder, online video*
- *Recognition of patient-centered medical homes* by Mina Harkins of NCQA
- *Integrating Pharmacists in the Patient-centered Medical Home* by Marghie Giuliano of the CT Pharmacists Association, Marie Smith and Tom Buckley of the UConn School of Pharmacy
- *Development of a Vermont Pilot Community Health System* by Jim Hester, VT Health Care Reform Commission
- *Pennsylvania's Efforts to Transform Primary Care* by Ann Torregrossa, PA Governor's Office of Health Care Reform
- *A national review of state patient-centered medical home initiatives* by Lee Partridge of the National Partnership for Women & Families
- *CT state employee plan patient-centered medical home initiative* by Cheryl Lescarbeau, ProHealth Physicians
- *CT's Primary Care Case Management program: HUSKY's patient-centered medical home initiative* by Ellen Andrews, CT Health Policy Project
- Ron Preston, New England regional PCMH collaborative
- *Risk Adjustment Basics* by David Williams and Diane Laurent, Milliman

An analysis of PCMH provisions in the 2010 federal Patient Protection and Affordable Care Act was provided for the committee and is attached. All committee meetings, minutes, agendas, reports, documents, webinars and videos were publicly available; all activities were transparent.

Contributing issues and trends impacting development of patient-centered medical homes in Connecticut

It is important to recognize important trends that are not part of the committee's charge but have profound impact on our work. These include health care workforce shortages, racial and ethnic health disparities, and payment reform trends.

Health care workforce

There is growing evidence of health professional shortages in Connecticut across fields. Between 1995 and 2015, Connecticut's total population is expected to grow by 464,000 people.^{xxvii} Between 2010 and 2030, the percentage of Connecticut residents over age 65 is expected to grow by 40% and the ratio of Connecticut seniors to 100 workers (ages 20 to 64) is expected to grow from 23 to 40.^{xxviii} An aging population will place greater demands on the health care system at the same time that many health professionals will be retiring.^{xxix} Shortages of primary care providers are particularly acute; PCMHs rely on primary care providers as clinical leaders. The Medicaid program faces particular challenges in engaging providers. Barely half of Connecticut physicians participate in the program.^{xxx} As plans for SustiNet involve merging the Medicaid and state employee plan pools, provider reluctance to participate in Medicaid is an important challenge to solve.

There is evidence that implementation of the PCMH model may ease the primary care shortage by improving primary care provider efficiency, easing time constraints on providers, easing responsibilities by reliance on team members and improving primary care provider satisfaction and retention in active practice.

Health disparities

Connecticut, like most states, is becoming more diverse. Unfortunately, our state is not exempt from the gap in health care access and outcomes between genders, races and ethnic groups. These disparities have complex causes^{xxxi}. There is evidence that the impact of fragmented care falls more heavily on minority patients. It is hoped that expansion of the PCMH model will work to reduce health disparities.

Payment reform and quality-based purchasing

There is a growing recognition that the current, fee-for-service system of paying for health care is fueling rising costs of care. Most payers are moving to a system of linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency. This is a significant transformation in the way providers and health systems are paid and the PCMH is directly aligned with this trend. In fact, new payment methodologies

that compensate practices for care coordination, expanded access to care, and patient self-management of care are critical to the success of PCMHs.

Committee recommendations

Principles and goals

- *PCMHs are organized around each individual patient and their needs.* As one PCMH nurse manager explained it “everything swirls around the patient.” Care is individually appropriate to each patient’s circumstances. What works for one will not necessarily work for another. Patients must be engaged in improving and maintaining their own health through shared decision-making. PCMHs provide the resources and treatment necessary to support patients in managing their own health. All policies and treatment decisions are based on the needs of the patient first, before the needs of providers, staff, or finances. Patient questions are expected, embraced, welcomed and solicited at every stage of care in a PCMH. Questions can provide important clues to how the individual practice and the overall PCMH model are working and should be a treasured resource for providers and evaluators.
- *PCMHs are for everyone.* All of us could be at risk. Everyone benefits, as does the greater health care system, from coordination, self-management, emphasis on prevention and maintenance.
- *Care in a PCMH is delivered by a well-organized, interdisciplinary team of professionals, working in a trusting environment.* Each team member feels comfortable asserting their opinion, offering guidance or even challenging any other team member when necessary. Everyone works at the “top of their license.”
- *PCMH teams are embedded in their communities,* with strong linkages to community medical and non-medical supports and services. Seamless integration as appropriate with behavioral health, oral health, medical nutrition therapy, specialty, alternative medicine, and other care is essential. Strong referral networks are critical to effective care management.
- *PCMHs track not only the health of individual patients, but the larger population of patients they serve.* Health problems identified in population tracking drive practice decisions about care and services offered.
- The committee was clear that “*one size does not fit all*” in PCMHs. There is wide disparity in opinions about how PCMHs should be structured and operated. Without clear and specific guidance from a strong evaluation literature, which does not appear to be imminent, the Committee recommends supporting different models, with robust evaluation of the differences to guide future policy development.
- While the goal is to provide access to a PCMH for every CT resident, *it is not necessary that every primary care practice become recognized as a PCMH.* It is critical to guide practices toward PCMH with incentives only and not invoke penalties for practices that are not interested or able to reach recognition. Practice transformation is very difficult and the decision must be voluntary to be successful. It must continue to be a viable

option for primary care practices in Connecticut to continue to provide care in the traditional model. **Connecticut cannot afford to lose any primary care capacity.**

- SustiNet needs to balance encouragement of evidence based medicine and clinical decision support with recognition that medicine is not an exact science. Overrides must be allowed, with explanation, and monitored for patterns and outliers. Some exceptions may be indicators of lower quality care, but some may be clues to innovations that improve health and efficiency. It is critical to build a learning system that identifies and evaluates departures from accepted practice. This will require thoughtful design of health information technology and data collection systems.

Standards for PCMHs in Connecticut

- While the goal is to expand the PCMH model in Connecticut to as many primary care providers as possible, it is also critical to maintain standards and not weaken the certification. The PCMH model must remain meaningful to be successful in providing better health outcomes and to attract and warrant enhanced funding from payers.
- The committee decided to endorse NCQA as the standard for PCMH recognition in Connecticut. NCQA is a nationally recognized standard, the result of a great deal of research, and is recognized currently by many payers. Connecticut and SustiNet should consider recognizing other national PCMH certification programs as they become available. The committee endorsed tying payment to NCQA levels of PCMH recognition. However, there must be recognition for practices that are making progress working toward NCQA certification; that recognition may not necessarily be financial.
- Providers in each PCMH must have authority to prescribe medications and have or have arrangements for hospital admitting privileges.
- Concerning the future of PCCM in the PCMH model, the committee was concerned that Connecticut not create two sets of quality standards for Medicaid and other SustiNet members. However the committee acknowledges that provider participation in Medicaid is low and creating new standards may serve as a disincentive. The committee recommends allowing for current PCCM agreements to remain in place with an understanding that those practices are expected to move toward NCQA recognition in the future.
- There was strong consensus that Connecticut should do all it can to remove any barriers to certification that are not related to quality, including financial and administrative barriers.
- PCMHs are encouraged to include complementary and alternative medicine providers, including Healing Arts Practitioners, as part of the PCMH team, when appropriate, for patients who are interested.
- The committee recommends allowing specialists to serve as clinical leaders for PCMHs at the request of patients, with approval from the state PCMH guiding group. It is expected that PCMH specialists will meet the same levels of certification and provide the same level and type of services as primary care providers.

PCMH functions

The committee agreed that some PCMH functions are core to the practice and should not be contracted to outside vendors. However the committee was split on which functions are core and which can be safely contracted out. The following table gives the majority opinion, but there was wide diversity of opinion on each function. Given the inability to come to a clear consensus, the committee recommends that four functions always be provided by the practice, three can be contracted out without approval, but to contract out any of six other functions, the PCMH must apply to the state guiding group for approval (see below). In its decision the state should consider the number of proposed contracted functions, adequacy of practice policies to ensure seamless integration for patients, and dedication of resources at the practice to ensure effective contract management. Approval should be provisional and be revisited regularly.

| Function | Core vs. contractual option |
|---|---------------------------------|
| Referral tracking | Can contract only with approval |
| 24/7 voice-to-voice coverage | Can contract |
| Patient reminders, communications | Can contract only with approval |
| Population health tracking and management | Can contract only with approval |
| Care management | Can contract only with approval |
| Self-management support | Can contract only with approval |
| Lab/test tracking and follow up | Core |
| Disease management | Can contract |
| Risk assessment tool administration | Can contract only with approval |
| Individualized care plan development | Core |
| After hours care | Core |
| Cultural competence, translation services | Can contract |
| Medication management | Core |

- Risk assessments for each patient should be connected to development of an individualized care plan created with the direct participation of patients, and their families when appropriate, in face-to-face interactions at the practice. Patient agreement with the care plan is critical; great care and sufficient time should be taken to ensure the plan is realistic and meaningful to the patient. The plan should clearly

identify common goals, timeframes, the responsibilities of each team member, and resources needed. The care plan should be updated regularly and provided to patients initially and after any significant revisions.

- Care management includes population management, wellness promotion, disease prevention and screening, chronic disease management, patient engagement and education. Care management must coordinate care between the PCMH and other providers including hospitals, emergency rooms, behavioral health care, oral health care, maternity care, specialists, pharmacy, medical nutrition therapy, and other providers. Particular attention must be paid to patients in transition between care settings or pediatric to adult medicine.
- Care management must be ongoing to implement the care plan, including regular reviews of goals, challenges, available tools, and revision of the plan if necessary. Care managers can be shared with other practices or, with approval, contracted out, but must be physically located at the practice at regular times. Patients must be assigned to an individual care planner they have met face-to-face and are able to reach by phone and email in a timely fashion. The care manager should always represent themselves as part of the care team and working for the practice. Consulting arrangements should be invisible to patients. Patients must have one point of entry to care management services. A phone number that connects to a service that refers them elsewhere does not qualify.
- The committee declined to identify specific qualifications for care managers in PCMHs. Clear job descriptions and duties are critical as is accountability and evaluation to ensure care is effectively coordinated.
- Expanded access to care is critical to the PCMH model. Expanded access must include extended hours of care, not just telephone coverage. PCMHs must meet standards for timeliness of appointments for both well and sick visits. Patients must have round the clock access to advice from a medical professional, to include appointment scheduling as needed. Practices must offer some afterhours access to care, and same day appointments for urgent issues. Group visits, secure electronic patient communications with the PCMH team and interactive websites are important features of the model.
- Self management supports available through the PCMH should include wellness programs, chronic disease management, integration with behavioral health care, linkages to dental care services, pharmacy medication management, smoking cessation, nutrition counseling, complementary and alternative medicine, Healing Arts Practitioners, and other community wellness resources.
- It is critical that differences between pediatric and adult patients be reflected in PCMH care management and service delivery.

Patient attribution

- A crucial element to PCMH success is accurate patient attribution to practices. The administrative burden and financial concerns of inaccurate attribution is a significant

disincentive to practices considering PCMH transformation. It is critical to invest the necessary resources and time to make this a priority in program development.

Implementation and direction of PCMH support resources

- The Sustinet law directs the committee to make recommendations for early implementation of PCMHs to prioritize enrolling patients “for whom cost savings appear most likely.”
- However, the Committee learned that practices are unlikely to undergo the hard work of transformation to a PCMH for only a subset of patients. Providers made it clear that they will not treat their patients differently; everyone gets the best care possible. Practices typically change the way they practice medicine for their entire population.
- The committee was also advised by PCMH leaders from other states to pilot the program first with practices that are enthusiastic about the concept, are willing to do the hard work of practice transformation, and most eager to change. When they are successful, these practices will serve as champions for PCMHs to their colleagues. Willing practices are more likely to have components of the PCMH model already in place, are more sophisticated about practice transformation, are likely less financially stressed, and have a patient population that will benefit from the model.
- The committee recommends that the state open applications broadly to find practices willing to begin the process. If the response overwhelms resources, the state can prioritize geographic areas of need, practices that disproportionately serve people with multiple chronic conditions, or under-served populations. The state should attempt to find a balance between large and small practices in early pilots to test the differences in resource needs and barriers. The state could also consider targeting clinical training sites for PCMH development to leverage the ability to disseminate the model to new graduates.

Payment methodologies

- Coordination of standards and payment methodologies across payers is critical. Practices will be less likely to embrace the PCMH model if payments diverge significantly between payers, i.e. enhanced fee for service rates for some patients, per member per month rates for some patients, quality incentives with different metrics for others.
- Many primary care practices in Connecticut are financially fragile. They must be certain that their investment in care management and enhanced access to care will be covered up front. There was little interest in or trust of a shared savings model to reimburse providers at some point in the future for a portion of the savings resulting from their efforts. There were mixed responses to the idea of global capitation rates or bundled payments. Most small primary care practices in Connecticut are not in a position to take financial risks.
- The committee endorsed a system of traditional fee-for-service reimbursement for medical care, in addition to a per member per month fee to compensate for care

management, in addition to performance bonuses such as current pay-for-performance payments.

- Any payment system must be clear and understandable.
- Rates must be risk adjusted using a methodology that tracks historical utilization for each patient, includes the continuum of health care services, and ideally includes socio-demographic metrics such as language barriers and literacy levels in addition to diagnoses. Risk adjustment methodologies that consider only diagnosis and aggregate cost projections foster negative incentives. For example, it is critical that a PCMH have more resources and no disincentive to care for a child with asthma who has not been well-managed and has had several emergency room visits in the last year compared to a child with the same diagnosis but that is already well managed and has had no visits to the emergency room.
- Risk adjustment methods that give providers information on likely future health care events and costs for each patient, such as event probability modeling, are important tools to target resources and care management, especially for new patients. It is critical to provide these tools to PCMHs after they have accepted patients into the practice to ensure they are not used to select patients.
- Many providers, especially in small groups, will need upfront financial assistance to implement a PCMH. The SustiNet law provides for low interest loans and availability of reduced price consultants to facilitate practice transformation. This gives practices the resources they need while fairly recognizing the investment already being made by others without outside support.
- Non-financial rewards for progress toward or for achieving PCMH certification could include reductions in licensure fees and/or extending licensure periods, or reduced patient cost sharing at these practices.
- The committee recommends creating resources to support individual consumer care plans. This could be a feature of SustiNet coverage through value-based insurance design or a simpler, dedicated fund that would accept individual applications from patient/provider/care manager teams. The funds are meant to provide supports not covered by typical insurance coverage such as a vacuum cleaner for a child with asthma, gym membership or weight loss program fees. These funds must be tied directly to the patient's care plan and address a specific barrier that is keeping the patient from managing their own care.

Federal and regional funding and technical assistance opportunities

- It is critical that Connecticut take advantage of momentum at the federal level to support PCMHs. Connecticut should consider taking advantage, at minimum, of 90% Medicaid matching rates on PCMH services for people with chronic conditions, as this does not require a competitive application but only a state plan amendment. Connecticut should also consider whether a more general "health home" application under the Patient Protection and Affordable Care Act is warranted and fits with the structure of developing PCMHs in Connecticut.

- Connecticut should join the other New England states in developing a Medicare waiver for a multi-payer PCMH pilot. Connecticut should also join other states in a learning and evaluation PCMH collaborative to share resources and best practices.
- A multi-payer initiative, to include Medicare, is critical to developing uniform standards, data elements, evaluation criteria, focused studies, disease management, compatible data formats, and compliance processes for practices and removing important barriers to PCMH transformation. This should include an all-payer claims database for accurate evaluation of costs, practice trends, and provider performance.
- A multi-payer PCMH initiative allows for aligned incentives reducing efficiencies due to cost shifting between payers. Standardizing data collection and incentives across payers allows seamless tracking and ensures that quality incentives will be large enough to be salient to providers.

Support services available to PCMHs

- No current state agency has the expertise or standing in the provider or consumer communities to serve as the lead agency for a multi-payer PCMH initiative in Connecticut. We recommend an independent guiding council or organization, with membership representing critical stakeholder groups, to coordinate PCMH activities including legislative and executive branch policymakers. If the state convenes the group, anti-trust concerns are minimized.^{xxxii}
- The PCMH guiding group should coordinate and identify responsible parties for PCMH support and evaluation activities including
 - Evaluation of the program and recommendations for policy revisions as needed
 - Data collection and analysis
 - Collect and address provider and consumer feedback and grievances
 - Administer the learning collaborative
 - Develop and publish PCMH patient education materials
 - Conduct public education campaign
 - Develop a list of approved vendors for PCMH functions that can be contracted out
 - Identify, list and recruit specialists and community, social resources and other resources for PCMH care coordinators
 - Offer suggested PCMH risk assessment, care management and other provider tools
 - Administer the “early warning system” to identify and assist PCMH practices in transition that are at risk of failing
- The state guiding group will convene and facilitate provider advisory groups to drive policy decisions. The groups should be both local and statewide, include representatives from all PCMH team members. The groups should solicit input across health provider and administration fields in separate forums. Participation in these advisory group activities must be compensated.

- The state guiding group will convene and facilitate one or more consumer advisory groups with subgroups to focus on pediatrics, children with special health care needs, people with multiple chronic conditions, behavioral health, oral health, nutrition, and healthier people. Consumers participating in these advisory groups will be provided child care and transportation support in addition to compensation for their time.
- The committee recommends allowing providers flexibility in choosing vendors. It has been suggested that the state select an entity, a provider organization, academic institution or a new public utility, to create local support networks such as in Vermont or North Carolina. PCMHs in each area would be required to use a set of services from that network. The networks would share in the PCMH per member per month fees with practices. The committee did not endorse this proposal. Connecticut practices are very diverse and have traditional relationships, often very strong ones, with different support organizations. Choosing any one entity could serve as a disincentive to many Connecticut practices in creating PCMHs. It is very possible that eventually single networks will develop naturally as a result of market forces. One or a few of the entities interested in providing coordinated PCMH support services may distinguish themselves through superior performance, attracting larger shares of PCMH business. It would be a mistake for the state to impose such a network on primary care providers.
- This model requires holding practices accountable for the full range of services, regardless of whether they are contracted out or not. If services are not provided it is up to the practice to resolve the problem, either by holding the vendor accountable or choosing another vendor. Placing the locus of accountability on practices requires a larger burden of contract management and oversight on PCMHs and should be considered in any application to contract out services.
- It is critical to create an “early warning system” to monitor the health and effectiveness of practices in transition to the PCMH model. Many primary care practices in Connecticut are fragile, financially and structurally. It is critical to ensure that even if eventually the PCMH model will strengthen a practice, the investment of time and money and staff disruption during the transformation does not endanger the practice. Connecticut cannot afford to lose any primary care capacity in the PCMH transformation. Any practice in transformation that signals a need for assistance should receive intensive technical assistance and resources, if necessary, to soften the transition and ensure success.
- SustiNet should develop community-specific resource referral lists for PCMH care coordinators including specialists, medication management, behavioral health, oral health, nutritional and other medical services as well as social service resources. The resource center should develop new lists in response to requests from PCMHs and patients.

Learning collaborative

To ensure best practices are shared throughout Connecticut's PCMHs we propose the development of a Connecticut PCMH Learning Collaborative.

- The Collaborative should provide ongoing training for providers, teams, care managers, contractors, and administrative staff in best practices, the latest research, and available resources in Connecticut. The Collaborative should employ practice coaches to visit PCMHs on a regular basis, to focus on under-performing practices.
- A standard level of participation in the Collaborative should be a condition of receiving PCMH funding by Sustinet and other payers. Practices that participate at a higher level, dedicating staff for advisory committee and other optional planning activities or providing training for others, should be compensated for staff time as well as further bonuses for higher levels of involvement such as opportunities to attend national conferences or representation on national/regional PCMH advisory committees.
- Areas for learning offered by the Collaborative should include, but not be limited to:
 - Care management best practices
 - Health Information Technology
 - Patient advocacy tools including legal rights
 - Community liaisons, resources, social and other programs available
 - Team building skills
 - Workflow improvement
 - Patient centered-ness – keeping the patient at the center of care, treating the whole person
- Learning opportunities in the Collaborative must be easy to access for busy providers and practice administrators. The Collaborative should employ webinars, online learning, conference calls, online networking and feedback options, and other media when appropriate. In person training sessions should be held locally whenever possible to reduce travel barriers.
- The Collaborative should provide CME certificates when possible.
- The Collaborative should give high performing Connecticut PCMHs opportunities to share their experience with others in Connecticut and nationally.

Data and evaluation of PCMHs

- It is critical that evaluation of PCMHs be constructive and not punitive. In the early stages of PCMH development in Connecticut and for individual practices in transition, emphasis should be placed on process evaluation over outcomes.
- To ensure meaningful evaluations, it is critical to involve all stakeholders in its design including consumers, providers, payers, practice administrators, employers, and policymakers.
- While evaluation should be a collaborative effort, the evaluators chosen must be strictly independent of contractors, vendors, provider groups, payers, employers, and other

stakeholders actively engaged in Sustinet. Even the perception that evaluators are not independent will compromise the integrity of the evaluation and limit its effectiveness.

- It is particularly critical to engage consumers in evaluation design, implementation, analysis and development of resulting recommendations and policy adjustments. Consumers can be effective partners with researchers in collecting data and provide an important “real world” context to understand the meaning of data and to design feasible, effective solutions to identified problems. Consumer engagement is not only the “right thing to do” it is critical to successful program evaluation.
- Before developing metrics it is critical to outline the goals of the evaluation, the questions to be answered, and design the evaluation to answer those questions. Too often, evaluation measures are chosen because they are easily available or they are standard operating procedure. What is chosen for measurement will drive the development of the program; it is critical that this process is thoughtful and deliberate.
- It is important to distinguish between evaluation of Connecticut’s PCMH system development for policymaking purposes and evaluation of performance by individual providers and practices.
- Evaluation design must consider differences between pediatric and adult patients and their needs.
- PCMH policy evaluation should emphasize replicable lessons that can be highlighted and shared with other practices and communities to improve the quality of care for every state resident.
- It is critical that any analysis be based on adequate sample sizes and appropriate control groups to ensure fairness and trust in the results. Meaningful policy decisions can only be based on valid evaluation. This may be difficult, especially early in PCMH development in Connecticut, as it is expected that early adopters may already have many PCMH components in place.
- Evaluation should standardize measures across practices and over time. Committee members encouraged use of HEDIS measures^{xxxiii} as they are already being collected by most Connecticut practices and allow comparisons between practices, populations, payers and with other states.
- The evaluation plan should include qualitative analysis of PCMHs including key stakeholder interviews with patients, providers and others to identify important outcomes not reflected in quantitative data.
- While PCMH evaluations must include cost effectiveness, it is critical to include benefits and costs across the health care system and should include avoidance of costs including impact on medical error rates, reductions in duplication of services, and administrative efficiencies. Baseline utilization measures, by individual, are important controls for cost effectiveness analysis and the impact of pent up demand for patients with historically low access, including the uninsured and Medicaid consumers, must be accounted for. Evaluations must include not only historical utilization before PCMH implementation, but likely increases in costs in the alternative traditional medical model. It is important to include estimates for long term impact on health costs such as changes in rates of smoking or obesity and overweight.

- Cost effectiveness of the PCMH model must include impact on patients' and families' costs of care.
- Eventually it will be important to evaluate the variety of PCMH payment models used in Connecticut, and assess each for conflicting incentives, incentives to encourage appropriate care, and for unintended consequences.
- It is also critical to measure the investment in PCMH by each entity compared to the benefits. Busy primary care practices are understandably reluctant to invest funds and, more importantly, staff time in practice transformation if they do not share in the benefits. An accurate assessment of the costs and benefits to Connecticut practices who have implemented the PCMH model could overcome concerns by providers considering it. The assessment must include the costs of staff time, but also include benefits in practice efficiency and time available with patients.
- Typical evaluation measures include hospital admissions, including readmissions and avoidable hospitalizations, appropriate use of medications, wellness and screening rates, and emergency room use. The committee urges caution in relying too heavily on one or a few metrics, such as emergency room use, which are ambitious goals and may require several rounds of system adjustment and time for patients to learn to trust the new system of care to see improvement. Evaluations should separate performance on processes practices control, such as completeness of wellness visits, in-office screening rates, from performance on health care processes not directly controlled by PCMH providers, such as hospital transition planning, referral compliance, and patients filling prescriptions.
- Evaluation of care coordination could include referral follow up, anticipation of patient needs, ensuring all necessary tests and services are assembled for each patient visit, accuracy of risk assessment, patient compliance and understanding of their conditions, care planning processes, review and follow up.
- Evaluation of PCMH effectiveness must consider the full continuum of care. Investments in care coordination may have positive impact outside the PCMH practice such as reducing administrative burdens for specialists and improved discharge planning for hospitals. When possible, effects outside the health care system should be included such as in employment, educational and correctional systems.
- PCMH evaluation must focus on patients' experience of care including, but not limited to, clear and effective communications, expanded access to care, effectiveness of care coordination, traditional patient satisfaction surveys, understanding of risk assessment, involvement in care planning, self-management supports, and a secret shopper survey.
- Evaluation must consider provider and other staff satisfaction, provider retention, particularly in primary care practice, team building and interaction, and whether each member of the team is performing at the top of their license. Team building and skills are an important area to evaluate as this is a critical component of the PCMH model and a significant divergence from current medical practices.
- Data collection should seek to minimize administrative burdens on providers and patients, focusing on metrics that are already collected or available outside the practice.

- Meaningful evaluations must cross payer populations but provide context to comparisons, for example socio-economic differences and access barriers between Medicaid and state employee populations.
- PCMH evaluation should address impact on racial and ethnic health disparities.
- As much as possible, Sustinet should work with the growing PCMH collaborative of New England and other states to pool evaluation resources and share best practices.
- Sustinet should provide public recognition for PCMH high performers and innovators through media outreach, communications with colleagues, local and national provider organizations, recognition at PCMH events, and notification of public officials.
- Providers who do not meet performance standards should receive technical assistance from the state PCMH guidance group to develop a correction plan, with mutually agreed upon goals and timelines, and resources to address shortfalls.

Patient centered-ness

- Patients must have a clear understanding of all available treatment options, and be encouraged to access second opinions. PCMHs go beyond informed consent to informed decision making and devote the time and attention to patients that is needed to ensure patients fully understand their care.
- PCMH providers and administrative staff shall receive ongoing training in effective patient engagement, communications, available tools, cultural competence, use of translation services, and population health issues relevant to the practice.
- PCMHs should provide regular in-person patient information sessions to describe the model and answer questions. These sessions can be provided at the practice or locally by the Learning Collaborative or state guiding group.
- Sustinet should develop a set of patient materials for self-management of disease, procedures for navigating the PCMH and the larger health care system, consumer rights and responsibilities, including legal rights, and advocacy tools.
- Materials must be provided in appropriate languages and a variety of media/formats, with regular monitoring to meet changing needs. Monitoring of population health issues, in the general population and specific to practices, should drive development of materials.
- All patient communications should be developed in collaboration with providers, employers, payers and consumers, followed by extensive consumer testing.
- Sustinet and PCMHs should discourage branded patient materials at practices, such as materials from drug companies and medical suppliers.
- With assistance from Sustinet, each practice should develop a guide to accessing care within that PCMH to include accessing care after hours, how to communicate with their care team, no show policies, what information to bring to each visit, risk assessment, creating and following a care plan, self-management tools available, tracking progress, the name and phone number of their designated care manager, and available patient information sessions.

- Each PCMH must have a robust process for involving patients in the design, operation and evaluation of the practice.

Health Care Workforce Implications

- Too many students across health training programs have no exposure to the PCMH model. It is critical to create clinical training slots in mature, successful Connecticut PCMHs for students in all health professions. Effective student training is labor intensive; PCMHs must be compensated for this effort. If incentives are not sufficient to ensure adequate training opportunities for students, Sustinet should consider it a requirement for PCMH certification and funding.
- Students rarely receive training in interdisciplinary teamwork or care management; those skills are critical to practice in a PCMH.
- Effective patient communication training is critical to PCMH practice.

Health Information Technology implications

- Effective health information technology (HIT) systems are essential to PCMH success. Health information exchange across the health care system is critical to care coordination and avoiding duplication of services.
- Understanding that Connecticut's HIT environment is developing, the committee outlined priority areas for PCMHs including afterhours access to charts and patient records, systems to notify providers when patients access urgent care or advice lines, preferably within hours, information on patient follow up on referrals and prescriptions, inclusion of care plans and risk assessments in patient records, and links to care coordination meetings (huddles) for follow up. Communications with retail clinics is critical and could be a requirement for operation of clinics.
- Health IT systems for PCMH should support population health tracking, performance comparisons between providers and practices, and identify "high utilizers" and "non-compliant" patients for follow up.
- As far as possible, provider and staff HIT training and PCMH training should be coordinated.

Public education campaign

- Despite strong public support for coordination of care, there is little public understanding of the PCMH model. A public education campaign to describe the model, its benefits to individuals, population health, and health care costs would support practices making this difficult transition as well as create momentum for other practices to consider the model.
- The public education campaign should emphasize information on the importance of showing up for appointments and the consequences of repeated no-shows.

- There is ample evidence that the US health care system often provides both too much and too little care to patients. While the public is acutely aware of the dangers of too little care, there is little understanding about the dangers of over-treatment. Unfortunately, public discussion about appropriate restraint in health care is often confused with emotional “rationing” arguments. One of the keys of PCMHs is providing appropriate care, which sometimes is “watchful waiting” or increased monitoring of a problem and delaying intensive treatment options to ensure they are indicated. PCMHs are built on a trusting patient-provider relationship which fosters a climate of more appropriate care. A public education campaign that includes information on over-treatment and its impact on health would support trust in those relationships and more effective treatment.

Role of employers in supporting PCMHs

- It is critical to engage employers in educating their workers about the benefits of PCMHs, self-management of disease, prevention and screening. Employers can provide incentives to workers who choose PCMHs such as reductions in cost sharing. Employers can also be instrumental in educating workers about their responsibilities in maintaining their health, the risks of over-treatment and in interacting with the health care system effectively. Employers can provide workers with tools to improve their health including pre-populated personal health records, coverage of community-based self-management support programs (i.e. weight loss or smoking cessation programs at work), connections to patient advocacy resources, and patient safety tools (i.e. prompts for questions to ask of providers during visits or before making treatment decisions).
- It is critical that employers design and implement these initiatives in collaboration with the PCMHs and administrators that serve their workers.
- We urge Sustinet leadership to engage and support Connecticut employers, large and small, in supporting PCMHs and patient education.

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