Child Health and Development Institute of Connecticut, Inc.

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Medical Homes: The Transformation of Pediatric Primary Care in Connecticut

Pediatric primary care providers in Connecticut are at a crossroads. A "medical home" model of care is steadily transforming health care statewide. Most providers recognize the medical home model can improve outcomes for their patients; but the road to becoming a medical home is costly, both in terms of time and dollars, and sometimes prohibitive for small practices. This Issue Brief summarizes recent policy changes in Connecticut regarding Person Centered Medical Homes (PCMH) and outlines supports for practices transforming to medical homes.

Why Medical Home?

Pediatric primary care providers can make a much greater contribution to children's healthy development by adopting a medical home model of care. A "medical home" is an accessible and family-centered primary care practice that is well coordinated with medical and community services that children need. To be recognized as a Person Centered Medical Home (PCMH) in Connecticut, providers need to meet practice standards from the National Committee on Quality Assurance (NCQA) in the following areas:

1. Enhancing access to and continuity in services
2. Identifying and managing at-risk patients
3. Planning and managing care for patients
4. Providing patients with self-care support and access to community resources
5. Tracking and coordinating care
6. Measuring and improving performance

Connecticut's Transformation: Managed Care to Medical Home

Connecticut has become a national leader in promoting the PCMH model of care as the optimal health care delivery system for children. **In January 2012, Connecticut was the first state to implement a statewide medical home system through Medicaid.** Governor Malloy called for a reorganization of HUSKY from a managed care system to a PCMH or "medical home" model.

Connecticut's medical home program provides increased Medicaid payments to primary care providers who achieve NCQA medical home recognition. Private insurers, including Aetna and CIGNA, have stated their intention to follow suit and restructure payments to support a medical home system of care in the coming years.

The change to a medical home system reflects the needs of children and the child health providers who care for them. The Department of Social Services (DSS) undertook an extensive planning process to encourage a wide range of provider and family input into the new system. CHDI convened pediatric providers to ensure that their concerns were addressed in the support plan including in the selection of pediatric performance measures. To assist practices in obtaining medical home recognition, DSS created an 18-month glide path program with structured steps for meeting NCQA medical home standards. Practices can receive enhanced payment and start-up funding for participating in the glide path program.

Addressing Challenges for Child Health Providers

Pediatric providers, particularly those in small independent practices, face several challenges in obtaining NCQA medical home recognition. The two most pressing concerns include a lack of electronic health records and a lack of care coordinators on staff in their practices. Several hospital and medical society initiatives are underway in Connecticut to assist practices in implementing electronic health records systems. CHDI is working to address the care coordination challenge.

CHDI has been instrumental in linking the state's Title V Children and Youth with Special Health Care Needs (CYSHCN) Medical Home Initiative through the Department of Public Health to other care coordination opportunities in the state, including Community Health Network, the HUSKY administrative

services organization. As part of this effort, United Way's 211 Child Development Infoline is leading a regional care coordination collaborative in Hartford, with a plan for replicating this model statewide.

In addition to the system building work, CHDI provides direct support to pediatric practices on a range of medical home topics through our EPIC (Educating Practices in the Community) program. Using EPIC, a free academic detailing program, we help providers access care coordination for their patients, implement family centered care, incorporate developmental surveillance and screening in their well child services, and address behavioral health concerns.

The Right Path

Connecticut is clearly on the right path. **Since the policy changes took effect January 2012, DSS has approved more than 100 practices (including almost 500 providers) as medical home providers in Connecticut.** Another 79 practices have applied for the state's glide path option to receive help in becoming a recognized medical home. Hundreds more are making practice changes to enhance the scope of their care, such as incorporating developmental screenings or other key components of the medical home model.

CHDI has helped nearly two-thirds of Connecticut's pediatric practices with change strategies through EPIC. This has contributed to a nearly seven-fold increase in the number of children who are screened for developmental and behavioral health issues in Connecticut since 2008. CHDI has also developed innovations that support providers in implementing the medical home model of care. These include:

- Integrating behavioral health and primary care
- Universal developmental screening in pediatric primary care (EPIC)
- Mid-level assessment as an immediate follow up to screening
- Co-management between primary care and subspecialty services
- Models of care coordination to ensure linkages to services

These innovations will contribute to better patient outcomes and experiences, as well as a more efficient health care delivery system.

To learn more about CHDI's work, visit www.chdi.org. To arrange a CHDI EPIC presentation, contact Maggy Morales at mamorales@uchc.edu or sign up online at: EPIC.

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