

**Administrative:**  
635 Main Street  
Middletown, CT 06457  
860.347.6971

**Locations:**

**CHC of Bristol**  
395 North Main Street  
Bristol, CT 06010  
860.585.5000

**CHC of Clinton**  
114 East Main Street  
Clinton, CT 06413  
860.664.0787

**CHC of Danbury**  
8 Delay Street  
Danbury, CT 06810  
203.797.8330

**CHC of Enfield**  
5 North Main Street  
Enfield, CT 06082  
860.253.9024

**CHC of Groton**  
481 Gold Star Highway  
Groton, CT 06340  
860.446.8858

**CHC of Meriden**  
134 State Street  
Meriden, CT 06450  
203.237.2229

**CHC of Middletown**  
675 Main Street  
Middletown, CT 06457  
860.347.6971

**CHC of New Britain**  
85 Lafayette Street  
New Britain, CT 06051  
860.224.3642

**CHC of New London**  
One Shaw's Cove  
New London, CT 06320  
860.447.8304

**CHC of Old Saybrook**  
263 Main Street  
Old Saybrook, CT 06475  
860.388.4433

**CHC of Waterbury**  
51 North Elm Street  
Waterbury, CT 06702  
203.574.4000

**Day Street CHC**  
49 Day Street  
Norwalk, CT 06854  
203.854.9292

**Franklin Street CHC**  
141 Franklin Street  
Stamford, CT 06901  
203.969.0802

[www.chc1.com](http://www.chc1.com)

Facebook/CHCInc

Twitter/@CHCConnecticut

STATE OF CONNECTICUT  
OFFICE OF THE  
HEALTHCARE ADVOCATE

DEC 06 2013



December 1, 2013

Ms. Victoria Veltri  
Office of the Healthcare Advocate  
PO Box 1543  
Hartford, CT 06144  
Re: Ct. State Innovation Model

Dear Vicky,

Thank you for the opportunity to submit comments on the State Healthcare Innovation Model. As a primary care provider, APRN and nurse practitioner, and Sr. VP/Clinical Director of the Community Health Center, Inc. (CHC), I appreciate the enormous effort that has gone into producing this draft document and applaud the work of so many individuals and groups over the past year in bringing the SIM plan to this point. I fully recognize the challenges of creating a model that is acceptable to all stakeholders and yet moves the agenda forward. I know that you are counting on feedback from many sectors in order to further improve upon the work already done. I submit my comments in that spirit and look forward to an opportunity to discuss the SIM plan further with you. For simplicity's sake, I will only address those areas that I would suggest warrant further attention. My comments fall into the following broad areas:

- Specific acknowledgement of FQHCs such as CHC, Inc. as both a model of innovation and a focus of support for further innovation efforts.
- Specific acknowledgement of the populations we serve, particularly the full scope of Medicaid enrollees, those newly insured under the ACA, and those that will be persistently uninsured, such as the undocumented, as a population of focus for innovation efforts.
- Broadening the scope of innovations to include a wider range of telehealth than just the eConsults.
- Recommendation for use of well established, well understood models for data reporting, performance transparency, and practice transformation recognition vs. establishing new models.
- Specific workforce recommendation and expansion of effective models of residency training.

My most general statement is that the entire plan is virtually silent on the subject of the populations and practices most of concern to me. There is



remarkably little attention to community health centers or other safety net settings, to the Medicaid population outside of the aged or dually eligible, and to the undocumented uninsured in our state. I recognize that the Plan calls for impacting 80% of the state's population, but I would hope that the remaining 20% who are unaffected by the planned innovations are not disproportionately those who are lowest income and served by the safety net organizations. In fact, *Exhibit 10: Clinical Integration Models to Attain Scale and Capabilities* references just about every possible type of organization health care system other than FQHCs. It would seem that this is the largest group of individuals that the state of Connecticut can actually have a rapid and direct impact on and should be considered as a primary focus of meaningful innovation efforts. Specifically, I would also strongly encourage that the needs of women and children, particularly in the undocumented population who will continue to lack access/coverage for such basic and essential healthcare as prenatal care, be addressed.

As you know, the Community Health Center Inc. is itself one of the leaders in primary care innovations and as such, has both much to offer and much to gain from significant investment in innovations. Many of the called for innovations, such as eConsults, care coordination, and strategies to impact the social determinants of health would be significantly leveraged by the infrastructure already found in our organization. I would encourage you to modify the Plan to specifically reference FQHCs and Medicaid populations as targets of each innovation strategy, and to consider whatever modifications in state regulations are necessary to do that.

I urge you to affirmatively state that support for any innovations, from increased support for care coordination to payment for community health workers to eligibility for participation as a "certified entity" include federally qualified health centers who meet the standards established in these areas under the SIM Plan.

The Plan is enthusiastic about the possibility for transformation and innovation that Accountable Care Organizations might offer, but there is no similar mention, nor commitment, to Medicaid ACOs. Other states are pursuing this strategy, with its focus on bringing together all players in the health care community within defined areas to leverage resources and effectively coordinate care. I would encourage the SIM planning group to consider studying the potential for Medicaid ACOs in Connecticut.

I appreciate the attention to enhanced access as a fundamental element of transforming primary care. As you know, CHC is the organization that brought the "eConsult" concept to Connecticut, implemented a pilot and designed a study focused on using eConsults between primary care providers and cardiologists in terms of provider satisfaction, clinical outcomes, and cost effectiveness. The results of that study will be published shortly, and confirm the experience elsewhere in the country that eConsults are a safe, effective, satisfying, clinically effective tool for improving access to specialists for Medicaid patients. We agree that this can be extended to other populations.

At CHC, we see eConsults as one point on a continuum of telemedicine interventions to improve care and quality, and reduce overall costs. I would urge you to consider including

virtual visits (email/telephone) as clinical encounters eligible for reimbursement in all payer groups, including Medicaid. I would strongly urge you to specifically address the use of case-based, distance learning via the Project ECHO-CHC model. This model is based on an evidence based strategy first pioneered by Dr. Sanjeev Arora at the University of New Mexico to address the need to train more primary care providers to manage Hepatitis C, but has been successfully expanded by CHC to include Project ECHO programs for chronic pain management, buprenorphine treatment of opioid addiction in primary care, and HIV/Hepatitis C management. It is a proven strategy that addresses the triad of better care and quality while significantly expanding access within primary care to what is often thought of as specialty services outside of primary care.

Along the same line of increasing access, I do not note reference to considering the location of care as part of the SIM. Specifically, I do not see reference to schools and school based health centers as logical sites for expanding health services, particularly medical and behavioral health services, in high need/high risk areas. In fact, support for well-established school based health centers to become truly neighborhood health centers, extending their care to include access by family members and students during the summer vacation months and after school hours might be a very promising strategy to increasing primary care capacity in some of our most underserved areas.

In the discussion of population health management, I would encourage specific reference to securing support for the remarkable data set developed by the Ct. Association of Health Directors, known as the Health Equity Index. This work, which considers the social determinants of health as well as the clinical indicators of health, provides the basis for community by community comparison and decision making relative to the investment of resources. Without support, I fear this remarkable work will not continue and to lose it would be a real loss to our efforts as a state at both population management but also in evaluation of the impact of our innovations.

Similarly, in the area of “community health improvement” and the development of “health enhancement communities (HECs)”, I would suggest establishing a “score” on the CADH health equity index below which any community would be designated as a HEC, rather than limit our focus to just a handful of highest need communities. In order to impact 80% of the population, we need to think and act beyond a small number of urban areas and extend our reach to the many mid-sized cities and rural areas that show significant need for innovation and improvement in health care and health status.

I applaud the focus on performance transparency. In the interest of consistency and efficient use of resources, I would suggest that the SIM build upon the model of a practice “report card” and consider building upon the system known as the Uniform Data Set (UDS) for all primary care practices. Developed and refined for FQHCs and FQHC look alike, it provides a detailed report card for individual practices on staffing, cost, utilization, demographics, and clinical outcomes that can then be aggregated, trended, and compared across settings and regions. The methodology is sound and has been thoroughly vetted over decades, with appropriate updates to accommodate electronic health records and to reflect current high impact clinical performance standards. Use of the UDS, at least by all

primary care providers, would provide a common performance standard for primary care providers across the public, private, and nonprofit sectors. Done annually, it provides an up to date analysis of growth, cost, and clinical performance.

I appreciate the statement that Connecticut must move from a volume to value based system. However, the reality is that volume is not going away. Instead, every primary care provider/practice is going to have to contend with how to take care of more patients, not fewer. Our challenge is to figure out innovations that allow a practice to manage larger numbers of patients without sacrificing quality of care or patient/provider satisfaction with the practice. Many of these, such as the use of virtual visits and eConsults, have already been discussed.

The use of a new term, Advanced Medical Home, is interesting but I would discourage creating an entirely new certification/recognition model from the ground up. Instead, the AMH should pick up where the NCQA or other PCMH certification leaves off. The NCQA Level 3 PCMH certification is extremely stringent. NCQA has invested enormous resources in defining and measuring standards, and the advances from the 2008 to the 2011 standards demonstrate that they have the resources to continually study, adapt, and evolve the standards to reflect emerging standards. I have heard commentary relative to NCQA PCMH certification and statements such a “you can just fill out the forms but it doesn’t mean you changed anything”. In my experience, this is simply not true. The level of evidence and documentation required is such that—absent willful misrepresentation and the luck to avoid an audit—one cannot achieve anything beyond Level 1 recognition without having done the hard work of practice transformation. The effort, time, expense, and administrative burden that would go into an entirely new certification program are simply not justified. I would urge the SIM group to use NCQA, from glide path to Level 3, as the standard, and then layer additional standards to achieve specific goals and challenges on top of the PCMH Level 3 to recognize the most transformed practices and allow them to participate in the most meaningful ways in the new models.

I applaud the focus on health equity, and if anything, this needs to be strengthened as an area of focus. Specifically, I would urge the SIM to state that Connecticut will mandate that all health care providers have the ability to provide telephonic medical interpretation services at the point of care via established contract with a service that provides such interpretation across all languages, and that all payers, private and public, reimburse for such services either directly or indirectly.

The SIM plan references areas where innovation is needed to improve clinical care. I would like to note that one such area where a problem is noted, but the opportunity to propose a solution is missed, is that of diabetic retinal screening. CHC, Inc. pioneered the use of special cameras, operated by trained medical assistants in our primary care centers. The medical assistants use the camera to capture the retinal image, upload and transmit that image to ophthalmologists for review and interpretation, with findings transmitted to the primary care provider within 48 hours. CHC has published the results of our first year of this service, showing dramatically increased rates of retinal screening in our diabetic

population and both clinical safety and effectiveness in determining which patients need immediate care, close monitoring, or periodic re-evaluation.

The SIM Plan has many very good references to the need to incorporate behavioral health into primary care and to improve the connection to higher levels of primary care. Indeed, at CHC, the full integration of behavioral health and primary care has been a successful strategic initiative for which considerable staff training, preparation, and workflow redesign had to be accomplished. We applaud this focus.

In the arena of workforce, I would offer a number of comments, bulleted for ease of reading.

- The terms used are often imprecise, and inconsistent with national standards. I would urge you to edit the document with the following suggestions: PCPs should be used to refer to physicians, nurse practitioners, and PAs. When referring to other professional groups, the specific groups should be stated (physicians, nurse practitioners, PAs, pharmacists, etc.) Please delete reference to physician extenders; there is no such recognized category of providers.
- We are all in agreement that we need better workforce data. I note that efforts were clearly made to document and substantiate the number of primary care physicians in Connecticut. With the new electronic on-line licensure for APRNs as well as physicians, I would hope that DPH would be tasked with providing the SIM group with a current, data based estimate of NPs in Connecticut as well, and to consider that in determining workforce adequacy.
- I applaud the inclusion of innovation in graduate medical and health professions education. The statement “much of what has been developed for physician residency should be extended to nurse practitioners” would be better expressed by a statement of support for the Institute of Medicine’s Future of Nursing Report (2010) and its call for the development of formal post graduate nurse practitioner residency training programs. Since the SIM Plan references many specific innovations in primary care practice and training in Connecticut, it would be appropriate to note that the Community Health Center, Inc. is the national leader in the development of NP residency training programs for NPs who aspire to practice as primary care providers in the complex setting of FQHCs. Our success is obvious in that virtually 100% of our alumni of this intensive, one year post-graduate residency are currently practicing as primary care providers. Additionally, our NP Residency program has been replicated in FQHCs across the country, with more in development. I would further encourage the SIM planners to call specifically for utilizing Medicaid GME as an existing potential, but untapped, funding source for the development post-graduate NP Residency Training programs in Connecticut.
- I would also encourage you to include reference to the THGME (Teaching Health Center GME) legislation enacted as part of the Affordable Care Act, which provides funding to FQHCs to establish physician residency training programs in FQHCs. We should not only encourage pursuit of such funds in Connecticut to establish FQHC based physician residency training programs, but Connecticut should encourage a modification in the legislative language to include funding for other types of residency training programs beyond medical residencies.

On behalf of the Community Health Center, Inc. I want to thank you again for all of your efforts in producing this State Innovation Model Plan and look forward to discussing my comments with you at your convenience.

Sincerely,

A handwritten signature in cursive script, appearing to read "Margaret Flinter".

Margaret Flinter, APRN, PhD, FAAN, c-FNP  
Senior Vice President and Clinical Director  
Community Health Center, Inc.