Child Health and Development Institute of Connecticut, Inc.

CHDI Transforming Pediatric Primary Care Webinar 3:

Primary Care Payment Reform

August 8, 2019
1 pm – 2 pm

Suzanne C. Brundage, MS
United Hospital Fund

Mark Schaefer, PhD
Connecticut Office of Health Strategy

Background and Introduction:

- *With funding from Children's Fund of Connecticut and Connecticut Health Foundation, the Child Health and Development Institute engaged the Center for Health Law and Economics / Health Law and Policy at Commonwealth Medicine, UMass Medical School to help us develop an agenda for pediatric primary care that would increase its contribution to:*

  - Population Health
  - Health Equity
  - Integration of Health Care *across services* for Children and Families

UMass Medical School Commonwealth Medicine

- **Reviewed literature** and existing innovations that address transformation of pediatric primary care
- **Facilitated a study group** consisting of stakeholders in Connecticut
- **Developed recommendations** for payment reform that would support transformation of pediatric primary care
- **Prepared a final report**: *Transforming Pediatrics to Support Population Health: Recommendations for Practice Changes and How to Pay for Them*

https://www.chdi.org/publications/reports/other/transforming-pediatrics-support-population-health/

Pediatric Primary Care Payment Reform Study Group
Recommendations to be Addressed Today

- **Payment reforms in pediatrics should reward effective health promotion and prevention among all children, receiving care in all practice settings, and covered by all payers**. Primary care should help promote family priorities such as:
  - Healthy weight / nutrition
  - Developmental milestones (kindergarten readiness)

- **Payment methods for pediatric primary care should motivate the restructuring of practices that can improve population health, health equity, health care quality, and address costs.**

  For Example, payments should:
  - Allow flexibility to support service innovations
  - Diversify care team members
  - Provide upfront funds to practices to implement changes
  - Support existing innovative care models

Pediatric Primary Care Payment Reform Study Group
Recommendations to be Addressed Today

Continued…

- **The participation of all payers in payment reform solutions for pediatric primary care is essential to success.**
  - Change is only feasible if implemented across the entire practice population
  - Participation by all payers mitigates the disincentive any single payer has to finance innovations that may yield its benefits (savings) to other payers later

- Payment methods need to take into account that **numerous sectors serve children and their families**.

- **The benefits of improved pediatric primary care are a public good;** they accrue across the lifespan, to many spheres of social policy, and to the state's economy in general.

Barriers to Pediatric Payment Reform

- Pediatric care is **not a cost driver** – the monetary Return on Investment (ROI) to the health care system is low
- **ROI for pediatrics can be over a longer time frame** (often more than 2 years) than most payers are used to when measuring value based initiatives
- **Cost savings are diffuse** – with cost benefits going to other payers and even other sectors
- The current system has not found a way to **capture the value of disease prevention and health promotion**

Study Groups Guiding Principles on Pediatric Payment Reform

- Payments based on the **benefit to society** that pediatric health promotion and preventive care provide.
- **All payers contribute** (and benefit) equally for pediatric reforms.
- Child Centered **Systems built across sectors can save money** across sectors.
- **Braided and blended funds** across sectors share costs and rewards.
- The payment model **promotes equity and equal opportunity** for all children to thrive.

Study Groups Guiding Principles on Pediatric Payment Reform continued…

- The model pays for **developmental promotion and early detection and provides for linkages** to community services.
- The system allows for behavioral health and developmental intervention for children and families **before the child has a diagnosis** (early intervention/health promotion).
- The **need for pediatric practice transformation is the goal and the driver of payment reform.** Payment change allows for innovations to be accessed from pediatric primary care, a place where all children go.
- Payment reform is part of the **comprehensive system for children** and ensures that the larger system supports child health services.

Approaches to Pediatric Primary Care Payment Reform

Suzanne C. Brundage, Director, Children's Health Initiative, United Hospital Fund

United Hospital Fund

United Hospital Fund

United Hospital Fund is an independent, nonprofit organization established in 1879 to help organize charitable support for voluntary, nonprofit hospitals in New York City and to help solve shared problems.

Today, UHF analyzes public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

Outline

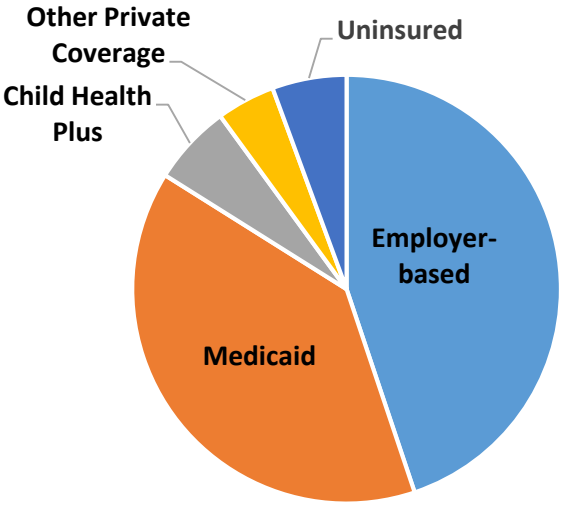
- Context
  - New York and Medicaid Payment Reform
  - National Observations
- Why a Pediatric Focus?
- New York's Children's Value-Based Payment Subcommittee
- Progress to Date and Lessons

Context

New York Medicaid Reform

- In 2015 New York Medicaid released a "Value-Based Payment Roadmap"
- Set goal of having 80% of *all* managed care payments to providers be value-based by 2020
- 43% of NY children are covered by Medicaid, with widespread enrollment in managed care organizations

Distribution of Children's Coverage, New York State, 2013-14



National Picture

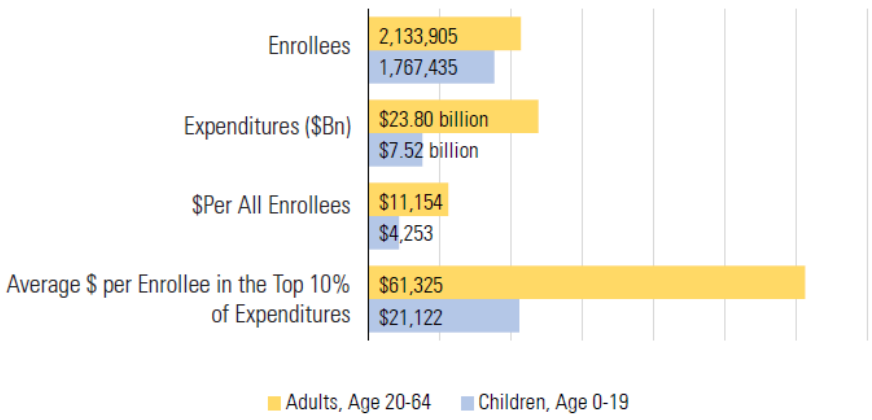
"…interviewees recognized the importance of a healthy childhood to becoming a productive adult and the key role that pediatricians have in providing critical developmental screenings, preventive services, anticipatory guidance, and in managing acute and chronic health care issues…payment models undervalue pediatric care because of the long-term payoff that is not reflected in current fee-for-service rates." –Bailit Health, *Value-Based Payment Models for Medicaid Child Health Services*

- Children's health services have a different value proposition than adult health services – long-term health promotion vs shorter-term utilization and disease management
- Pediatric Accountable Care Organizations and bundled payments initiatives to date have focused more on cost than quality, and don't include accountability for social determinants of health
- Research doesn't differentiate between delivery models (e.g., PCMH) and payment models (capitation, episodes, etc.)

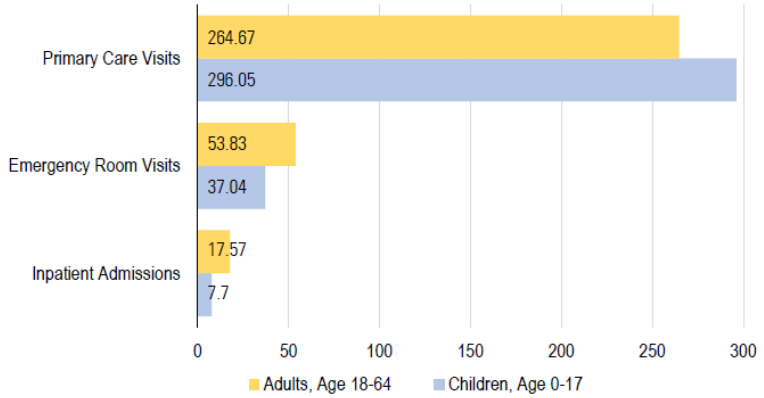
Why a Pediatric *Primary Care* Focus?

Differences in Adult and Child Utilization and Expenditures

2014 New York Medicaid Expenditures for Continuously Enrolled Children and Adults



2017 New York Medicaid Managed Care Enrolled Child and Adult Utilization Rate Comparison (per 1,000 Member Months)



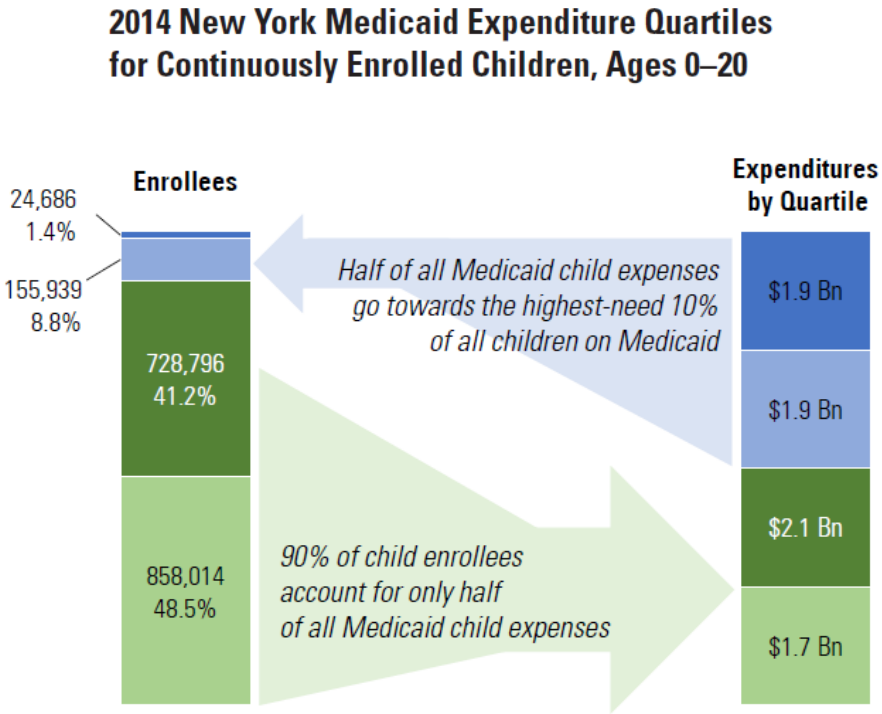
Source: NYS DSRIP Public Facing Dashboards: C1, C3, and C5. https://dsripdashboards.health.ny.gov/

Sources: Shearer C and Kennedy-Schaffer L. Understanding Medicaid Children in New York State. United Hospital Fund, 2016. https://uhfnyc.org/media/filer_public/b4/83/b4830a5c-b72a-4bf0-a324-a0ec54902d70/medicaid-childrens-chartbook-final-20160707b.pdf

NYS DSRIP Public Facing Dashboards: C1, C3, and C5 https://dsripdashboards.health.ny.gov/

Differences Within The Child Population

- **Children who are "generally well":** 90 percent of child enrollees accounted for only half of all child health expenditures.
- **Children with physical or behavioral health "complexity":** 10 percent of child enrollees accounted for the remaining half of all child health expenditures. Their health conditions were very heterogenous.



NY Medicaid Children's Value-Based Payment Subcommittee

About New York's Children's VBP Subcommittee

- Children's VBP Subcommittee launched in Fall 2016 with the charge of assessing how children fit within the "VBP Roadmap".
- One year later, it provided the state with four types of recommendations:
  - Principles and goals that should guide the state's VBP approach
  - Goals for children's payment reform
  - Quality measures to be used in VBP contracts
  - Proposed pediatric-specific payment model
- NY Medicaid program and the VBP Subcommittee continue to work together towards implementation

Guiding Principles for Children's VBP

Guiding Principles for Children's Value-Based Payment

The Subcommittee developed a set of principles to guide children's VBP design, including:

1. Children are not "little adults." Typical value-enhancing strategies and disease-oriented quality measures may miss key aspects of child well-being.

2. Maximizing the healthy growth and development of children today will reduce future health care needs and bring long-term value to Medicaid and other public systems. For these reasons, a longer timeframe for assessing cost savings must be considered.

3. Addressing social determinants of health and mitigating the effects of adverse childhood experiences is critical.

4. Access to high-quality primary care is essential, and access to specialty care—especially for maternal and child behavioral health—should be integrated into primary care settings.

5. Current investment in children's health may not be enough to fully meet the unique needs of children.

Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

United Hospital Fund

Preterm to 1 Month	1 Month to 1 Year	1 Year to 5 Years
Overarching "North Star" Goals		
Optimal birth outcomes for mother and child	**Optimal physical health and a secure attachment with a primary caregiver**	**Optimal physical health and developmentally on track at school entry**
Key Indicators		
• Birthweight <2500 grams • Preterm births • Severe maternal morbidity	• On-target developmental and social-emotional screens • Reported cases of abuse and neglect	• On-target developmental and social-emotional screens • ED visits for unintentional injury • Expulsions/suspensions • Kindergarten readiness using standardized tool (aspirational) • Reported cases of abuse and neglect
High-Value, Often Underutilized Primary Care Strategies		
Early and regular prenatal care visits including: • Birth spacing/contraceptive use counseling • Breastfeeding encouragement • Care transition plan for use by obstetrician, newborn nursery and primary care doctor • Screening/treatment for preterm birth risks and tobacco/substance use **Co-located/integrated behavioral health services** **Screening/referrals for:** • Adverse Childhood Experiences (ACEs) • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers (when mother is primary caregiver of child)**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral • Dental screening/treatment • Eye and hearing examination/referral • Vaccinations **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health **Enhancing parental skills through evidence-based educational programs** **Management/treatment of chronic conditions**

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Quality Measure Set

Recommended Children's VBP Measures (Category 1)	Classification
Pediatric Quality Indicator Asthma Admission Rate, Ages 2 Through 17 Years (PDI #14)	P4R
Adolescent Well-Care Visits	P4R
Adolescent preventive care – assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression	P4R
Annual dental visit	P4R
Asthma Medication Ratio	P4P
Childhood Immunization Status, Combination 3	P4P
Follow-up care for children prescribed ADHD medication	P4R
Immunizations for adolescents, Combination 2	P4P
Medication management for people with asthma (NQF 1799)	P4P
Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	P4R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	P4P
Well child visits in the first 15 months of life	P4P
Well child visits in the third, fourth, fifth, and sixth year of life	P4R

Note: "P4R" stands for "pay for reporting" and "P4P" stands for "pay for performance."
The Children's VBP Measure Set is reviewed and updated annually. The measures listed here reflect the 2019 measure set.

Proposed Payment Model Features

- **A capitated, voluntary payment arrangement** for child-serving pediatric and family medicine primary care providers.
- **A target population of the bottom 90th percentile of the Medicaid managed care plan's child members according to cost/utilization.**
- **A risk-adjusted payment rate that is higher than the current payment rate** to sufficiently pay for health and developmental screenings (including parent screenings); care coordination for medical and social services; and behavioral health integration.
- **A payment adjustment based on quality performance.**

Progress to Date and Lessons

Results

- Increased attention to quality measures for children. Beginning this year (pending CMS approval), all VBP contracts must include at least one child quality measure.
- Agreement between NY Medicaid and stakeholders on payment principles.
- Commitment by NY Medicaid to piloting a children-specific payment model.
- Greater focus on the role of Medicaid in early childhood resulting in the First 1,000 Days on Medicaid Initiative.

Lessons

- Create a multi-stakeholder process to genuinely engage the children's health community.
- Review data to better understand child health needs and utilization in the state and to assess which part of the child population to focus on.
- Be honest about how much savings will accrue, over what time horizon, and to whom, because of payment reform.
- Identify or define the model(s) of children's health services meant to be supported by payment reform.
- Carefully select quality measures.
- Test proposed payment models through small pilots.

Primary Care Modernization: Enhancing Pediatric Primary Care to Promote Health, Prevent Disease and Improve Affordability

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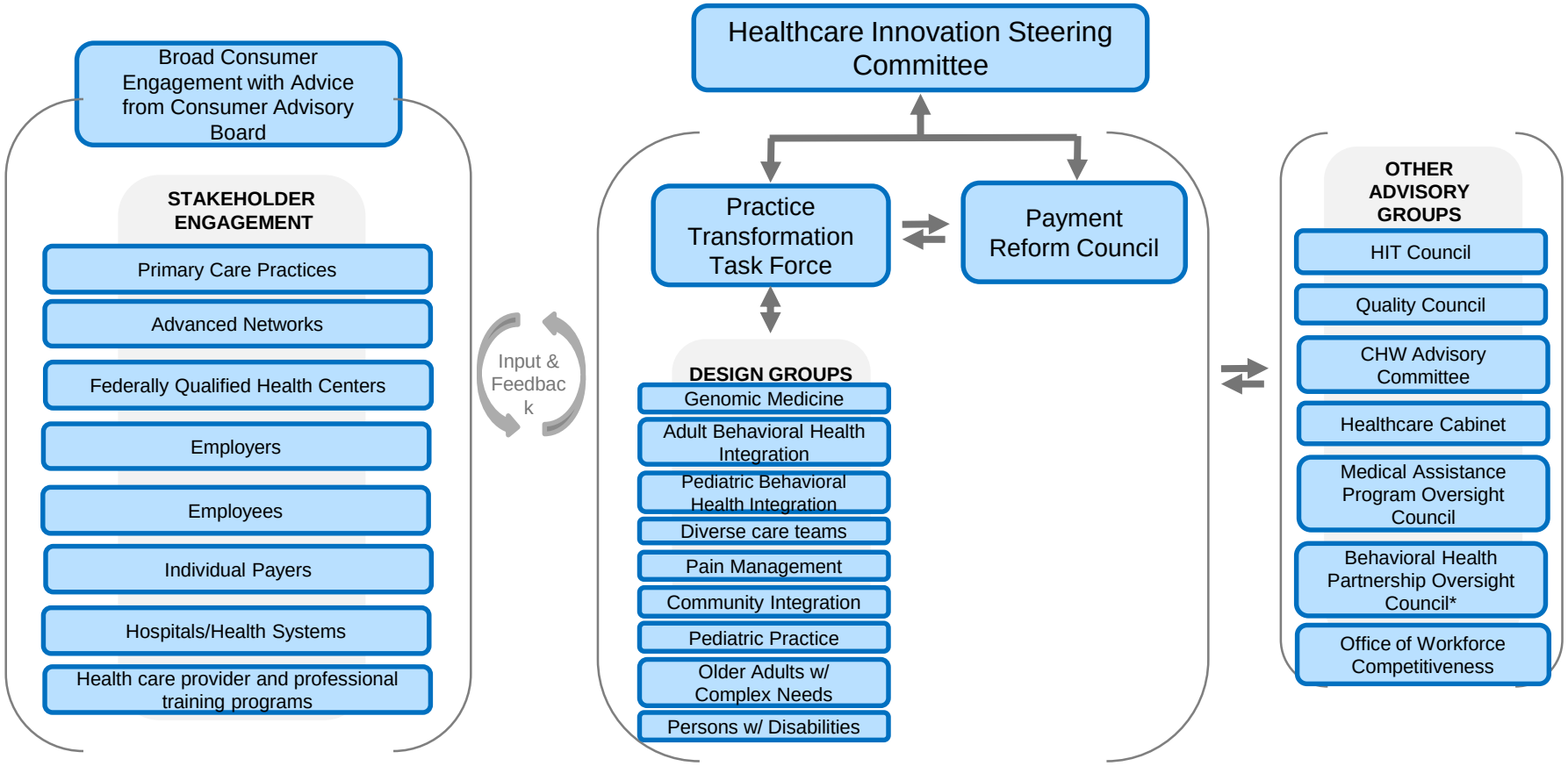
HEALTHCARE REFORM IN CONNECTICUT

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- More than 1.2m residents (all payer) attributed under shared savings arrangements

HOW WELL IS IT WORKING?

- Primary care remains largely untransformed
- Limited impact on total cost of care
- Limited investments in preventing avoidable illness and injury

STAKEHOLDER ENGAGEMENT



SIM connecticut state innovation model

TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

- BETTER ACCESS
- BETTER PATIENT EXPERIENCE
- BETTER QUALITY
- REVITALIZED PRIMARY CARE
- LOWER COST

INPUTS

- PATIENTS AND FAMILIES
- CARE TEAMS
- PRIMARY CARE CAPABILITIES
- HEALTH NEIGHBORHOOD
- POPULATION HEALTH MANAGEMENT
- SCHOOL HEALTH CENTERS

ENABLERS

- FLEXIBLE PAYMENTS
- COST ACCOUNTABLE PAYMENT
- CONSUMER SAFEGAURDS
- QUALITY MEASUREMENT
- PEFORMANCE ACCOUNTABILITY

IMPACTS

- HEALTH PROMOTION AND PROTECTIVE FACTORS IMPROVE
- REDUCED AVOIDABLE HOSPITAL, ED, AND SPECIALTY CARE
- MORE USE OF HIGH VALUE SERVICES
- PROVIDER RECRUITMENT AND RETENTION IMPROVES
- AFFORDABILITY IMPROVES
- ACCESS TO COMMUNITY RESOURCES IMPROVES

HEALTH PROMOTION TO IMPACT HEALTH EQUITY

Through capabilities focused on identifying and addressing health disparities and payment model options that recognize social factors impact cost, PCM would improve health equity in Connecticut.

Families with young children from communities of color, non-English speakers, and other underserved populations, particularly those experiencing poverty, violence, mental illness, and other potentially toxic exposures have higher rates of disease, less access to quality care, and poorer health outcomes.

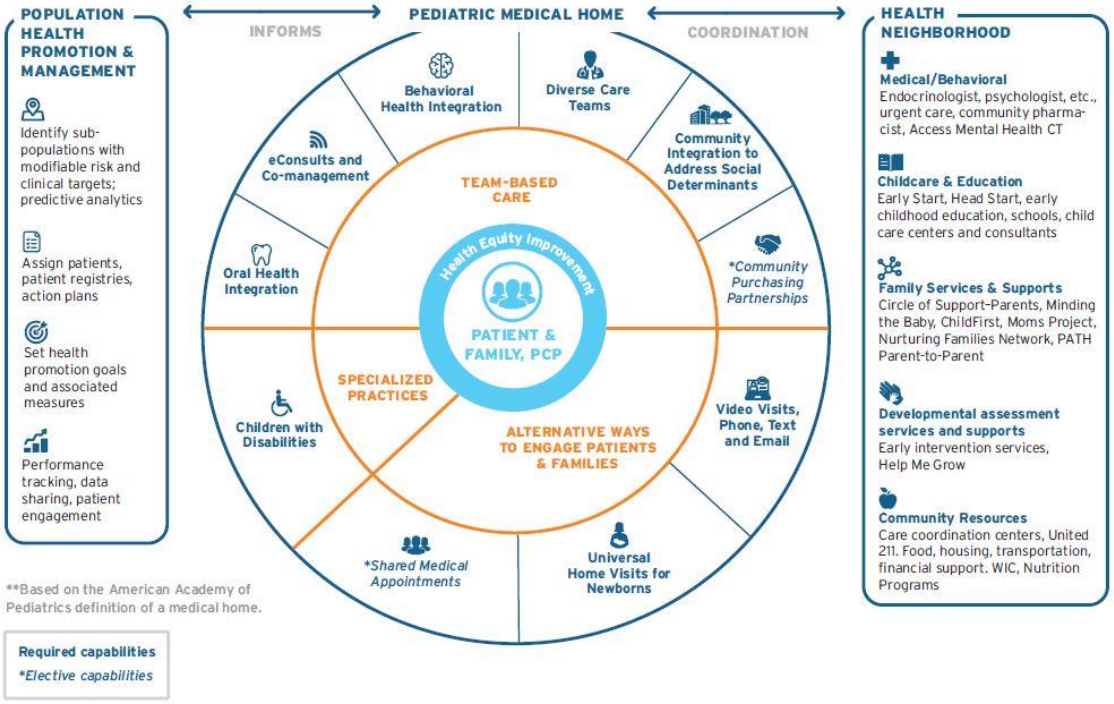
By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to promote health, address disparities and promote protective factors, such as:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social-emotional competence of children

ADDRESS SPECIFIC NEEDS OF PEDIATRICS

Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Pediatric Primary Care Capabilities



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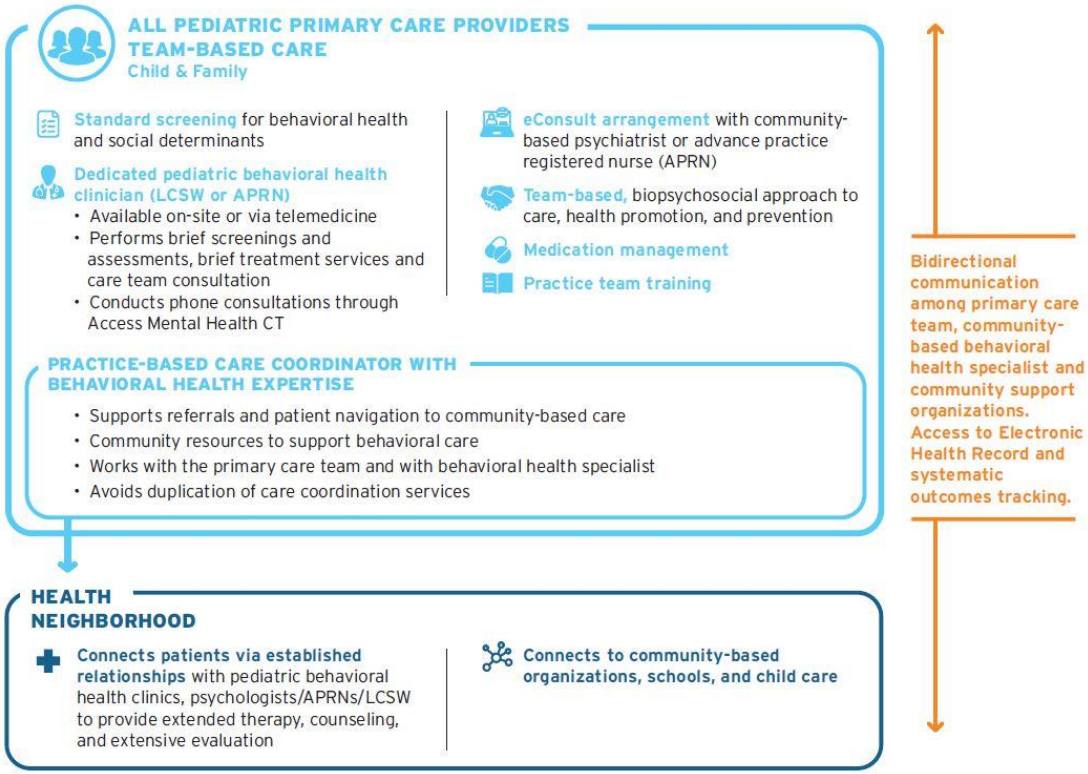
PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

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.



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WHY ABC HEALTHCARE NEEDS PCM

When ABC Health Partners began a new shared-savings program, it hired new care team members including a community health worker, an LCSW, a nurse coordinator and a lactation consultant. They immediately saved money. Patients loved the program. Then, ABC Health Partners abruptly ended the program.

Why did ABC end the program?

- With training and overhead, the new employees cost about $300,000.
- It estimated savings of $450,000 due to avoided ED visits and hospital stays.
- ABC had to split those savings with the payer, 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 and families and weak connections to community resources.
- ABC realized it needed advance funding across its payers to redesign its systems and maximize the shared investment.

THE CASE FOR ADVANCE FUNDING

Today, many care delivery investments are not made due to structure of some shared savings programs. With upfront investment, providers have greater incentive to transform care delivery and lower costs.

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**

No Win

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**

Win-Win

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UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.

Embedded within **shared savings arrangement** that rewards management of total cost of care

UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.

Embedded within **shared savings arrangement** that rewards management of total cost of care

Attribution

- Prospective
- Prioritize patient choice
- Not standardized across payers

Basic Bundle

Time of primary care providers

- Caring for patients
- Leading care teams
- Learning and peer support

Supplemental Bundle

Other investments to achieve the capabilities

- Care team staff
- Infrastructure and HIT
- Patient incentives
- Patient-specific expenses to address social needs

BASED ON

- Historical cost of primary care services included in the bundle
- % Primary care spend targets applied consistently across providers

ADJUSTED FOR

- Clinical risk
- Changes in services and use
- Unit cost trend
- Clinical risk
- Social risk
- Conditions with intensive management needs (e.g., dementia)

PAID TO

- The same provider or tax ID number receiving today's fee for service payments
- Advanced Networks and FQHCs participating in shared savings programs with Medicare and other payers

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COST OF ACHIEVING THE CAPABILITIES

Data on condition prevalence, evidence-based use of diverse care team members, published salary information adjusted for Connecticut and the experience of state and national experts informed the estimates below.

Capability or Capability Support	Estimated Incremental PMPM Cost	Assumptions (Based on 2,000 patient pediatric practice)
Diverse Care Teams	$4.00	Includes access to RN Care Manager (.25 FTE), Health Coach/Educator (.10 FTE) Nutritionist (.10 FTE), Community Health Worker (CHW), Asthma Educator (.20 FTE) Medical Interpreter/Interpretation Services (.05 FTE)
Behavioral Health Integration	$2.00	Licensed Clinical Social Worker (0.5)
Newborn Home Visits	$1.00	CHW/ Lactation Consultant (.20 FTE); portion of nurse care manager included in diverse care teams
Training and Technical Assistance	$1.00	Training in collaboration and leadership for expanded care teams.
Investments in HIT	$1.00	Additional investment in HIT to support improved care coordination and access tracking
Total	$9.00	

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

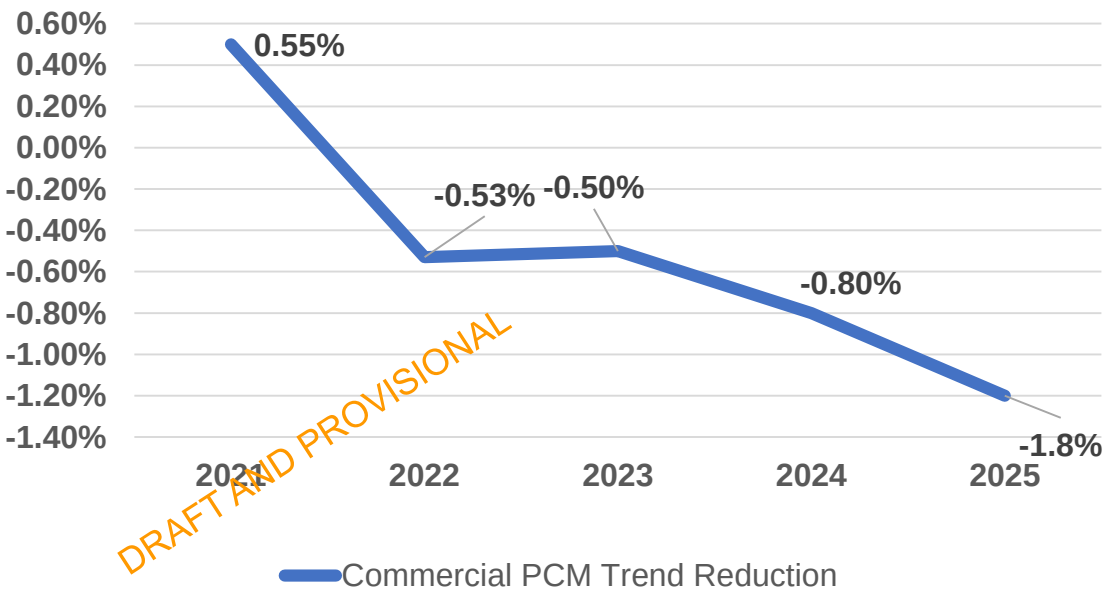
PMPM savings reflects the estimated per member, per month savings across the entire Commercial population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Patients Benefiting from the Capability	Savings Applied to Entire Pediatric Population (PMPM) Commercial
Diverse Care Teams	Emergency department costs decrease 10%; inpatient costs decrease 6%; outpatient hospital costs decrease 11% *(Lu, 2012), (Milliman, 2009), (Washington Health Alliance 2015)*	$ 8.16
Behavioral Health Integration	Total medical expense decreases 0.5%. *(CDC, 2019), (Tyler, 2017)*	$ 1.32
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 3.6% *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$ 0.58
eConsult and Co-management	Assumes about 3 eConsults per week and 31% of patients will still require face to face visit. *(The Annals of Family Medicine, 2016)*	$ 1.05
Universal home visits for newborns	Infant emergency department and inpatient visits decrease 11% *(Dodge, 2014)*	$ 3.80

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year five.

PCM Impact on Commercial Pediatric Total Cost of Care



PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment by year 5
- Less spending on low value services and more spending on high value services

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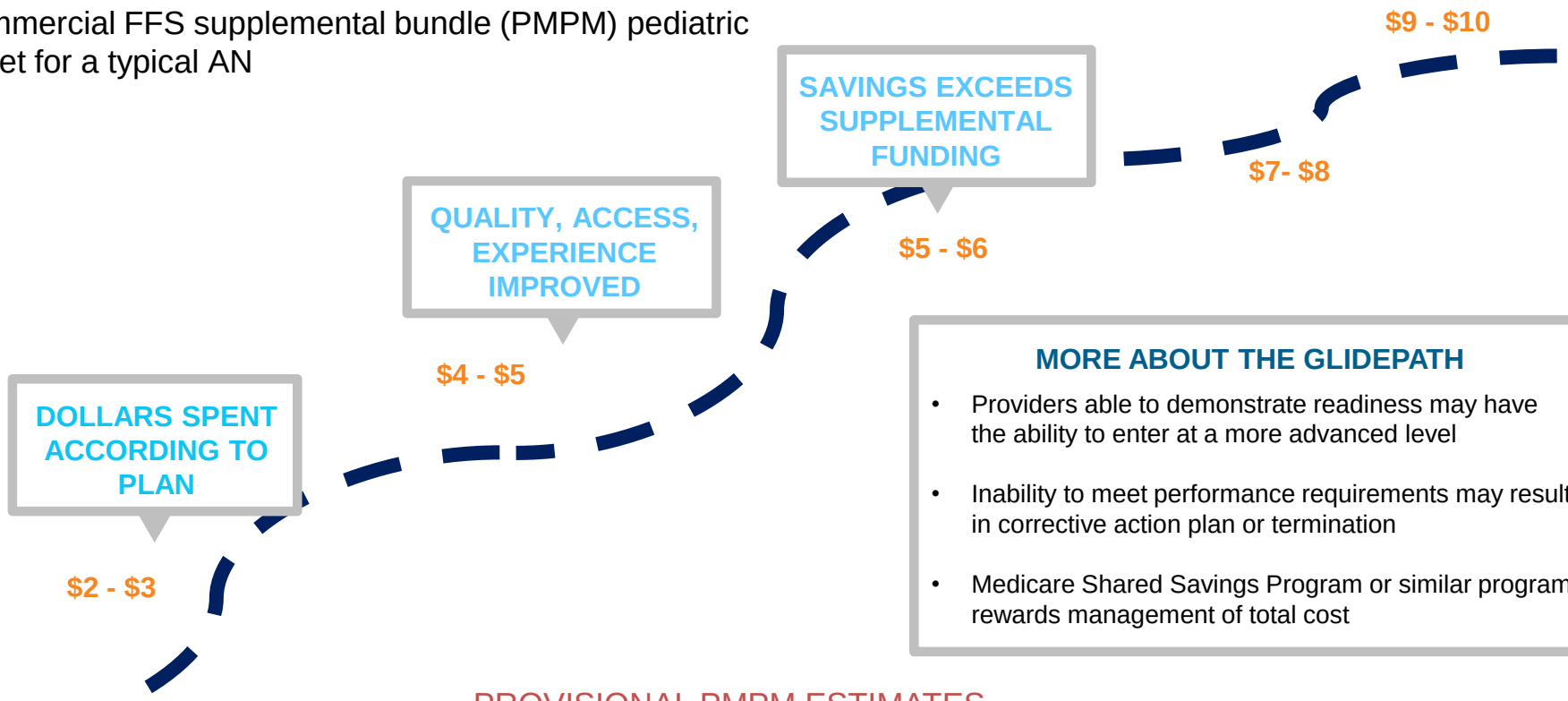
GLIDEPATH ENCOURAGES SMART INVESTMENT

Supplemental payments will increase gradually and “proof of performance” will be required to advance.

Commercial FFS supplemental bundle (PMPM) pediatric target for a typical AN



MORE ABOUT THE GLIDEPATH

- Providers able to demonstrate readiness may have the ability to enter at a more advanced level
- Inability to meet performance requirements may result in corrective action plan or termination
- Medicare Shared Savings Program or similar program rewards management of total cost

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PROVISIONAL PMPM ESTIMATES

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TRANSFORMING CARE FOR CHILDREN AND FAMILIES

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

BETTER ACCESS
- Convenience
- Timeliness
- Flexibility
- Community Support

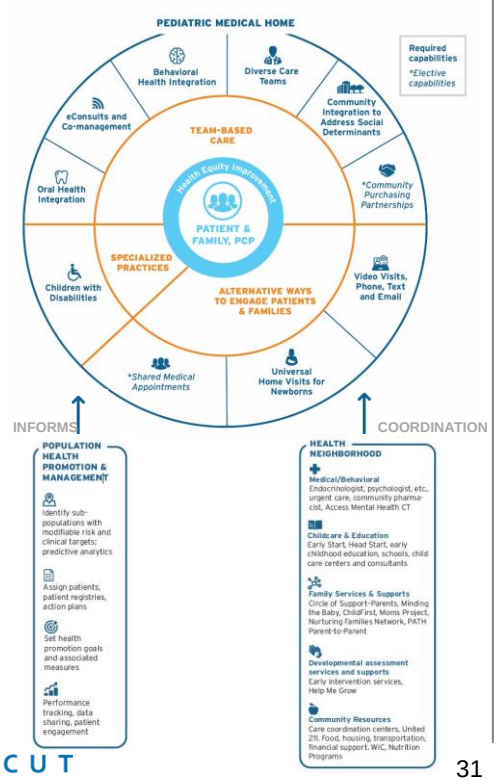
BETTER PATIENT EXPERIENCE
- Courteous and welcoming
- Listens and shares decision-making
- Advises and informs
- Coordinates and navigates

BETTER QUALITY
- Preventive care outcomes
- Chronic care outcomes
- Health equity

REVITALIZE PRIMARY CARE
- PCP and care team satisfaction
- Make primary care a more rewarding profession
- Incent incremental improvements in value

LOWER COST GROWTH
- Reduce cost growth
- Improve affordability for consumers

INPUTS



ENABLERS

BASIC BUNDLE
Advance payment for primary care provider time

SUPPLEMENTAL BUNDLE
Advance payment for primary care team staff and infrastructure

FLEXIBLE PAYMENTS

Shared savings program rewards total cost of care management

CONSUMER SAFEGAURDS
- Payments adjust for clinical and social risk
- Reporting demonstrates higher level of patient service and support

QUALITY MEASUREMENT
Quality and experience scorecard ties performance to shared savings rewards

ACCOUNTABILITY
"Proof of performance" required to qualify for supplemental payment increases

IMPACT

HEALTH OUTCOMES IMPROVE
- Improve appropriate use of asthma and behavioral health medications
- Improve rates of screening, early identification, and immunizations
- 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 and hospital costs
- Reduce specialty care spend
- Improve school readiness, attendance, and communication with primary care resources

AFFORDABILITY IMPROVES
- 1.8% net reduction in total cost

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QUESTIONS?

Contact: Mark Schaefer
mark.schaefer@ct.gov

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Thank you for participating in the

CHDI Transforming Pediatrics 3-Part Webinar Series

Contact Information

Commonwealth Medicine, UMass Medical School, Health Law and Policy

Hilary Deignan, Senior Policy Analyst

Hilary.Deignan@umassmed.edu

617-886-8152

About CHDI

The Child Health and Development Institute improves the health and well-being of Connecticut's children.

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https://www.chdi.org/publications/reports/other/transforming-pediatrics-support-population-health/

Study Group Members

Craig Anderson, United Healthcare

Patricia Baker, Connecticut Health Foundation

Peter Bowers, Anthem Blue Cross and Blue Shield of Connecticut

Ryan Calhoun, Connecticut Children's Medical Center

Sandi Carbonari, American Academy of Pediatrics, Connecticut Chapter

Mehul Dalal, Connecticut Department of Public Health

Tiffany Donelson, Connecticut Health Foundation

Paul Dworkin, Connecticut Children's Medical Center

Eminet Gurganus, Connecticut Children's Medical Center

Lisa Honigfeld, Child Health and Development Institute of Connecticut

Craig Keanna, ProHealth Physicians

Monica Ordway, Yale School of Nursing

Katie Piwnica-Worms, Yale School of Medicine

Mark Schaefer, Connecticut Office of Health Strategy

Karen Siegel, Connecticut Voices for Children

Megan Smith, Yale School of Medicine

Tesha Tramontano-Kelly, Connecticut Family Support Network

Jeffrey Vanderploeg, Child Health and Development Institute of Connecticut

Jesse White-Frese, Connecticut Association of School Based Health Centers

Robert Zavoski, Connecticut Department of Social Services