Improving Healthcare Value with *ADVANCED* Primary Care (APC)

FAST FACT:

The Patient-Centered Primary Care Collaborative provides real-world examples of how medical homes can improve care while saving money. For example, Horizon Blue Cross Blue Shield of New Jersey has been able to cut emergency room use by 26% and hospital readmissions by 25% among its medical home enrollees. And HealthPartners in Minnesota reports 39% fewer ER visits, 40% fewer hospital readmissions, and a reduction in appointment wait times from 26 days to one.

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_health_reform_and_you_health_reform_primary_care_612.pdf

Over 80% of patients with common chronic conditions (diabetes, high blood pressure) access primary care, the most prevalent type of office visit. But misaligned incentives (i.e., fee-for-service), lack of behavioral health (BH) integration, and infrastructure and technology challenges can compromise healthcare quality and drive up costs.*

*MEPS (2014) reported by Robert Graham Center (2018)

In a traditional fee-for-service (FFS) model, health care providers may be expected to see 25+ patients/day, leading to insufficient time for engagement, a tendency to refer, and high frustration levels for all.

What Makes Primary Care *ADVANCED* Primary Care? National Alliance Identified SEVEN Key Attributes

1 Enhanced access for patients
Convenient access, same day appointments, walk-ins, virtual access, no financial barriers to primary care

2 More time with patients
Enhanced patient engagement and support, shared decision-making, understanding preferences, social determinants of health

3 Realigned payment methods
Patient-centered experience and outcomes, quality and efficiency metrics, deemphasize visit volume

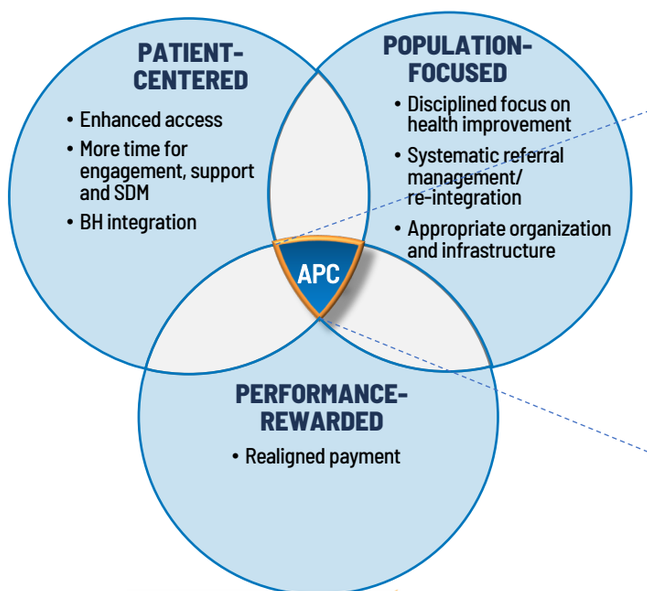
4 Organizational & infrastructure backbone
Relevant analytics, reporting and communication, continuous staff training

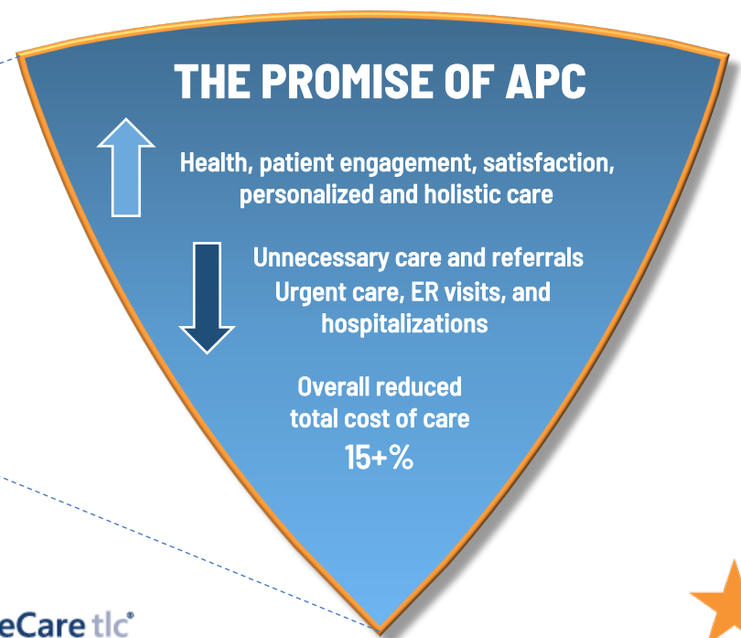
5 Disciplined focus on health improvement
Risk stratification and population health management, systematic approach to gaps in care

6 BH Integration
Screening for BH concerns (e.g., depression, anxiety, substance use disorder) and coordination of care

7 Referral Management
More limited, appropriate and high-quality referral practices, coordination and reintegration of patient care

Most of these attributes are consistent with critical success factors identified by respondents to a National Alliance survey





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Advanced Primary Care and COVID-19

Six of the seven key attributes of the APC approach have been mapped out to show high value and quality of care during the COVID-19 environment.

Enhanced Access for Patients

- Provides multiple ways of care when face-to-face option is restricted (text, email, online equipped with virtual visit option).
- Supports easy access to assess new symptoms informed by strong relationship and knowledge of patient history.
- Supports active management of chronic conditions.
- Supports referral when appropriate.

More Time with Patients

- Complete medical history and documentation of social determinants of health (SDOH) is in the electronic medical record (EMR) and provides data for a variety of purposes.
- Can use SDOH to identify patients who need more social or community support to meet basic needs (food, management of children at home, risk of domestic violence).
- More complete information supports data mining to identify patients with specific risks.
- Trusted source of information is customized to the patient's needs and condition(s).

Organizational & Infrastructure Backbone

- Offers a complete medical record and IT tools.
- Supports risk stratification and identification of high-risk patients; can support public health efforts.
- Allows communication of medical history for those who need acute hospital care.
- Triggers follow up for chronic conditions or of recent acute care in the absence of scheduled office visits.
- Coordinates information with local public health authorities and resources.

Disciplined Focus on Health Improvement

- Supports identification of those who should have priority for early testing and interventions.
- Supports trusted, targeted messaging to patients who need more aggressive efforts to avoid exposure.
- Provides patients with information about medicines and supplies.

BH Integration - APC has BH Capabilities

- Using the patient record, APC identifies people who may need outreach to assess BH needs.
- APC has multiple methods of connecting with patients to support ongoing treatment of BH conditions.
- BH staff proactively provide resources to patients and families to avoid and manage stress.

Referral Management

- Trusted source of reassurance and/or referral.
- Aware of community resources such as testing sites and specialists.

How EMPLOYERS Can Advance Primary Care to Deliver Value

1

Ensure appropriate infrastructure and focus:

- Patient-centered care
- Population focused
- Data driven

2

Insist on BH integration (co-located or virtual):

- Systematic approach to screening
- Consult/triage BH support as needed
- Follow-up assessment and incorporation into broader care plan

3

Align payment to support APC:

- Increase APC investment to decrease total cost of care
- Reward performance, not volume
- Influence downstream care

FAST FACT: Nationally, only <2% of all ambulatory visits included screening for alcohol misuse or substance use disorder and 4.4% included screening for depression *(NAMCS, 2015)*

Time/Infrastructure/Payment Needs

Key attributes/activities of APC	WHAT IS NEEDED: Time	Infrastructure	Payment
Enhanced access for patients	●	●	●
Patient engagement, support and shared decision-making	●	●	●
BH integration	●	●	●
Disciplined focus on health improvement	●	●	●
Effective referral management & reintegration	●	●	●

The fee-for-service model, based on relative value unit (RVU) or resource based relative value scale (RBRVS) does not adequately pay for primary care physicians' (PCPs) time, particularly for complex patients. This creates an incentive for unnecessary referrals to specialists and other healthcare providers.

Alternative Ways to Pay for Value: Payment Should be Aligned with Key APC Elements

APC practices currently are receiving payments under multiple methods such as fixed fees per patient, shared or full risk, pay-for-performance, and traditional FFS. Realigned payments incentivize patient activation, case and care coordination, and accountability for health and health outcomes as well as downstream referrals. While current models are relatively simple, future models may incorporate bundled payment for chronic condition management with outcome-based adjustments.

Effective use of analytics and services for health and care improvement

Successful BH integration and appropriate referral patterns

Convenient access and sufficient time spent with patients in shared decision-making