Key Employer Insights: What makes Primary Care *ADVANCED* Primary Care (APC) and How does it Add Value to Healthcare?

September 22 | 3:00 pm ET

National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

Speakers

MODERATOR
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Agenda

- Welcome & Introductions
- Assessing the Efficacy of CHW Programs and Integrating CHW into Primary Care
- MNCARES - Minnesota Care Coordination Effectiveness Study
- Advanced Primary Care Innovation – What it means for employers
- Reactor Panel
- Questions?

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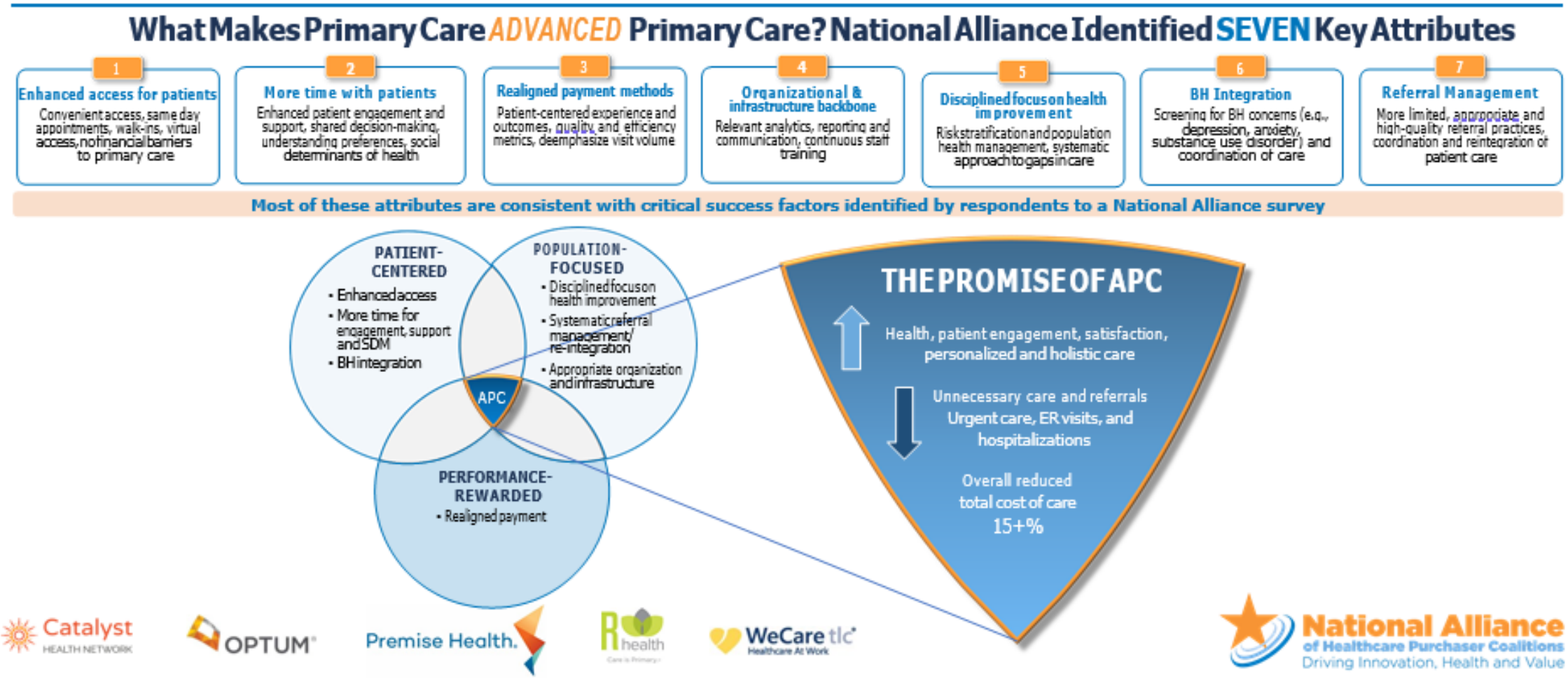
Driving Innovation, Health and Value

The National Alliance – Advanced Primary Care Perspective

The National Alliance - Advanced Primary Care Perspective



Catalyst HEALTH NETWORK OPTUM Premise Health. R health WeCare tlc Healthcare At Work

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Driving Innovation, Health and Value

PCORI Introduction

Greg Martin
Deputy, Chief Engagement and Dissemination Officer
Acting Director, Engagement Awards
PCORI

National Alliance
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Assessing the Efficacy of CHW Programs and Integrating CHW into Primary Care

Judith A. Long, MD
University of Pennsylvania Perelman School of Medicine
Center for Health Equity Research and Promotion
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Acknowledgements

- Collaborators: Shreya Kangovi, MD, MS; Nandita Mitra, PhD; Tamala Carter, CHW; David Grande, MD, MPA

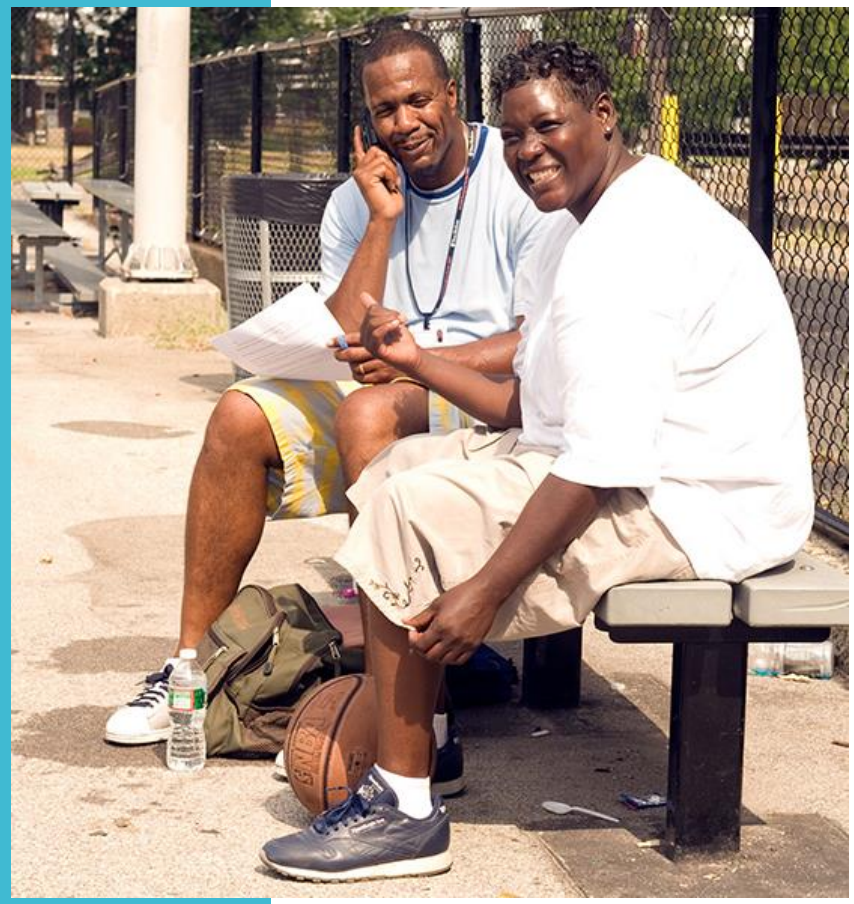
- Patient-Centered Outcomes Research Institute (PCORI-1310-07292); National Heart, Lung, and Blood Institute(K23-HL128837)

- No conflicts of interest to report

Social Determinants of Health

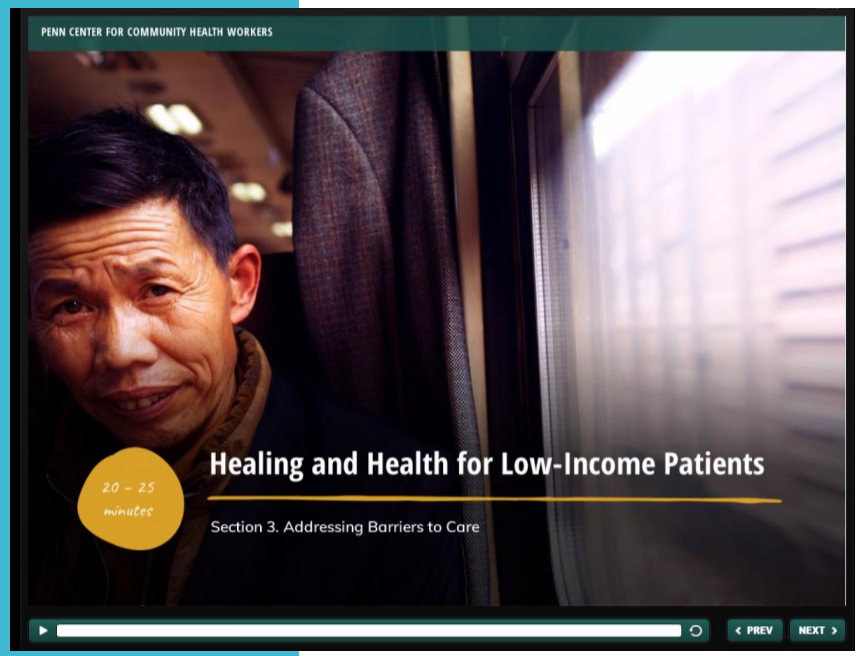
Photo Credit: JGJ Consulting
Gottleib et al Am J Prev Med 2017

IMPaCT®



1. Patient-Centered

2. Standardized



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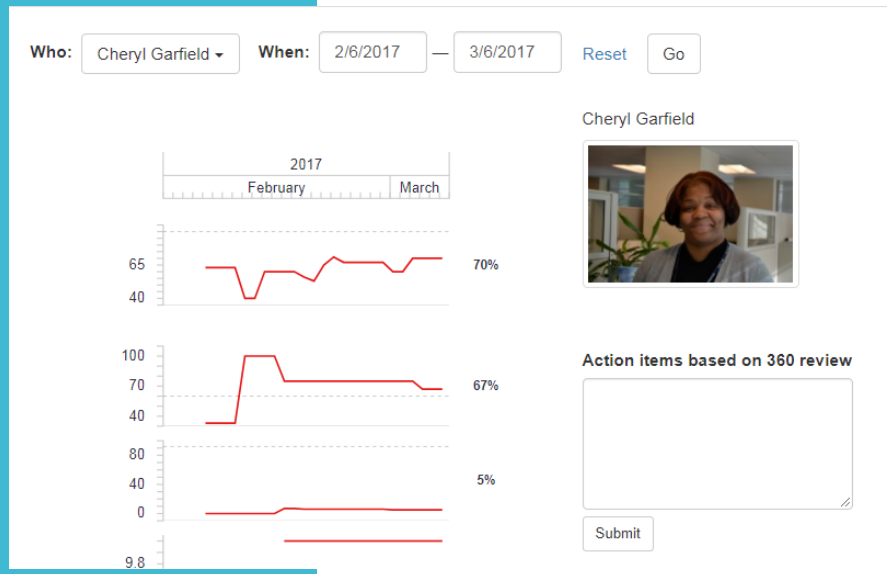

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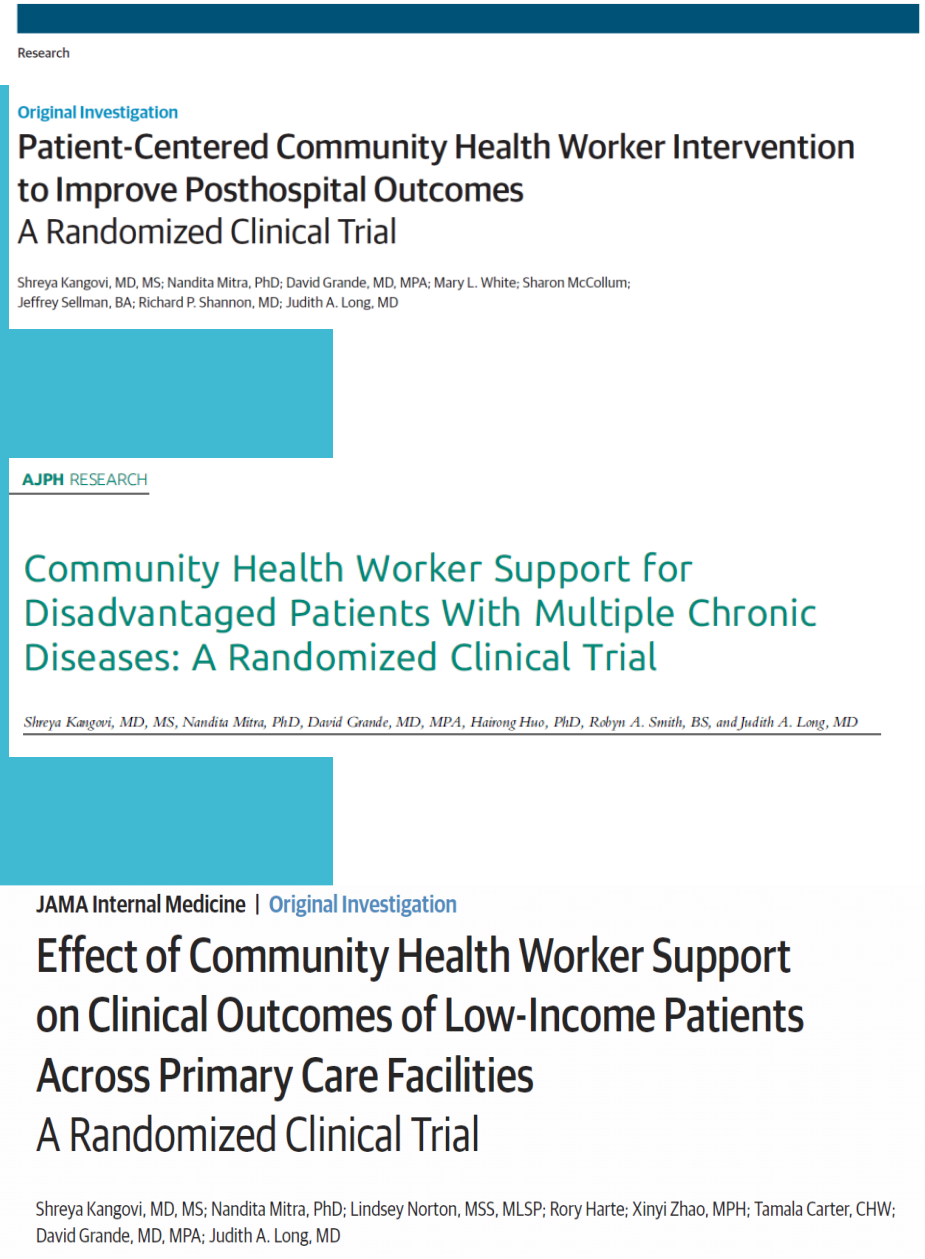


Research

Original Investigation

Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes
A Randomized Clinical Trial

Shreya Kangovi, MD, MS; Nandita Mitra, PhD; David Grande, MD, MPA; Mary L. White; Sharon McCollum; Jeffrey Sellman, BA; Richard P. Shannon, MD; Judith A. Long, MD

AJPH RESEARCH

Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial

Shreya Kangovi, MD, MS, Nandita Mitra, PhD, David Grande, MD, MPA, Hairong Huo, PhD, Robyn A. Smith, BS, and Judith A. Long, MD

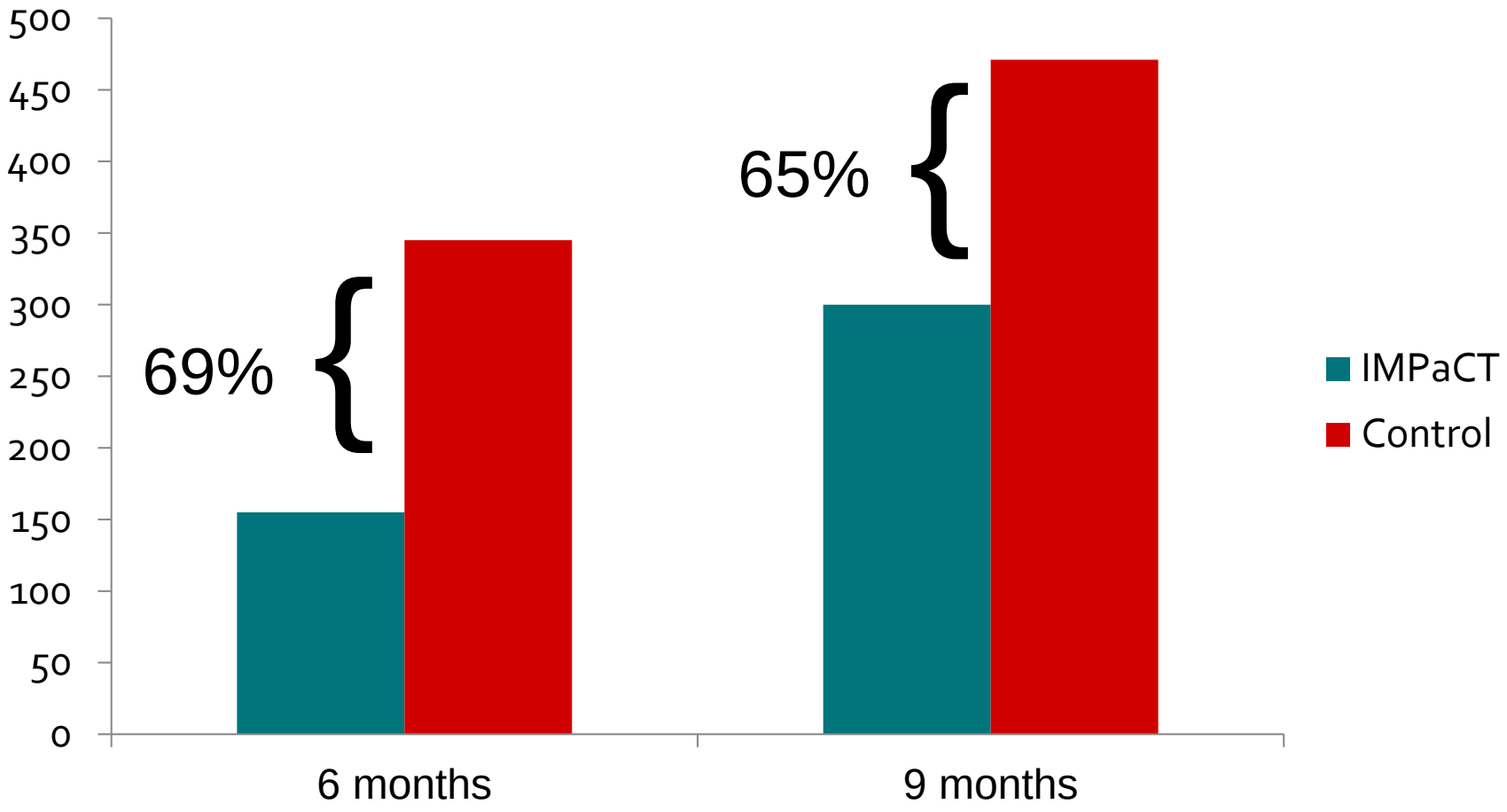
JAMA Internal Medicine | Original Investigation

Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities
A Randomized Clinical Trial

Shreya Kangovi, MD, MS; Nandita Mitra, PhD; Lindsey Norton, MSS, MLSP; Rory Harte; Xinyi Zhao, MPH; Tamala Carter, CHW; David Grande, MD, MPA; Judith A. Long, MD

3. RCT Evidence

Total Hospital Days

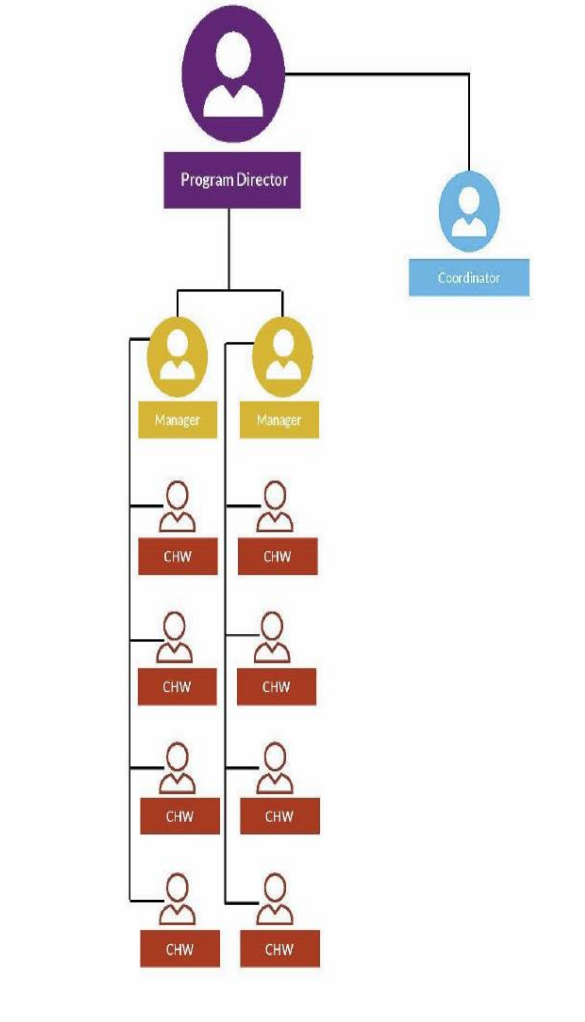


Hospitalization

	Diff-in-diff	P value
Mean length of stay	-3.1	0.06
	Odds Ratio	P value
Repeat admissions[ǂ]	0.4	0.02
30-d readmission[ǂ]	0.3	0.04

[ǂ]Among those with index admission


Director
Manager
Coordinator
CHW


Program Director
Coordinator
Manager
Manager
CHW
CHW
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CHW

IMPaCT PATIENT CARE

$2:1

Return on Investment

>10,000

Patients in Philadelphia

Kangovi, Long, Et al. *Health Affairs*: 2020

Blueprint

Community Health Worker Program

Wilmington VA Medical Center

Thank You

http://chw.upenn.edu/

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MNCARES
Minnesota Care Coordination Effectiveness Study

Principal Investigators

Leif Solberg, MD & Steve Dehmer PhD

Research reported in this presentation was funded through a PCORI (Patient-Centered Outcomes Research Institute) Award HIS-2019C1-15625

Major Partners

- **HealthPartners Institute**
  - Prime site for PCORI award and lead for data collection & analysis
- **MN Dept. of Health, Health Care Homes Program**
  - Subject matter experts & point of contact with health care home clinics
- **MN Community Measurement**
  - Data collection manager and data source for health care quality
- **Health plans**
  - MN Dept. of Human Services, UCare, BCBS of MN, & HealthPartners as data sources for claims/utilization
- **Primary care clinics and care systems**
  - Care delivery experts and key information source
- **Patients**
  - Advisors and key information source
- **National consultants**
  - Subject matter experts

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The Back Story

- MN Health Care Homes
  - 2010 law empowered the MN Dept. of Health to certify clinics
  - 5 standards (access, registry, care plans, QI, & care coordination)
  - 400 of 700 PC clinics are certified

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Background

- Systematic reviews of care coordination find:
  - Patients needing care coordination have multiple chronic conditions, use 2/3 of healthcare $, & are mostly managed in primary care
  - Probably some health & cost benefits for patients with particular chronic conditions
  - Not clear which coordination strategies and circumstances are best, nor which types of patients benefit the most

Specific Aims

1. To compare key outcomes for adult patients receiving care coordination services from clinics using a **“nursing/medical” model** versus a **“medical/social” model** that includes a social worker on the care coordination team

2. To identify the key components of the two models and test their association with desired outcomes

3. To explore how organizational, community, care process, and patient factors help explain differences in the models or outcomes

About care coordination in MN

- Type of care coordination model adopted is closely split in MN

Clinic type	Nursing-Medical Model	Medical-Social Model
Critical access hospital	5	2
Federally-qualified health center	10	11
Hospital-based	3	5
Independent medical group	38	20
Integrated delivery system	104	176
Other	14	1
Grand Total	**174**	**215**

Study Design

- Observational study comparing which coordination model produces best outcomes among clinics that have already made their own choice of model
  - Compare existing quality and utilization data before and after each patient receives care coordination
  - Add patient outcomes from a patient survey after enrolled in care coordination
  - Use interviews of care coordinators and patients to create clinic surveys that will determine the model and its impacts

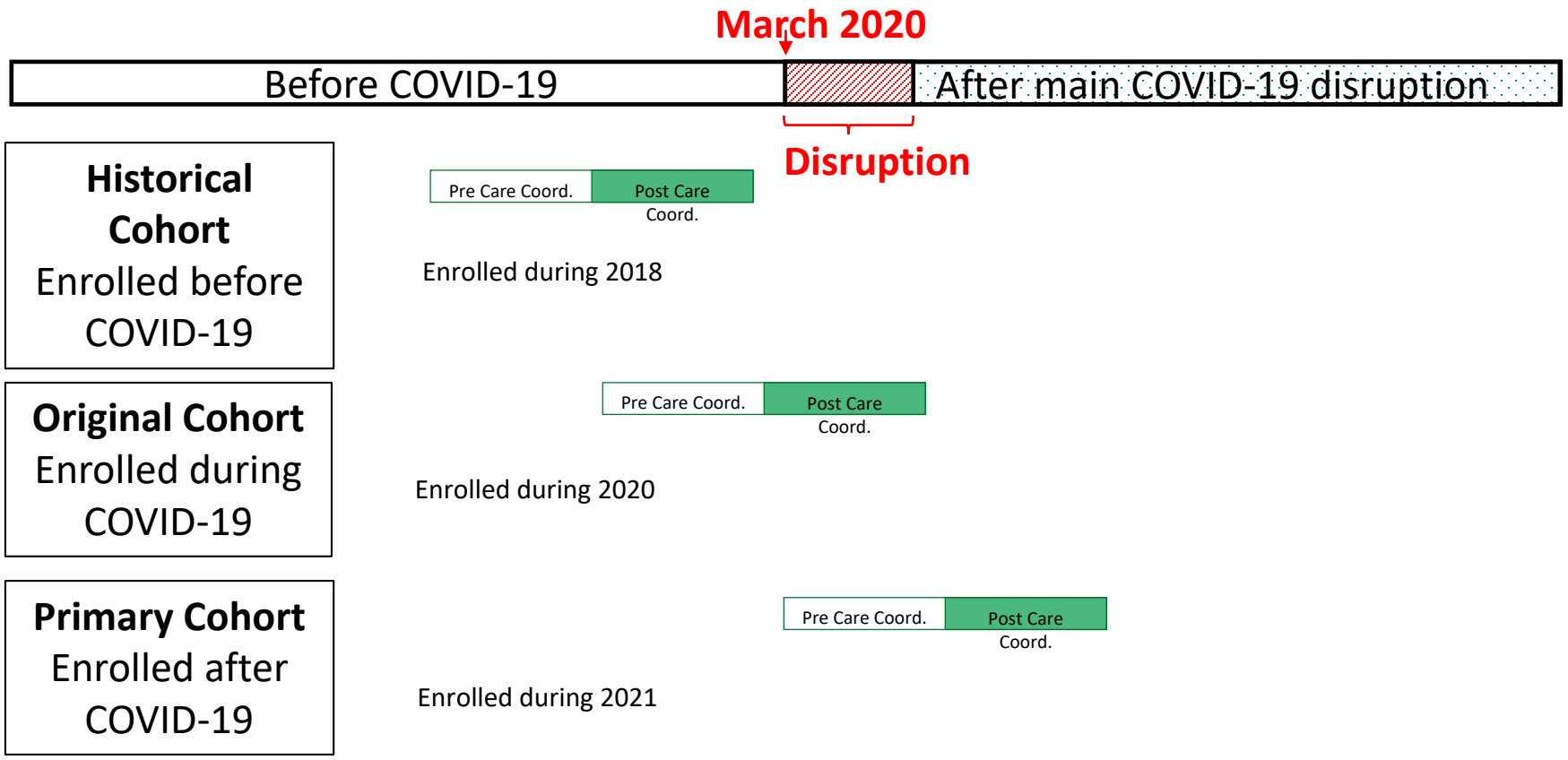
Primary Outcome Measures

1. **Quality of care:** Composite % of chronic disease/prevention measures that are relevant and achieved *(MN Community Measurement)*
2. **Utilization:** Emergency dept. visits and hospitalizations (Payor claims data)
3. **Patient-reported outcomes:** Satisfaction and health status (Patient survey)

And then COVID-19 happened

- Our original plan was to ask each clinic to identify all of their *currently active* care coordination patients in 2/21
- Now, that would mean much fewer patients starting care coordination and receiving more limited services

MNCARES – 3 Possible Cohorts of Care Coordination Patients



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What will we be able to tell you?

- Which approach to care coordination improves outcomes the most
- What components of either model make the most difference in outcomes
- What types of patients benefit the most from care coordination
- How these high cost/high need patients were affected by the COVID-19 care disruption, and whether there were disparities in services or impacts

Thank you!

- Leif Solberg, MD – Leif.I.Solberg@HealthPartners.Com
- Steve Dehmer, PhD – Steven.P.Dehmer@HealthPartners.Com

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IN HEALTH CARE

Advanced Primary Care Innovation

National Alliance of Healthcare Purchaser Coalitions

Bob Phillips, MD MSPH
Executive Director

Table 1
Distribution of Annual Visit Pattern and Self-Reported Mental Health Rating

Visit pattern	SF-12, MCS[a] ≥35 (Better) % (*n*)	SF-12, MCS[a] <35 (Poor) % (*n*)
Primary care only	49.8 (84,512)	49.5 (7392)
Mental health only	1.0 (1697)	5.0 (747)
Mental health and primary care	2.2 (3734)	13.6 (2031)
Other combinations	18.5 (31,395)	14.1 (2106)
No visit	28.6 (48,535)	17.7 (2643)
Person-year observations	169,703	14,933
Weighted percent	91.9	8.1

[a] Short Form-12, Mental Component Score.

Distribution of Annual Visit Pattern and Self-Reported Mental Health Rating

65% of elderly patient visits for depression were made in primary care in 2000/2001

Harman, J.S., Veazie, P.J. & Lyness, J.M. Primary care physician office visits for depression by older Americans. *JGIM* **21,** 926–930 (2006).

Petterson, S., Miller, B. F., Payne-Murphy, J. C., & Phillips, R. L., Jr. (2014). Mental health treatment in the primary care setting: Patterns and pathways. *Families, Systems, & Health, 32*(2), 157-166. doi:10.1037/fsh0000036

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Can Primary Care Afford Behavioral Health?

- Retrospective Cohort Study of integrated behavioral health model vs. usual practice found lower ED visits, hospitalizations, and better quality of care but practices received ***less*** reimbursement than usual care

Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *JAMA*. 2016;316(8):826-834.

- "providing integrated mental health and primary care is the right thing to do for the sake of the patient, but the resultant financial benefits of reduced resource utilization accrue to someone else—the employer who pays for health insurance, the insurance company itself, or a large health system—and not to the practice that bears the expense and reduced reimbursement"

Schwenk TL. Integrated Behavioral and Primary Care: What Is the Real Cost? *JAMA*. 2016;316(8):822–823.

See also: Basu, S., Landon, B.E., Williams, J.W. *et al.* Behavioral Health Integration into Primary Care: a Microsimulation of Financial Implications for Practices. *JGIM* **32,** 1330–1341 (2017).

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Hennepin Healthcare

Hennepin Health

Hennepin population-based health system

Direct transfers of health care funding into social services

“Ambulatory ICU” has behavioral health, substance use, community workers, housing stability for very small panels to manage very chaotic families

Care coordination, which includes access to a care coordinator

Transportation and housing assistance

Mental health Alcohol and drug abuse

Chiropractic, Dental, Hearing, Vision and eye glasses

Family planning, reproductive health, and doula services

Home care and hospice

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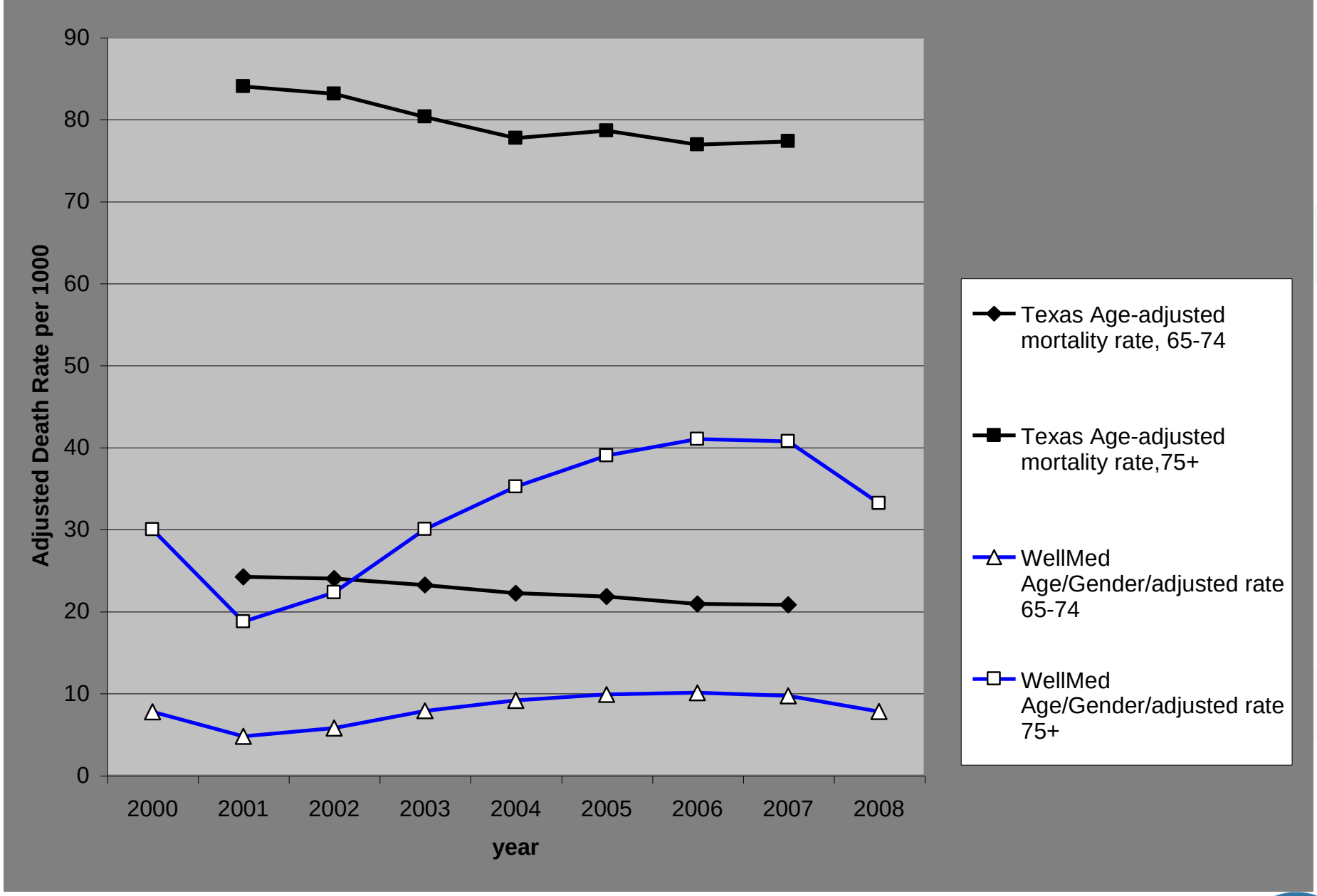
Cross-Sector Service Use Among High Health Care Utilizers In Minnesota After Medicaid Expansion Vickery et al Health Affairs 2018 37:1, 62-69

Medicare Advantage Plans

https://www.wellmedhealthcare.com/

For-profit primary care clinic network of 23 practices in San Antonio, TX partnered with a Medicare Managed Care Plan. First identified as having unusually high quality measures as part of a practice-based research network



Phillips et al. Case Study of a Primary Care–Based Accountable Care System Approach to Medical Home Transformation. J Ambulatory Care Management. 2011;34(1)" 67-77

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The Role of Massively Powerful Primary Care
April 2020
Doug Eby, MD, MPH, Vice President of Medical Services
65,000 Voices
Malcolm Baldrige National Quality Award
2011 & 2017 Award Recipient
Southcentral Foundation

Why listen to our story?

40%
DROP IN ER VISITS
2000-2017

36%
DROP IN HOSPITAL STAYS
2000-2017

6%
INCREASE IN OPERATING MARGIN FROM 2012-2017

97%
CUSTOMER-OWNER SATISFACTION

95%
EMPLOYEE SATISFACTION

75th to 90th percentile
ON MANY HEDIS OUTCOMES

The Nuka System of Care

Replaces medical culture with

- Relationship
- Shared Responsibility
- Customer-Ownership
- Story and
- Complex Adaptive System

What does it take for Advanced Primary Care?

- Teams to increase Comprehensiveness
- Panels adjusted for complexity
- Population Payment, beyond visits—including social needs
- Relationships—patients, family, community = Trust
- Bringing care in, avoid referring out; Coordinate
- Facilitation, because change isn't easy
- We've known this for a LONG Time

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Reactor Panelist

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Director, Performance Improvement and Innovation
Washington Health Alliance

Emily Transue, MD, MHA, FACP
Medical Director
Washington State Health Care Authority

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Questions?

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Thank you!

Your opinion matters!

Please fill out the short survey that pops up after this webinar closes. The webinar recording and deck will be shared by the end of the week.

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