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
Speakers

MODERATOR
Scott Conard, MD, DABFP, FAAFM
CEO
Converging Health
Chief Medical Advisor
National Alliance of Healthcare Purchaser Coalitions

Judith A. Long, MD
Sol Katz Professor of Medicine
University of Pennsylvania Perelman School of Medicine
Chief, Division of General Internal Medicine
Co-Director VA Center for Health Equity Research and Promotion,
Corporal Michael J. Crensenz VA Medical Center

Leif I. Solberg, MD
PCORI-funded Principal Investigator
Senior Investigator
HealthPartners Institute

Robert Phillips, MD, MSPH
Health Care Professional and Expert in Primary Care Innovations
Founding Executive Director, Center for Professionalism and Value in Health Care
American Board of Family Medicine Foundation

Karen S. Johnson, Ph.D
Director, Performance Improvement and Innovation
Washington Health Alliance

Emily Transue, MD, MHA, FACP
Medical Director
Washington State Health Care Authority
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?
### The National Alliance – Advanced Primary Care Perspective

### What Makes Primary Care Advanced Primary Care? National Alliance Identified SEVEN Key Attributes

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enhanced access for patients</td>
</tr>
<tr>
<td>2</td>
<td>More time with patients</td>
</tr>
<tr>
<td>3</td>
<td>Realigned payment methods</td>
</tr>
<tr>
<td>4</td>
<td>Organizational &amp; infrastructure backbone</td>
</tr>
<tr>
<td>5</td>
<td>Disciplined focus on health improvement</td>
</tr>
<tr>
<td>6</td>
<td>BH Integration</td>
</tr>
<tr>
<td>7</td>
<td>Referral Management</td>
</tr>
</tbody>
</table>

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

### The Promise of APC

- **Health, patient engagement, satisfaction, personalized and holistic care**
- **Unnecessary care and referrals**
- **Urgent care, ER visits, and hospitalizations**
- **Overall reduced total cost of care 15+%**

---

**Logos:**
- Catalyst Health Network
- OPTUM
- Premise Health
- R Health
- WeCare TLC
- National Alliance of Healthcare Purchaser Coalitions

**Motto:**
Driving Innovation, Health and Value
PCORI Introduction

Greg Martin
Deputy, Chief Engagement and Dissemination Officer
Acting Director, Engagement Awards
PCORI
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
Corporal Michael J. Crescenz VA Medical Center
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
1. Patient-Centered
2. Standardized
2. Standardized
2. Standardized
3. RCT Evidence
Total Hospital Days

- **6 months**: IMPaCT - 69%, Control - 65%
- **9 months**: IMPaCT - 65%
<table>
<thead>
<tr>
<th></th>
<th>Diff-in-diff</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean length of stay</td>
<td>-3.1</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>Odds Ratio</td>
<td>P value</td>
</tr>
<tr>
<td>Repeat admissions(^\dagger)</td>
<td>0.4</td>
<td>0.02</td>
</tr>
<tr>
<td>30-d readmission(^\dagger)</td>
<td>0.3</td>
<td>0.04</td>
</tr>
</tbody>
</table>

\(^\dagger\)Among those with index admission
IMPaCT PATIENT CARE

$2:1
Return on Investment

>10,000
Patients in Philadelphia

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

http://chw.upenn.edu/
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

MNCARES
Minnesota Care Coordination Effectiveness Study
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
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
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

<table>
<thead>
<tr>
<th>Clinic type</th>
<th>Nursing-Medical Model</th>
<th>Medical-Social Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical access hospital</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Federally-qualified health center</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Hospital-based</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Independent medical group</td>
<td>38</td>
<td>20</td>
</tr>
<tr>
<td>Integrated delivery system</td>
<td>104</td>
<td>176</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>174</strong></td>
<td><strong>215</strong></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Enrolled during</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Historical Cohort</strong></td>
<td>Before COVID-19</td>
</tr>
<tr>
<td>Enrolled before COVID-19</td>
<td>Enrolled during 2018</td>
</tr>
<tr>
<td><strong>Original Cohort</strong></td>
<td>After main COVID-19 disruption</td>
</tr>
<tr>
<td>Enrolled during COVID-19</td>
<td>Enrolled during 2020</td>
</tr>
<tr>
<td><strong>Primary Cohort</strong></td>
<td>March 2020</td>
</tr>
<tr>
<td>Enrolled after COVID-19</td>
<td>Enrolled during 2021</td>
</tr>
</tbody>
</table>

Disruption
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
Advanced Primary Care Innovation
National Alliance of Healthcare Purchaser Coalitions

Bob Phillips, MD MSPH
Executive Director
65% of elderly patient visits for depression were made in primary care in 2000/2001


**Table 1**

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

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

^a Short Form-12, Mental Component Score.
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


• “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”


Hennepin Healthcare

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

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

Texas Region

Medicare

WellMed

2006

2008

ER visit rates (%)

28.1

17.8

Hospitalization rates (%)

22.1

14.4

Re-hospitalization rates (30 days) (%)

19.9

13.9

Hospital Bed - Days/1000

2559

1002

1:1 cohort match on age, gender, number of chronic conditions

The Role of Massively Powerful Primary Care

April 2020

Doug Eby, MD, MPH, Vice President of Medical Services

65,000 Voices
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-owners 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
Reactor Panelist

Karen S. Johnson, Ph.D
Director, Performance Improvement and Innovation
Washington Health Alliance

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