ACTION BRIEF

Employer Strategies that Drive Value

National Alliance of Healthcare Purchaser Coalitions

WHAT MAKES PRIMARY CARE *ADVANCED* PRIMARY CARE (APC)

HOW APC ADDS VALUE TO HEALTHCARE

ACTION STEPS FOR EMPLOYERS:

1. Examine and assess patient access to services.
2. Evaluate organizational infrastructure to measure and support health improvement.
3. Review care management services.
4. Include integrated care options.
5. Realign payment methods.

Although primary care delivers value for our health system, its overall effectiveness and impact have suffered due to misaligned reimbursement strategies, lack of care coordination, and infrastructure limitations. These flaws have compromised our ability to support a population with increased health needs and, particularly, to treat the whole person, rather than just the presenting condition.

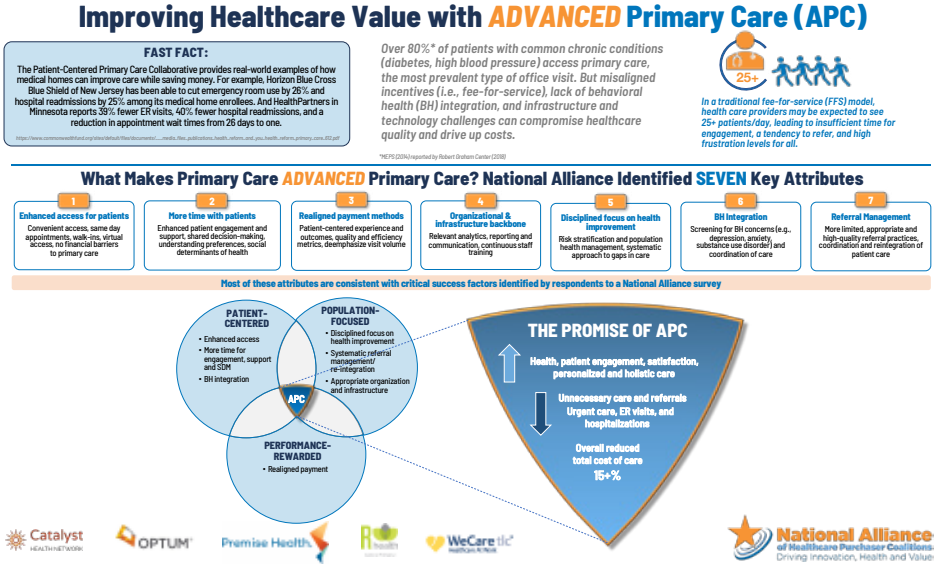
In a traditional fee-for-service (FFS) primary care model, healthcare providers may be expected to see 25+ patients/day,[1] leading to insufficient time for engagement, a tendency to refer, and high frustration levels for all. Despite these challenges, a growing body of research shows that better health outcomes and lower healthcare costs are strongly linked to the use and availability of primary care physicians.

We define advanced primary care (APC) as a primary care system that delivers increased value for both patients and purchasers by encompassing seven key attributes:

1) enhanced access for patients, 2) more time with patients, 3) realigned payment methods, 4) organizational and infrastructure backbone, 5) behavioral health integration, 6) a disciplined focus on health improvement, and 7) referral management.[2]

NATIONAL ALLIANCE 7 KEY ATTRIBUTES OF PRIMARY CARE

(Click on the image to view and download the infographic)



1. **Enhance access to services, including more personalized and effective patient engagement; flexible patient access to providers; and increased appointment time with patients.**

Access to primary care is a critical first step in establishing a pathway for ongoing, coordinated, high-value care and reducing the chance of unnecessary visits to emergency care facilities. For patients, enhanced access to primary care includes care when and where they need it, at a cost they can afford.

CASE STUDY:
APC Improves Care

The NUKA System of Care, a patient-centered value-based healthcare organization, provides a real-world example of how an APC approach can improve care while saving money.

Southcentral Foundation operates this whole-healthcare system, which provides medical, dental, behavioral, traditional, and healthcare support services to more than 65,000 Alaska Native and American Indian people (https://scfnuka.com/our-story).

See the infographic below for outcomes produced through their unique whole-person APC approach.

Allowing physicians to spend more time with individual patients encourages better patient engagement, improves the identification of social determinants that can impact patient health, and ensures continuity of care over time.

Purchasers and health plans should assess and monitor the following when evaluating the enhanced access services of a potential primary care practice offering APC:

- The extent to which they set, measure and meet standards for access to urgent and routine care
- Availability of care after normal business hours and on weekends

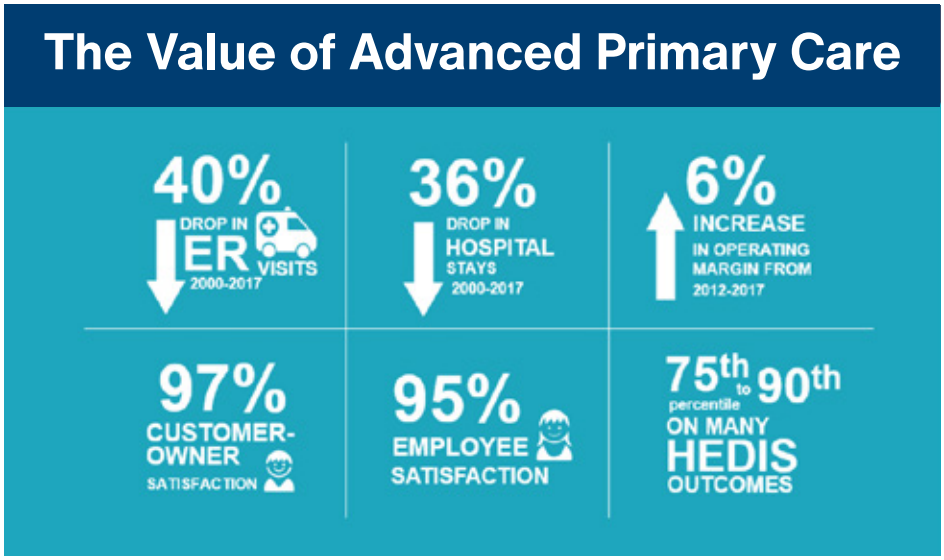
- Patient engagement strategies, including metrics (e.g., average duration of visits)
- Approach to and measurement of treatment plan development and follow-up care

There is widespread agreement that enhanced access is a critical factor in the success of APC. Yet one barrier many providers face is insufficient compensation for spending the "necessary amount of time" with patients. Purchasers must be willing to consider contracts with providers, directly or through their health plans, that adequately compensate for the added cost of enhanced access services, with the understanding that this investment will eventually lead to an overall reduction in the total cost of care.

"Purchasers are essential to improving the value of primary care; APC will not take root unless purchasers demand and pay for it. The opportunity is great — potentially saving 15% or more of overall healthcare spend."

— Achieving Value through Advanced Primary Care, National Alliance of Healthcare Purchaser Coalitions (April 2020)

Southcentral Foundation's NUKA System of Care is an Alaska Native-owned, nonprofit healthcare organization



NCQA.org/hedis/

"Risk stratification is an ongoing process of assigning all patients in a practice a particular risk status — risk status is based on data reflecting vital health indicators, lifestyle and medical history of its adult or pediatric population."

— American Academy of Family Physicians

serving approximately 65,000 Alaska Native and American Indian people living in Anchorage, the Matanuska-Susitna Borough, and 55 rural villages in the Anchorage Service Unit.

2. Evaluate organizational infrastructure to measure and support health improvement including quality, value, and population risk factor analysis.

Organizational infrastructure, which constitutes the backbone of a primary care practice, is the overarching driver of APC and patient satisfaction. When considering contracts that include practices offering APC, purchasers and health plans should review assessments of the ways that leadership, training, staff expertise, and IT capabilities support a commitment both to quality improvement (QI) and to a broad understanding of population health-risk factors.

Organizations that invest in the infrastructure necessary for a disciplined APC approach demonstrate a commitment to understanding how a primary care practice undertakes risk stratification. An overview of IT capabilities, access metrics, quality control metrics, and population health services will allow purchasers to evaluate whether an organization has the infrastructure to effectively manage an APC approach to improving population health. See chart examples of these metrics.

3. Review care management services, including care coordination services and a breakdown of the referral management process.

Care coordination can help curtail unnecessary testing, avoid unnecessary visits to the emergency department (ED), and help improve long-term outcomes. In addition, patients who understand their health issues and care options can better participate in care-related decisions and are more likely to be satisfied with their care. At a minimum, purchasers might expect these care coordination services to be included as part of APC:

- Gathering a complete medical history, including mental health status and social determinants of health (SDoH)
- Educating the patient about their diagnosis(es) and developing a realistic care plan
- Developing a trusting relationship that engages the patient's supporters
- Scheduling appropriate follow up, either in person or virtually
- Scheduling referrals as appropriate (see sidebar)

RESEARCH CASE STUDY

A Comparative Effectiveness Research (CER) study recently funded by Patient Centered-Outcomes Research Institute (PCORI) will compare key outcomes for adult patients receiving care coordination services from clinics that use a "nursing/medical" model versus those that use a "medical/social" model that includes a social worker on the care coordination team. To learn more and get updates when results are available, visit:

https://www.pcori.org/research-results/2019/comparing-two-approaches-care-coordination-high-costhigh-need-patients-primary

Important questions that will be addressed in this study may guide purchasers and health plans in the evaluation of APC care coordination services including:

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

Monitoring care coordination is particularly important when a patient receives care outside the primary care practice, for example during a visit to the ED, through inpatient services at a hospital, or from external medical specialists.

When purchasers and health plans review care-management referral services offered by APC practices, they should include some or all of these important metrics:

- In-network status
- Prior quality metrics performance
- Timely follow-up communication from specialist back to the APC practice
- Availability of shared data
- Platform used when selecting hospitals or specialists

4. Include integrated care options, especially behavioral health integration (BHI) and expanded social services, both internally and externally through partnerships

In general, primary care clinicians, rather than mental health or substance use specialists, provide the majority of behavioral healthcare, and the effectiveness of that care is poor. Treatment of behavioral health conditions in primary care falls short of minimal best-practice standards as much as 85% of the time.

Incorporating behavioral health integration into an APC approach can greatly improve patient mental health outcomes. If purchasers and health plans find significant differences in the level of care between "medical" and "behavioral health" services offered in the practices they are assessing, they should request an explanation for those differences and establish timelines for remediation. In general, these metrics are important for achieving the expected BHI through APC:

- Promoting early identification and intervention for behavioral health issues by evaluating measurement tools
- Measuring behavioral health performance, including accountability metrics
- Integrating mental health into total health and wellbeing strategies
- Using systematic patient referrals to specialists and follow-up where appropriate

APC integrated care can go beyond BHI to include social-service assistance, as well transportation and housing assistance; alcohol and drug treatment; chiropractic, hearing, vision, family-planning, reproductive health, doula, home-care, and hospice services; and more.

A PCORI-funded CER Study

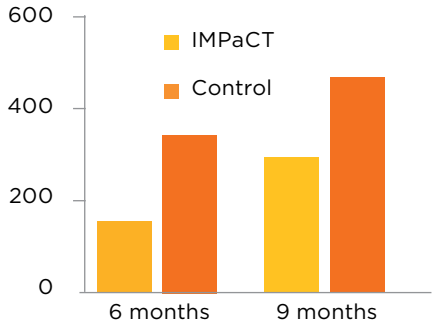
A PCORI-funded CER study completed in 2018 was designed to answer the question, "As a patient with a chronic illness and limited resources, how can I address real-life challenges that make it hard for me to stay healthy?"

To address this question, standard services from a primary care practice and integrated services from individualized management for patient-centered targets (IMPaCT) were compared in a clinical trial. IMPaCT is a standardized community health worker (CHW) intervention program that includes CHW training and guidance in how to integrate CHW's into a primary care clinic.

The trial demonstrated that IMPaCT can improve the outcomes that matter to patients, healthcare delivery systems, and purchasers, resulting in fewer days in the hospital, improved patient-reported quality of care, and increased patient activation, which may lead to lower healthcare costs and improved patient-centered outcomes.

Project link: https://www.pcori.org/research-results/2019/implementation-impact-community-health-worker-intervention

IMPACT STUDY SHOWS REDUCED HOSPITAL STAYS



https://www.pcori.org/research-results/2019/implementation-impact-community-health-worker-intervention

5. Realign payment options so reimbursement and incentive programs support the key APC attributes.

The premise that APC can deliver increased value is clear, but there are concerns that inadequate fee-for-service (FFS) payments typically do not cover the care management services and the patient engagement strategies necessary to provide APC.

Practices are experimenting with alternatives to FFS, such as shared risk arrangements and fixed payment methods, typically implemented through a direct primary care (DPC) contract. DPC is a payment model in which patients/consumers (or purchasers) compensate physicians or practices directly with periodic payments for a defined set of primary care services.

Other payment methods that encourage APC include:

- Shared savings
- Pay for performance (P4P)
- Bonus payments based on measures of quality and/or efficiency
- Case management fees

Whatever payment method is used, purchasers are encouraged to consider the relationship of the cost of primary care to the total cost of care; they can expect an APC practice to provide this data.

Research increasingly shows that better health outcomes and lower healthcare costs result from the availability and use of primary care. Additionally, in areas of the country where there are more providers per person, death rates are lower, and people are less likely to require hospitalization.[3] These findings build a solid business case for moving toward a more integrated model that delivers high-quality care to patients and allows physicians to achieve better outcomes.

ENDNOTES

1–4 "Achieving Value through Advanced Primary Care Deep Dive Powered by eValue8." National Alliance of Healthcare Purchaser Coalitions, April, 2020.

3 Source: https://www.aafp.org/medical-school-residency/choosing-fm/value-scope.html

ACKNOWLEDGEMENT

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RESOURCES FOR EMPLOYERS:

- Resource: Primary Care Collaborative
- Webinar: "Key Employer Insights: What makes Primary Care ADVANCED Primary care and How does it Add Value to Healthcare."
- Research: "PCORI-funded Research: Implementation of the IMPaCT Community Health Worker Intervention."
- Research: "PCORI-funded Research: Comparing Two Approaches to Care Coordination for High-Cost/ High-Need Patients in Primary Care."
- The Healthcare Effectiveness Data and Information Set (HEDIS)

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Driving Innovation, Health and Value

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