Improving Healthcare Value with ADVANCED Primary Care (APC)

FAST FACT:

US adults who have a primary care physician have **33% LOWER** healthcare costs and **19% LOWER** odds of dying than those who see only a specialist. As a nation, we would **SAVE $67 BILLION** each year if everybody used a primary care provider as their usual source of care.

"Contribution of Primary Care to Health Systems and Health," Milbank Quarterly

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.

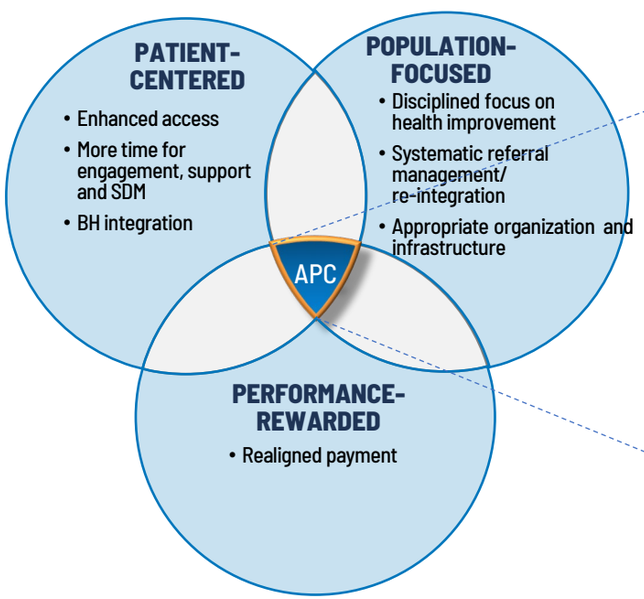
*MEPS (2014) reported by Robert Graham Center (2018)

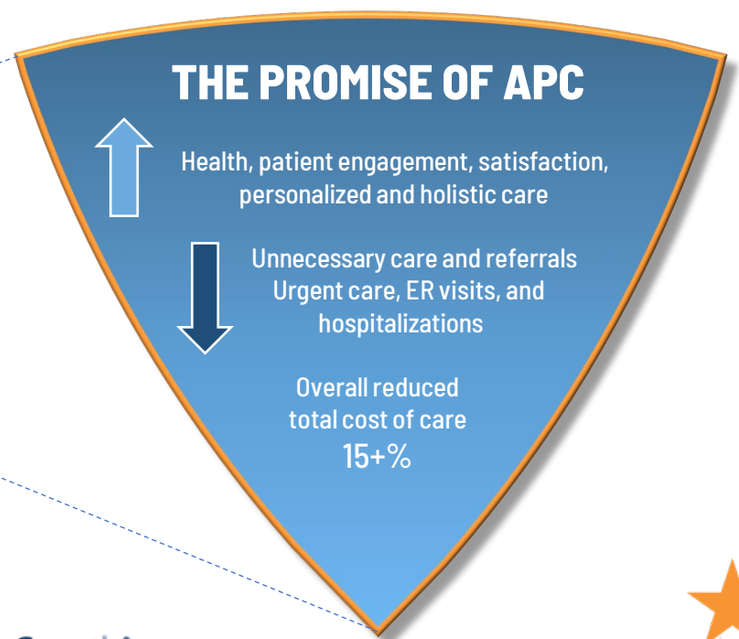
In a traditional fee-for-service (FFS) model, health care providers may be expected to see 25+ patients/day, leading to insufficient time for engagement, a tendency to refer, and high frustration levels for all.

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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Preliminary Survey Observations

All support enhanced access (same-day appointments, walk-ins, some virtual, extended and weekend hours) for medical. Not all measure wait times.

Access is not consistent for BH.

All have processes in place to reach out to "non-engaged" patients and covered individuals.

All support some shared-decision making activities with varying breadth and depth.

All require clinical staff to be trained in key activities such as population health management, motivational interviewing, risk stratification, shared decision-making techniques and social determinants of health, and training.

All have a measurement and quality improvement process with feedback reporting; patient experience is an important measure; outcomes measures used vary.

Most common referrals are for gastroenterology, cardiovascular and orthopedics; all use a broad range of criteria including prior performance, cost relative to others, and timely follow-up back to practice.

Unclear how well BH is integrated:

- Some, not all, monitor that clinicians are screening for depression and alcohol use.
- Some, not all, reported percent of patients where BH consult (internal/external) occurred: Range: 7%-14%.
- None reported encounters/claims for Collaborative Care; BH integration; or screening, brief intervention, and screening, brief intervention, and referral to treatment (SBIRT).

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