Better Health Now: Relooking at Primary Care Strategy

August 4, 2022

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

Speakers

Michael Thompson
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pcc primary care collaborative

Convening + Uniting + Transforming

Better Health NOW

August 2022
National Alliance Town Hall

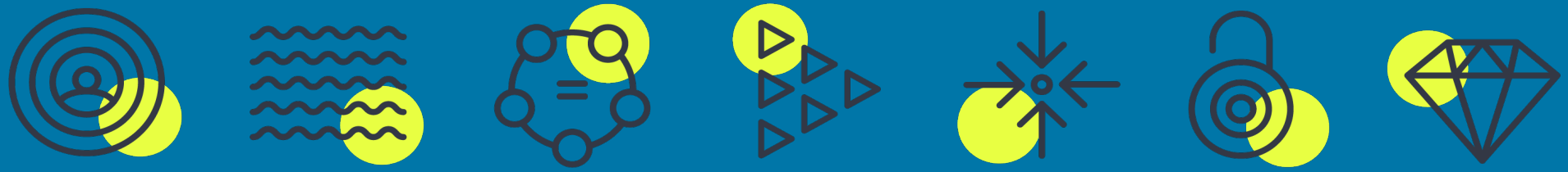
PCC Mission and Vision

OUR MISSION

Advance comprehensive primary care for all communities, through convening, uniting stakeholders

OUR VISION

Shared Principles of Primary Care



Person and Family-centered

Continuous

Comprehensive and Equitable

Team-based and Collaborative

Coordinated and Integrated

Accessible

High-value

66+ Members

From AARP to URAC and 64 organizations in between, including the National Alliance of Healthcare Purchaser Coalitions

96% of PCC members renewed in 2021

pcc primary care collaborative

PCC's 2022 Board of Directors

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Senior Vice President
Ascension
President
Ascension Medical Group

PCC's Journey

2007–2016

Founded to promote PCMH

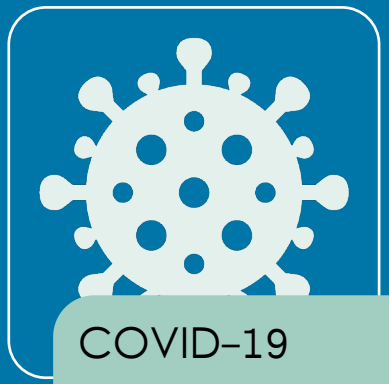
- Multi-stakeholder
- Align on vision, standards
- P4P payment model

2017–2019

PCMH Payment misalignment

- Progress stalls
- Consolidation
- New entrants(+, –)
- State investment efforts = bright spot

2020–2022



COVID–19

- Exacerbates inequities
- Weakens already vulnerable PC
- Yet PC reinvents itself, is resilient & demonstrates value

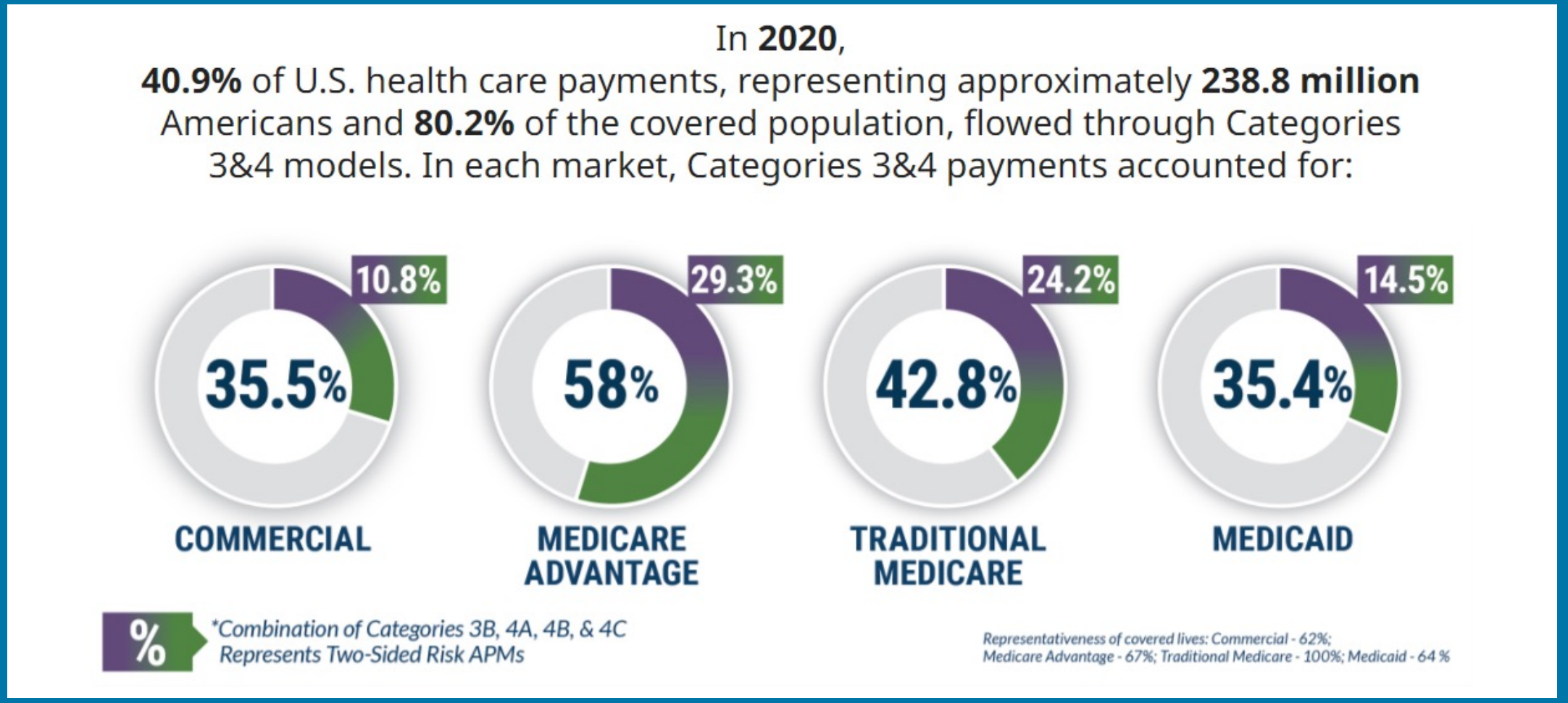
2021

NASEM report = PC launch pad

- Align around payment
- Expand coalition
- Launch Better Health – NOW
- Sustain urgency, build momentum

PCC's Theory of Change

2020 LAN Analysis



Source: APM Measurement Effort 2020. Health Care Payment Learning and Action Network. https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/

Shaping the Environment for Bold PC Investment + Payment Reform

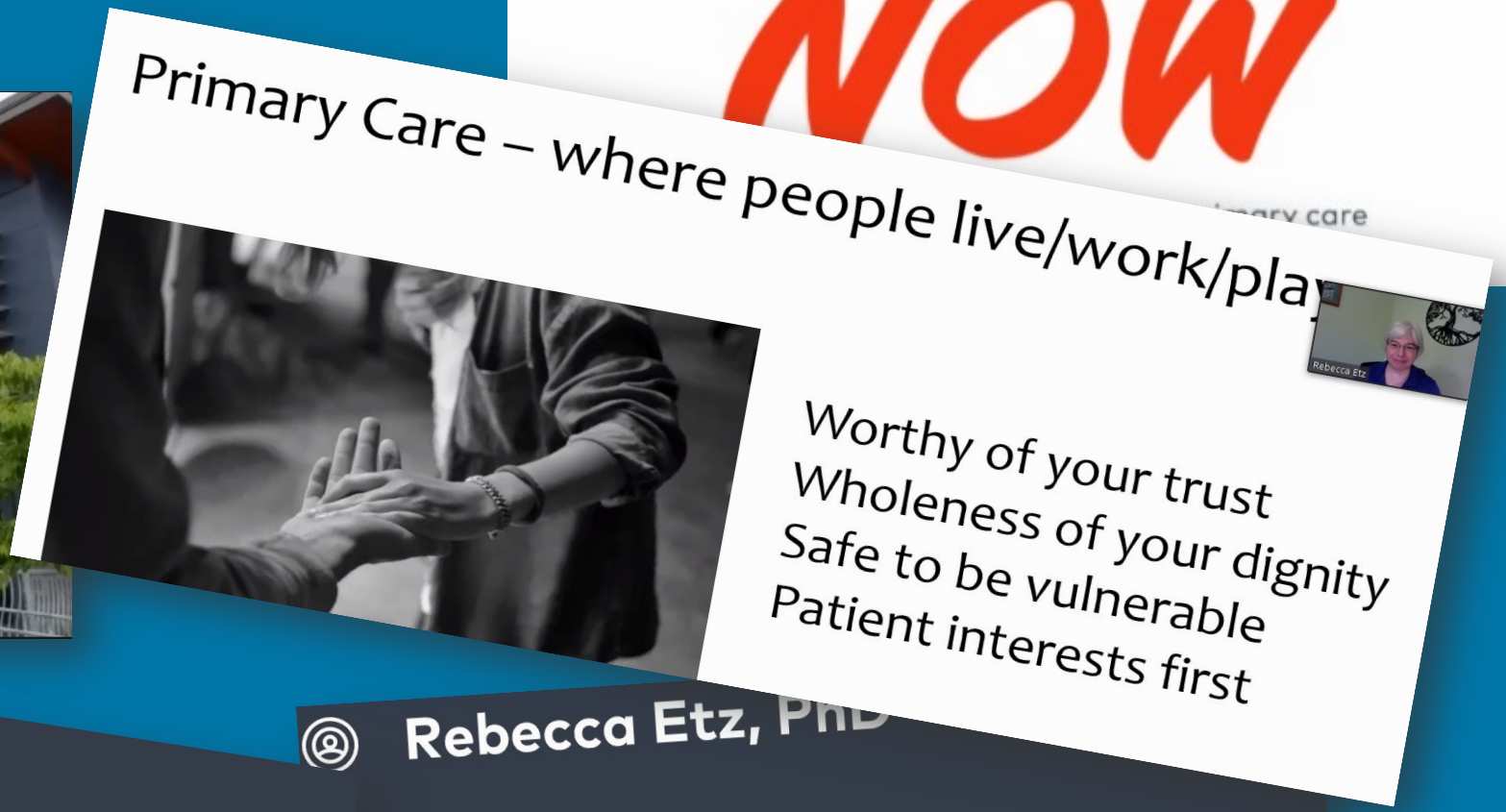
Coalition-building

Communications

Policy Development & Implementation

We Launched 3.29 !

Better Health NOW



Message Frame

There's nothing more important than our health. That's why many of us rely on primary care to partner with us and our families on the path to healthier, more fulfilling lives.

That's why we need strong primary care in every community, **so we all have improved access to health. We have a way to make this vision a reality.**

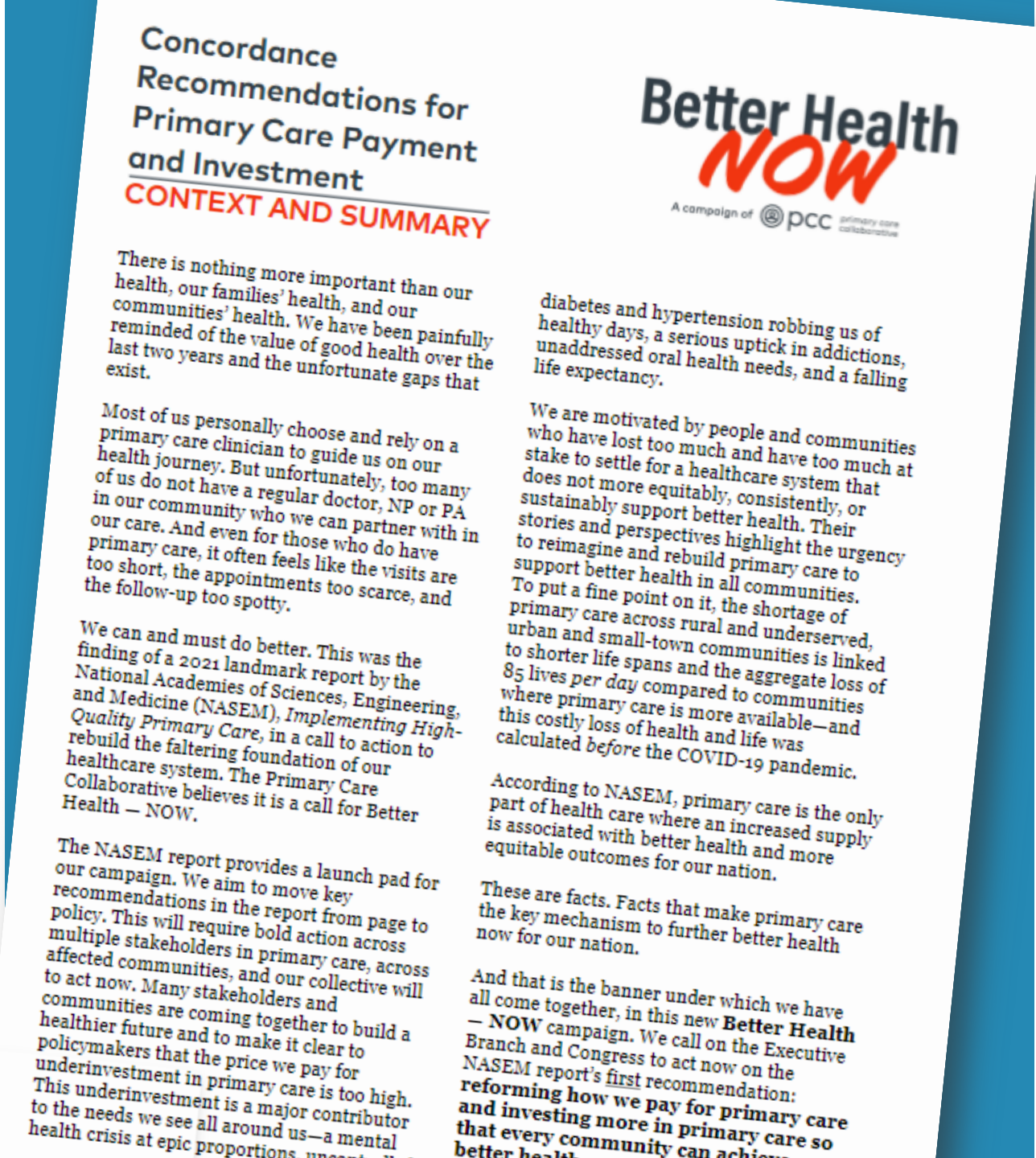
Better Health NOW

PCC is the only national multi-stakeholder organization focused on primary care, with a track record of bridging divides and broadening perspectives within its big tent.

Better Health NOW

A campaign of pcc primary care collaborative

48 + signatories



Concordance Recommendations for Primary Care Payment and Investment

CONTEXT AND SUMMARY

Better Health NOW

A campaign of pcc primary care collaborative

There is nothing more important than our health, our families' health, and our communities' health. We have been painfully reminded of the value of good health over the last two years and the unfortunate gaps that exist.

Most of us personally choose and rely on a primary care clinician to guide us on our health journey. But unfortunately, too many of us do not have a regular doctor, NP or PA in our community who we can partner with in our care. And even for those who do have primary care, it often feels like the visits are too short, the appointments too scarce, and the follow-up too spotty.

We can and must do better. This was the finding of a 2021 landmark report by the National Academies of Sciences, Engineering, and Medicine (NASEM), *Implementing High-Quality Primary Care*, in a call to action to rebuild the faltering foundation of our healthcare system. The Primary Care Collaborative believes it is a call for Better Health — NOW.

The NASEM report provides a launch pad for our campaign. We aim to move key recommendations in the report from page to policy. This will require bold action across multiple stakeholders in primary care, across affected communities, and our collective will to act now. Many stakeholders and communities are coming together to build a healthier future and to make it clear to policymakers that the price we pay for underinvestment in primary care is too high. This underinvestment is a major contributor to the needs we see all around us—a mental health crisis at epic proportions, diabetes and hypertension robbing us of healthy days, a serious uptick in addictions, unaddressed oral health needs, and a falling life expectancy.

We are motivated by people and communities who have lost too much and have too much at stake to settle for a healthcare system that does not more equitably, consistently, or sustainably support better health. Their stories and perspectives highlight the urgency to reimagine and rebuild primary care to support better health in all communities. To put a fine point on it, the shortage of primary care across rural and underserved, urban and small-town communities is linked to shorter life spans and the aggregate loss of 85 lives *per day* compared to communities where primary care is more available—and this costly loss of health and life was calculated *before* the COVID-19 pandemic.

According to NASEM, primary care is the only part of health care where an increased supply is associated with better health and more equitable outcomes for our nation.

These are facts. Facts that make primary care the key mechanism to further better health now for our nation.

And that is the banner under which we have all come together, in this new **Better Health — NOW** campaign. We call on the Executive Branch and Congress to act now on the NASEM report's first recommendation: **reforming how we pay for primary care and investing more in primary care so that every community can achieve better health**

PCC Concordance Recommendations

1. **Invest in what works: primary care.**
2. **Pay for what we want – better health.**
3. **Reduce economic and social barriers to better health.**

Consider Signing onto CR:

https://www.pcpcc.org/concrecs

primary care collaborative

Policy Building Blocks: Consistent w/Concordance Recommendations

Pivot resources to primary care

Behavioral Health Integration Proposal

Pay for better health

- Considering hybrid payment within Medicare Shared Saving Program (MSSP)
- 7.15.22 Health Affairs Blog

Reduce barriers to better health

- Medicaid RFI
- Equity Brief with NCPC/Morehouse School of Medicine

Payment Alignment is Critical

- CMMI PC models demonstrate that public and private model alignment is critical for success
- Multi-payer geographic concentration is key e.g., CA, MI, WI
- An agreed upon, limited set of performance measures is n
- It's a long game but the evidence shows you will have succ

Better Health NOW

To Learn More
https://www.pcpcc.org/betterhealthnow

To Join Us, Contact:

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To continue our Conversation:

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Twitter: @AnnGreiner1

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.*

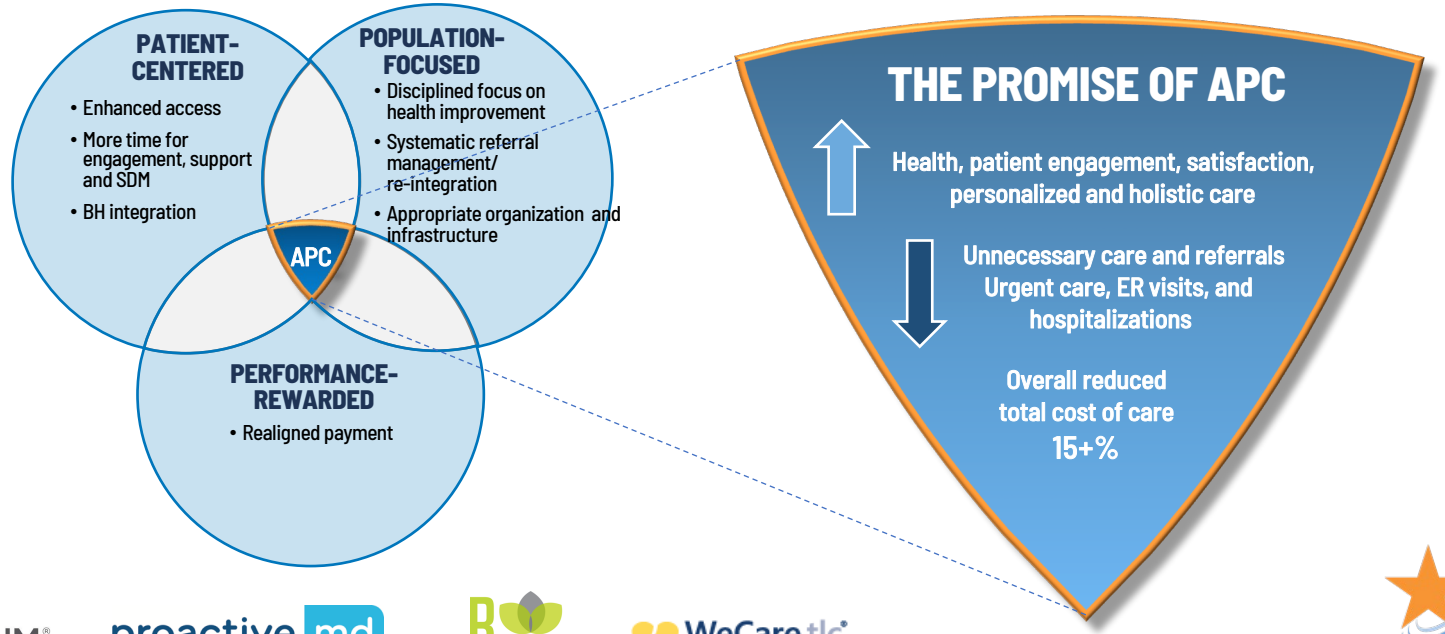
**MEPS (2014) reported by Robert Graham Center (2018)*

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



Catalyst HEALTH NETWORK · OPTUM® · proactive md · R health Care is Primary® · WeCare tlc Healthcare At Work

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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

Discussion

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Upcoming Webinars and Meetings

- **5 Tenets to Managing Health in an Uncertain "VUCA" Environment**
  August 17, 1 p.m.-2 p.m.

- **2022 Annual Forum: November 7–9 (Call for speakers open until August 5!)**

All times are ET

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