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

ACHIEVING VALUE THROUGH ADVANCED PRIMARY CARE

A Deep Dive Powered by eValue8™

APRIL 2020

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Primary care has always been a cornerstone in supporting patients and delivering value for our health system. But over the years, its overall effectiveness and impact have suffered due to misaligned reimbursement strategies, lack of care coordination, and infrastructure limitations. This has 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 primary care model, healthcare 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. Despite these challenges, there is a growing body of research showing better health outcomes and lower healthcare costs are strongly linked to the use and availability of primary care physicians and in areas of the country where there are more providers per person, death rates are lower and people are less likely to require hospitalization[1]. Because of this, there is a serious business case to move toward a more integrated model that delivers high quality care to patients and allows physicians to obtain better performance and outcomes. In fact, a number of providers and provider organizations are doing just that — providing "advanced primary care" — with clear benefits accruing to their patients. In addition, these innovative models have had a dramatic impact on overall healthcare costs and trends. This report provides an overview of a process led by the National Alliance of Healthcare Purchaser Coalitions (National Alliance) to define and assess the key attributes of primary care that drive improved overall healthcare value so purchasers will redirect their strategies to optimize and improve the delivery of care to their workforces.

Our Approach

In response to growing interest in primary care by its members and their constituents, the National Alliance undertook a process in the fall of 2019 (eValue8 Deep Dive) to better understand which attributes of primary care organizations drive superior value to improve health outcomes while mitigating healthcare costs for employers and other plan sponsors. Industry experts, advisors and coalition leaders were consulted and confirmed the identification of seven key attributes of Advanced Primary Care (APC).

Five leading primary care organizations agreed to participate in an assessment of their practices to determine the extent to which they demonstrate the seven identified APC attributes. They deliver primary care to over 1.9 million covered individuals and are served by over 500 primary care practices in over 900 locations. Ultimately, the seven APC attributes were used as benchmarks and real world observations were gathered to help inform which APC strategies are increasingly under development by purchasers and other plan sponsors.

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

The Value of Advanced Primary Care

We define APC as primary healthcare *structured to deliver increased value for both patients* and *purchasers* when it encompasses the seven key attributes: (1) Enhanced Access for patients; (2) More Time with Patients; (3) Realigned Payment Methods; (4) Organizational & Infrastructure Backbone; (5) Behavioral Health Integration; (6) Disciplined Focus on Health Improvement; and, (7) Referral Management.

Primary care is a key cornerstone to any purchaser's healthcare strategy. Based on the numbers alone, it presents a great opportunity not only to initiate early treatments, but also to establish a continuous relationship with patients before, during and after an acute episode or in management of chronic conditions. Over 80% of patients with common chronic conditions (diabetes, high blood pressure, asthma) access primary care[2] and it is the most common gateway for downstream referrals to specialists and other healthcare providers.

Advanced Primary Care: Definitions of the Seven Key Attributes

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. The following key attributes can support purchasers to identify areas within their healthcare delivery approach that need to be addressed.

- **Enhanced Access for Patients** – Access to primary care is a critical first step to 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 they need it, (e.g., outside of normal business hours or over the weekend) and without a hefty price tag.
- **More Time with Patients** – When physicians can spend more time with individuals, it encourages better patient engagement, improves identification of social determinants that can impact their health and underpins continuity of care over time. APC practices need to overcome communication challenges so that patient needs and preferences can be incorporated into treatment plan development and continuity of care.
- **Realigned Payment Methods** – Realigned payments need to support and incentivize patient activation, case and care coordination, and accountability for health outcomes as well as downstream referrals.
- **Organization & Infrastructure Backbone** – Organizational infrastructure (Leadership, training, commitment to quality improvement (QI), staff and IT) is the backbone of primary care practice and is an overarching driver of APC and patient satisfaction. In many ways it is foundational to support a provider practice to move toward and sustain APC.

2 Medical Expenditure Panel Survey (MEPS), 2014, reported by Robert Graham Center (2018), p. 16.

- **Behavioral Health Integration** – Integration of behavioral health capacity in primary care is no longer a "nice to have" — it is an essential ingredient of APC if it is to deliver "whole person health." When contracting for APC services, the extent to which the organization or practice has systematically integrated appropriate tools and processes is critically important.
- **Disciplined Focus on Health Improvement** – A focus on health improvement requires an understanding of population risk factors and a strategy to focus resources where they will drive the greatest improvements.
- **Referral Management** – The process of referring appropriate patients to another healthcare provider or service — hospital, specialist, lab, imaging center, physical therapist — is a critical step in the influence of primary care on the cost and quality of downstream medical care.

Recommendations for both purchasers and health plans are available within the body of the report under each of the above areas.

Acknowledgments

We want to thank the organizations that participated in this process. They are all leaders in this movement. The five are:

- Catalyst Health Network
- R-Health
- Take Care Health/Premise Health
- WeCare TLC
- Optum

This report highlights how these organizations collectively are currently performing against our recommendations for purchasers to use when implementing an APC strategy.

INTRODUCTION

About this Report

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) seeks to drive health and healthcare value, a mission that cuts across all aspects of our healthcare system. One of its key Initiatives brings a focus to *primary care* — an important delivery modality that also spans the entire spectrum of our healthcare system. Purchasers have long recognized its importance in their overall healthcare planning and generally have focused on offering a modest cost sharing to ease access to primary care visits. As purchasers demand more value across all aspects of their healthcare strategy, they are questioning their primary care delivery approach. For those that have implemented high deductible health plans (HDHPs), they are questioning their benefit coverage strategy (e.g., whether subjecting primary care to a high deductible makes sense) to improve value for their employees.

The value of primary care today is generally underrated and, if properly structured and reimbursed, can provide far more value.

To answer these questions, the National Alliance conferred with industry experts and advisors, including its member coalitions across the country. These coalitions represent 12,000 employers/purchasers and 45 million Americans spending $300 billion annually on healthcare. These conversations quickly concluded that the value of primary care today is generally underrated and, if properly structured and reimbursed, can provide far more value. They concluded that "high-value" primary care, "Advanced Primary Care" (APC), has seven key attributes that drive superior value to improve the health of patients while mitigating healthcare costs for employers and other plan sponsors. In the fall of 2019, the National Alliance engaged five leading primary care organizations across the country through its eValue8 Deep Dive process to better understand the extent to which they exhibited the seven key attributes of APC.

The balance of this report details the results of this assessment and identifies what purchasers and health plans should take into account when considering an APC strategy.

Why Investment in Primary Care is Important

Even though primary care physicians make up less than one-third of all office-based, direct patient care physicians, they provide two-thirds of all non-surgical physician office visits.[3] Simply stated, primary care is the type of healthcare many people receive most of the time, typically from primary care physicians (PCPs).[4] Based on the numbers alone, primary care presents a great opportunity not only to initiate early treatments, but it also inherently establishes a continuous relationship with patients before, during and after

3 Robert Graham Center, The State of Primary Care in the United States: A Chartbook of Facts and Statistics, 2018, p.13.

4 Primary Care "Specialties" comprise Internal Medicine, Family Practice, OB/GYN and Pediatrics

U.S. 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.

Source: Annals of Family Medicine, www.annfammed.org, Vol. 2, Supplement 3, November/December 2004

treatment, and this is highly beneficial for acute episodes as well as the management of chronic conditions.

Research is also showing that better health outcomes and lower healthcare costs *are strongly linked* to the use and availability of primary care and in areas of the country where there are more providers per person, death rates are lower and people are less likely to require hospitalization. No matter how important it may be to promptly and efficiently address a current or chronic care need, there is broad evidence that a holistic view of the patient developed over time can detect social and behavior determinants of health and encourage behavioral and environmental changes to improve health outcomes and mitigate costs.

Advanced Primary Care and COVID-19

Six of the seven attributes of the Advanced Primary Care (APC) approach have been mapped out below to show high value and quality of care during the current COVID-19 environment.

Enhanced Access

- Provides multiple modalities of care when face-to-face option is restricted (text, email, online portal; should be equipped with virtual visit options
- Supports easy access to assess new symptoms informed by strong relationship and knowledge of patient's history
- Supports active management of chronic conditions
- Supports referral when appropriate

More time with patients

- Complete medical history and documentation of Social Determinants of Health (SDOH) is in the Electronic Medical Record (EMR)
- Can use SDOH to identify patients who need more social or community support to meet basic needs—food, management of children at home
- More complete information supports data mining to identify patients with specific risks
- Trusted source of information customized to the patient's needs and conditions

Organization and Infrastructure Backbone

- Offers a complete medical record and IT tools
- Supports risk stratification and identification of high-risk patients—can support public health efforts
- Allows communication of medical history for those who need acute hospital care
- Triggers follow up of chronic conditions or of recent acute care the absence of scheduled office visits
- Coordinates information with local public health authorities and resources

Disciplined Focus on Health Improvement

- Supports identification of those who should have priority for early testing and interventions
- Supports trusted, targeted messaging to patients who need more aggressive efforts to avoid exposure
- Provides patients with information about medicines and supplies

Referral Management

- Trusted source of reassurance and/or referral
- Aware of community resources such as testing sites and specialists

BH Integration – APCs have BH capabilities

- Using the patient record, APCs can identify people who may need outreach to assess BH needs
- APCs have multiple methods of connecting with patients to support ongoing treatment of BH conditions
- BH staff proactively provide resources to patients and families to manage and avoid stress

THE DETAILED RESULTS

Enhanced Access for Patients

Timely and affordable access to primary care is important because it facilitates early intervention, eliminates need for use of other sites of care (e.g., emergency rooms), encourages appropriate monitoring of chronic conditions and limits lost time from work. Insufficient access can result in morbidity due to delays in receiving necessary care or costly increases in lost time from work. For patients, enhanced access to primary care includes care when they need it, (e.g., outside of normal business hours or over the weekend) and without a hefty price tag.

What We Found

There was widespread agreement among the participants that "excellent access" is a critical success factor for APC.

- All reported that they offer ***same-day*** and ***walk-in appointments*** and ***weekend and extended weekday hours*** to enhance patient access. In addition, the majority offer ***phone and virtual visits***.
- While most had set access standards for urgent and routine appointments, many did not monitor if these standards were being met.

Recommendations

Purchasers or health plans seeking to implement APC should assess and monitor:

- The extent to which potential APC providers set, measure and meet standards for access to urgent and routine primary care appointments, including number of hours or days until the appointment occurs and waiting room times.
- A primary care organization's availability after normal business hours and during weekends to mitigate the need for unnecessary use of emergency room and urgent care facilities.

More Time with Patients

Physicians' spending more time with individuals encourages better patient engagement, improves identification of social determinants that can impact their health, and underpins continuity of care over time. With sufficient time, a PCP or care team member can:

- Gather a complete medical history, including mental health status
- Gather information about a patient's exposure with specific social determinants of health (SDOH)
- Educate the patient about their diagnoses
- Develop a realistic care plan
- Develop a trusting relationship
- Engage the patient's supporters
- Schedule appropriate follow up either in person or virtually
- Schedule referrals as appropriate

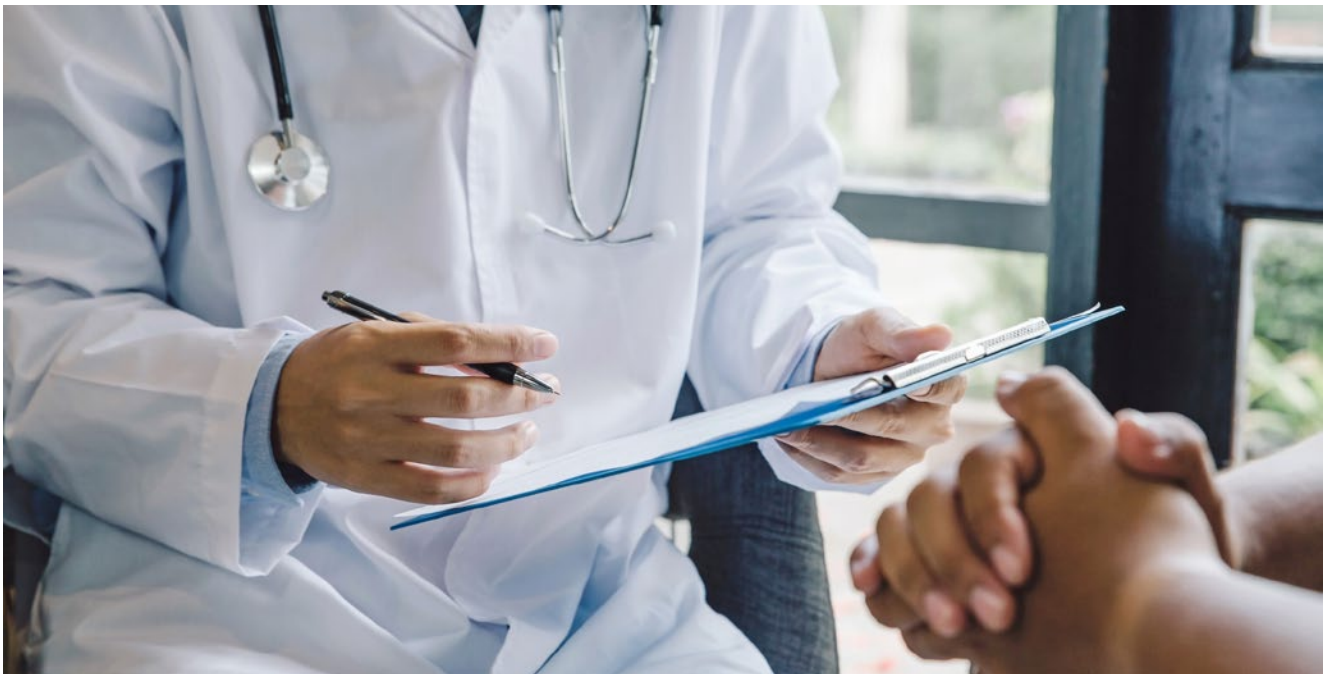
These steps can improve the value of primary care, help curtail unnecessary testing, avoid unnecessary visits to the emergency room, and help improve overall long-term outcomes. In addition, patients who understand their health issues and various options for care can better participate in care-related decisions and are more likely to be satisfied with their care.[5]

Treatment Planning for Chronic Conditions is Critical

- Shared care and treatment planning (e.g., medication plan, diet/exercise, and action steps to address problems) take quality face-to-face time
- APC practices include resources that address the "total person" and treatment plans should be developed with the patient
- May include engagement with other healthcare providers, e.g., BH specialists, educators or referral to various education programs, all to complement the treating physicians.

Few participants reported that they:

- Review potential costs with the patient
- Provide patient with questions for their insurer
- Use patient decision aids



5 Suh WS, Lee CK., J Prev Med Public Health. 2010 Jan;43(1):26-34. doi: 10.3961/jpmph.2010.43.1.26.

What We Found

Most participating organizations identified "more time with patients" as a key success factor for delivery of primary care and indicated that one way they encouraged this was by limiting the number of patients seen by PCPs in an average day. As one said, this allows doctors to be "truly listening" and can therefore develop a more "meaningful relationship."

A barrier cited by many was not being paid for spending "the necessary amount of time" with patients; to be adequately compensated, most incorporated provisions in their contracts to allow more time with patients. In addition, most used one or more of the following techniques to engage their patients:

- Elicit member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.)
- Discuss treatment/condition, i.e., symptoms, stages of disease, and expectations/trade-offs from treatment
- Review information about what the decision factors are with their condition and/or circumstance
- Review benefits and risks
- Review likely condition/quality of life if no treatment
- Call patient's health plan to review details while patient is in the office
- Discuss patient's or caregivers' role or responsibilities

Recommendations

APC practices should engage with patients so that patient needs and preferences can be incorporated into treatment plan development and continuity of care. Purchasers or health plans should ask:

- How APC practices ensure patient engagement, including metrics (e.g., average duration of visits).
- How practices approach and measure treatment plan development and follow-up care.
- That the following three metrics[6] be incorporated into patient follow-up assessments to support continuity of care:
  1. How much effort was made to help you understand your health issues?
  2. How much effort was made to listen to the things that matter most to you about your health issues?
  3. How much effort was made to include what matters most to you in choosing what to do next?

6 These three questions are based on the CollaborRATE questionnaire described in: Elwyn G, Barr PJ, Grande SW, Thompson R, Walsh T, Ozanne EM. Developing CollaboRATE: a fast and frugal patient-reported measure of shared decision making in clinical encounters. Patient Educ Couns. 2013;93:102-107.

Realigned Payment Methods

In a traditional fee-for-service (FFS) model, healthcare 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. Realigned incentives can encourage better patient activation, improved case management and care coordination, accountability for health outcomes, and follow-up with downstream referrals.

What We Found

While all responding organizations agreed with the premise that APC can deliver increased value, they expressed concern about the *adequacy* of fee-for-service (FFS) payments that typically do not cover *care management services and the patient engagement strategies* necessary to provide APC. All were interested and experimenting with alternative payment methods.

The alternatives to FFS used by most participants were fixed payment methods (e.g., pass-through, total budget, or per employee per month), typically implemented through a ***direct primary care*** contract. In addition, most participants were experimenting with shared risk arrangements.

Participants also differed in the extent to which they experiment with multiple payment methods: one participant reported use of seven different methods, while others only one. Only a few of the participants reported use of these alternative payment methods:

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

While there can be benefits of moving away from FFS, participants noted that alternative payment methods may be limited in the data captured to evaluate primary care utilization and cost. We also noted that use of FFS does not preclude alignment of payment with promoting APC attributes, for example, bonus payments based on measures of quality and/or efficiency.

Whatever payment method is used, purchasers should consider the relationship of the cost of primary care to the total cost of care. Most participants could report this key metric, and the results for those who did varied, probably due to differences in underlying populations and/or operational effectiveness.

RELATIONSHIP OF THE COST OF PRIMARY CARE TO TOTAL COST OF CARE

Reported a range of

6% to **10%**

Direct Primary Care (DPC) Model

A practice and payment model where patients/consumers (or purchasers) directly pay their physician or practice in the form of periodic payments for a defined set of primary care services.

— American Academy of Family Physicians

Recommendations

Purchasers and health plans should consider payment methods that encourage APC by:

- Aligning reimbursement levels and incentives to more appropriately support the attributes of APC, e.g., convenient access, more time with patients, development and execution of comprehensive treatment plans, behavioral health integration, disciplined focus on health improvement, and referral management.
- Including in any APC payment method, an assessment of the extent to which the cost of primary care delivers a reduction in the total cost of care (TCC).

Organization and Infrastructure Backbone

Organization and infrastructure constitute the backbone of primary care practice and represent the overarching drivers of APC and patient satisfaction. In many ways it is foundational to support a provider practice to move toward and sustain APC. Leadership, training, commitment to quality improvement (QI), staff, and IT are needed to transform practices into APC practices and maintain quality of care delivered.

Electronic medical records (EMR) accessible by all treating providers and by patients are fundamental to APC; however, APC's need for technology goes far beyond EMR. Data analytics fostered by technology investment enable APCs to:

- Mine data to identify gaps in care and inform practice operations
- Stratify the population by risk
- Assess cost effectiveness of care
- Generate data for feedback and alerts for each provider

APCs also need proficiency integrating their own systems with multiple platforms — internet, cellphone, landline — to enable:

- Communication with patients through the EMR system to share test results
- Scheduling appointments and requesting prescription refills
- Sending reminders to patients
- Supporting virtual visits
- Ability to perform some or all of these tasks using cellular data (i.e., no internet connection)

What We Found

The good news is that most participants reported that nearly 100% of their patients' medical records were in EMRs, accessible to all providers and this extensive access to EMR enabled not only QI reporting, but also tracking patients and care coordination metrics.

Beyond EMRs, QI and its place in the organization, should enter into any assessment of value in primary care. Purchasers should ask how practices monitor quality and quality improvement to close gaps in care. As shown in Exhibit 1, participants varied considerably in the quality metrics they collect. Practices typically shared QI feedback with a broad cross-section of staff, but not with behavioral health practitioners.

It's hard to manage what isn't measured. For example, all participants reported offering same day, walk-in, extended weekday and weekend appointments, but not all track their use. (See Exhibit 2)

Monitoring care coordination is particularly important when a patient receives care outside of the primary care practice, for example, for a visit to the emergency room or the inpatient services of a hospital. Participants' standards for follow up and compliance with standards varied considerably:

- Standards for patient follow up after an ER visit ranged from within 24 hours to 48 hours and compliance with those standards tracked in a range of 33% to 100%

- Standards for patient follow up after a hospital stay ranged from within 24 hours to 30 days and compliance ranged 34% to 100%

Whereas visits to the ER and hospital stays are important examples, perhaps the most important is the most frequent navigational challenge for patients—planned referral management, which is discussed later in this report.

Exhibit 1. Quality Improvement Metrics Reported by Participants

MOST FREQUENTLY USED

- Meeting access standards
- Meeting quality threshold
- Health IT adoption or use
- Utilization results

LESS FREQUENTLY USED

- Quality improvement over time
- Quality compared to peers
- Patient experience
- Reducing waste/inappropriate use
- Longitudinal efficiency relative to target and/or peers
- Financial results
- BH integration
- Pharmacy management
- Care coordination

RARELY USED

- Patient safety (e.g., Leapfrog, AHRQ, medication related safety issues)
- Application of specific APC practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)

Exhibit 2. Monitoring Access Metrics

APPOINTMENT TYPE	TRACKED?
Same Day	
Walk-in	
Extended Weekday	
Weekend Hours	
Phone	
Virtual	

The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program. 

Recommendations

Purchasers and health plans should:

- Determine appropriate metrics for identifying additional training needs.
- Ensure that organization has capability to track/monitor performance against metrics.
- Assess and monitor quality improvement metrics and determine accountability tactics to implement if metrics fall below agreed upon range.
- Assess the adequacy of practices' staffing as a ratio to population served for: primary care physicians, nurse practitioners, physician assistants, and behavioral health specialists (the latter on-site or virtually).
- Assess the extent to which the organization measures and manages to key APC attributes identified in this report or which the practices otherwise highlight in their proposals; emphasis should be given to measurement of the impact of primary care on the total cost of care.
- Evaluate the technology in place to ensure it supports risk stratification, identifies gaps in care, measures cost, and improve outcomes.
- The extent to which the organization and its technology infrastructure systematically measures and manages key APC attributes identified in this report.

Behavioral Health Integration

There continues to be widespread concern among purchasers and purchaser coalitions across the country about several issues impacting access to behavioral health specialists.[7] This includes the quality and management of patients with mental health and substance use issues by both primary care and behavioral health specialists. In general, primary care clinicians provide the majority of behavioral healthcare rather than mental health or substance use specialists 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. In addition, screening for all illnesses, including mental health conditions, occurs solely in the general medical system and common mental health conditions are not identified at a similarly disappointing rate. As a result, early intervention in the life cycle of common conditions, like depression and anxiety, is not possible and this contributes to poor outcomes for people living with these and related conditions.

What We Found

Participants demonstrated some attributes of behavioral health integration (BHI), for example, we observed that standards set for urgent behavioral health visits were the same as for urgent medical visits for the majority of organizations that reported both. That said, there were disparities apparent with respect to access to routine appointments (Exhibit 3).

Most reported the percent of patients where BH consult (internal/external) occurred and for those who reported, the range was 7%–34%.

We also observed differences in the extent to which tracking preventive services varied *within* the behavioral health space. In contrast to tracking of preventive services (Exhibit 4), monitoring selected key screening services recommended by authoritative sources[8] showed consistency, but in the wrong direction; no participant monitored:

- Depression remission after 6 months
- Depression progress toward remission — 6 months
- Screening for clinical depression and follow-up Plan
- Initiation and engagement of alcohol and other drug dependence treatment

Exhibit 3. Behavioral Health vs Medical Access to Appointments

APPOINTMENT TYPE	AVAILABLE FOR MEDICAL CONCERNS?	AVAILABLE FOR BH CONCERNS?*
Same Day		
Walk-in		
Extended Weekday		
Weekend Hours		
Phone		
Virtual		

* Note: One participant, reflected in Exhibit 3 as not having availability of appointments for BH Concerns reported: "BH is not consistently provided. Offering these services is core to our practices in several areas of the country which are actively being evaluated for expansion opportunity as best practice."

7 National Alliance of Healthcare Purchaser Coalitions, *Achieving Value in Mental Health Support; a Deep Dive Powered by eValue8,* August, 2018

8 National Quality Forum (NQF), Minnesota Community Measurement (MNCM), Centers for Medicare & Medicaid Services (CMS), or National Committee for Quality Assurance (NCQA)

We also noted that the availability of the following services across participants was basically the same for medical and behavioral health services:

- 24/7 Nurse on-call line-incoming calls*
- 24/7 Non-clinical staff on-call line-incoming calls*
- Online chat feature support or similar interactive feature*
- Mobile app text inbound messaging support

*includes services provided by health plans with a "warm" connection

The final element of BHI pertained to provision of emotional and psycho-social support. To end on a positive note, participants reported more attention to BHI with respect to "processes or systems in place to support patients who need emotional and psycho-social support," (though not on a specifically specialized basis) as shown in Exhibit 5 below:

Exhibit 5. Meeting Emotional and Psycho-social Support Needs

SUPPORT SERVICE PROVIDED*	DIRECTLY PROVIDED?
24/7 nurse on-call line for incoming calls	
Proactive care team outreach to assess the member's compliance to prescribed regimen	
24/7 pharmacist on-call line for incoming calls	
24/7 masters social work (MSW) or higher level BH specialist on-call line for incoming calls	
Online chat feature support or similar interactive feature	
24/7 non-clinical staff on-call for incoming calls (is this psycho-social?)	
Mobile application text inbound messaging support	
Transportation	

* Excludes responses indicating that they "can provide" or that they "provide through insurer" or that they provide, but not 24/7

Exhibit 4. U.S. Preventive Services Task Force Recommended Preventive Services

PREVENTIVE SERVICE	TRACKED?
Alcohol misuse: screening	
Depression screening at each visit: adolescents (12–18)	
Alcohol misuse: counseling	
Depression screening at each visit: adults	

Recommendations

APC attributes should apply equality to medical and behavioral health conditions. To this end, purchasers should:

- Review the primary care practice's metrics discussed in this report split between "medical" and "behavioral health" and, if there are differences, seek explanations for the differences and establish timelines for remediation.
- Assess the organizations' current and planned programs for Improving Behavioral Health quality and performance that includes:
  - Promoting early behavioral health identification and intervention by evaluating the tools practice use to accomplish these objectives
  - Measuring behavioral health performance including accountability metrics
  - Integrating mental health within total health and wellbeing strategies
  - Systematic referrals and follow-up of patients to specialists where appropriate

Disciplined Focus on Health Improvement

A focus on health improvement requires an understanding of a population's health risk factors and a strategy to focus resources where they will drive the greatest health improvements. The process starts with a systematic analysis and stratification of the overall population, both those in the healthcare system as well as covered members who are not ill or injured. Organizations that take this disciplined approach to improve the health of their population have an interest in understanding how a primary care practice undertakes risk stratification and provides screening and prevention services.

What We Found

All participants conducted risk stratification using methodologies ranging from a handful of discrete, plausible indicators to proprietary risk stratification systems. There was a broad range observed — from real-time to annual — of the frequency of this risk stratification. There were also substantial variations in the extent to which participants followed up on risk stratification results by screening for known risks and complying with professionally accepted preventive measures.

Given the attention paid in recent years to diabetes, high blood-pressure, and obesity in adults, it was not surprising that all participants reported that they monitored the United States Preventive Services Task Force (USPSTF) recommended screening services for these conditions. Additional conditions for which the majority — but not all — of participants said they monitor USPSTF recommended screening included:

- Tobacco use screening, counseling and interventions: non-pregnant adults and pregnant women
- Obesity counseling/referral to counseling: adult

Participants generally were limited in actually *reporting* what they said they did; for example, even though all participants reported monitoring high blood pressure and obesity, not all were able to report specific rates of compliance. Additional USPSTF metrics for which monitoring lagged are shown in Exhibit 6.

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.

Source: American Academy of Family Physicians

Exhibit 6. Screening and Prevention Interventions Monitored by 50% or fewer of Participants

- Obesity screening: children >= 6
- Obesity counseling/referral to counseling: children>= 6
- Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors
- Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk
- Hepatitis C virus infection screening: adults at higher risk)
- BRCA risk assessment and genetic counseling/testing
- Hepatitis B screening: pregnant women
- HIV screening: nonpregnant adolescents and adults
- HIV screening: pregnant women

Recommendations

To assess the extent to which primary care practices have incorporated this critical attribute into their organizations, purchasers and health plans should assess:

- The frequency of risk stratification—identifying subpopulations with high health ROIs—undertaken by the practices and the comprehensiveness of the factors they use (e.g., age, gender, presence of chronic diseases).
- The extent to which the practices successfully engage patients identified as high-risk or otherwise warranting focused care management.

Referral Management

Referring a patient to another healthcare provider or service — hospital, specialist, lab, imaging center, physical therapist — is a critical step in the influence of primary care on the cost and quality of downstream medical care. On average, primary care represents less than 10% of total healthcare costs, yet it is generally the first step patients take when entering the healthcare system.

To the extent that referrals are to *high-value* destinations, primary care can make a substantial contribution to an overall population health approach and improve the quality of care. It can also mitigate the total cost of care by driving more targeted appropriate and high-quality referral practices, and coordination and reintegration of patient care. APC practices should select specialist and hospital referral destinations based on their high-value performance.

The most common specialties to which participating primary care practices refer are:

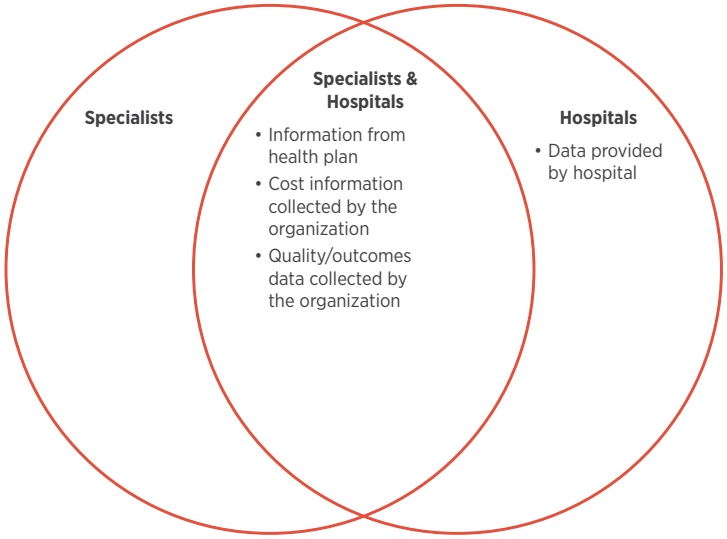
- Gastroenterology
- Cardiology
- Orthopedics

What We Found

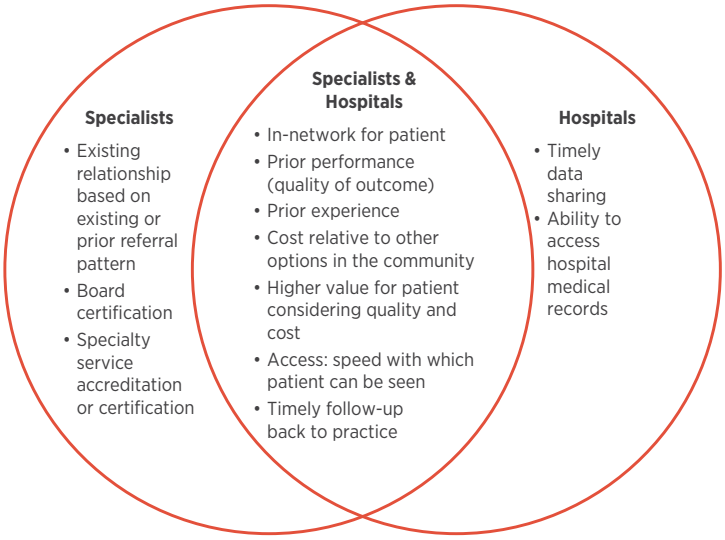
Generally, participants have similar, specific criteria and sources of information to support the selection process. Results showed:

- All practices consider in-network status, prior performance, timely follow-up back to practice, cost, and value when referring to specialists or hospitals.
- Only half participants consider the availability of a shared data platform when selecting hospitals or specialists.
- One participant reported business coalitions as a source of information for selecting hospitals.

Information Sources for Evaluating Referral Sources



Selection Criteria for Referrals



Recommendations

Purchasers and health plans should evaluate and support primary care practices in referral management by:

- Assessing the criteria and data primary care organizations use to identify and refer to outside physicians, hospitals and other healthcare providers (e.g., in- vs. out-of-network, past experience with timely return of referral report, and cost-effectiveness).
- Review the extent to which the primary care practice refers out services and procedures that often can be done by their own practitioners, such as:
  - routine GYN care
  - management of common conditions such as dermatology, allergy, and musculoskeletal
  - ongoing care of patients with diabetes vs referral to an endocrinologist all of their care instead of just a periodic consult

National Alliance
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The National Alliance of Healthcare Purchaser Coalitions is a nonprofit network of business coalitions, representing more than 12,000 purchasers and 45 million Americans, spending more than $300 billion annually on healthcare. The National Alliance is dedicated to driving innovation, health, and value along with its coalition members through the collective action of public and private purchasers. To learn more, visit nationalalliancehealth.org or connect with us on Twitter or LinkedIn.

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Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks and a roadmap for improvement. Plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and ultimately, improve health and quality of care.

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4/20