PRIMARY CARE COLLABORATIVE

SEPTEMBER 5, 2018

OVERVIEW DR. GREENGLASS

- Address reimbursement for primary care services
- Reduce the administrative burden of practices
- Reduce the fragmentation of the system and improve communication across providers.
- Facilitate centralized services for patients
- Provide expertise and facilitation for clinicians to share
- Institute tort reform to remove the financial and emotional specter of malpractice
- Provide financial incentives for young physicians to enter primary care in DE
- Focus on the roles of nurse practitioners, physician assistants and community health workers

DISCUSSION OF WORK TO DATE

- Provider Roundtable
- Consumer Roundtable
- Driver Diagram
- Practice Transformation
- Behavioral Health Integration

PROVIDER ROUNDTABLE

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- A convening of primary care provider stakeholders to discuss the challenges and opportunities for primary care in Delaware
- June 19, 2018, 5:30-7:30 pm
- Participants were identified and invited by HCC and DCHI
- DCHI facilitated the discussion – gathering information from the participants and from the general audience which included other providers and stakeholders.

ATTENDEES

- Providers and other health system stakeholders including representatives from these organizations:

Represented Organizations	
American Cancer Society, Primary Care Systems	Delaware Valley Outcomes Research
American Psychological Association, Center for Psychology and Health	Highmark, Provider Contracting
Christiana Care, Family Medicine	Jefferson School of Medicine (DIMER)
Delaware Academy of Medicine	Mid-Atlantic Family Practice
Delaware Academy of Physician Assistants	Nanticoke Health Services
Delaware Center for Health Innovation	United Medical, Contracting
Delaware Health Care Commission	Westside Family Healthcare

KEY THEMES FROM THE PRIMARY CARE PROVIDER ROUNDTABLE

What we heard:

- Primary care physicians are adopting new practice models
- New payment models can increase investment in primary care
- An inadequate number of medical students are choosing to enter primary care
- Physician assistants (PAs) and advanced practice nurses (APNs) face barriers in contributing to the primary care workforce
- Administrative requirements are a significant burden to primary care providers and they impact productivity, quality of life and practice models.

PRIMARY CARE PHYSICIANS ARE ADOPTING NEW PRACTICE MODELS

- PCMH functionality is important, but formal certification* has little value.
  - If certification is required, then it needs to be simpler, less expensive, and financially recognized by payers.
- The trend toward higher patient co-payments and deductibles for primary care services translates into patients wanting all of their issues addressed in a single visit, putting more strain on the primary care provider.
- Primary care physicians who switch to concierge or direct patient care are seeking a model with less administrative burden. This is a primary driver for these physicians.
- The viability of small independent practices is uncertain.

NEW PAYMENT MODELS CAN INCREASE INVESTMENT IN PRIMARY CARE

- Adopting alternative payment models may be a way to increase payments to primary care, but the administrative burden must be minimized.
- Increasing payments in primary care is a long-term investment, although some stakeholders (payers, consumers, employers) want to see short-term returns.
  - *Some roundtable participants advocated for increased FFS payments in the near term. Participants were not in agreement on this issue.*
- In order to engage primary care physicians, value-based payment needs to include a significant upfront PMPM payment.
- Payments for care coordination need to be substantial and should be seen as investments.
- The administrative burden associated with quality metrics has become untenable without clear improvements in patient outcomes or sufficient reimbursement for the additional administrative work.

AN INADEQUATE NUMBER OF MEDICAL STUDENTS ARE CHOOSING TO ENTER PRIMARY CARE

- Students accumulate school debt and are concerned about the financial outlook of entering primary care compared to a higher paying specialty.
- Students entering primary care are looking at health systems or large provider groups as the small independent practice model no longer seems feasible from an economic or quality of life perspective.
- Loan forgiveness programs may incentivize more students to enter primary care.
- To ensure students are prepared to enter primary care, training should incorporate population management under value-based payment models, the business of running a practice, and team-based models of care.
- Foreign medical graduates are a potential source for the primary care workforce, but may lack access to residency programs.

PA'S AND APN'S FACE BARRIERS IN CONTRIBUTING TO THE PRIMARY CARE WORKFORCE

- Physician assistants (PAs) are more likely to work with specialists as it entails a narrower scope of practice.
- PAs find it challenging to find primary care physicians who can afford to hire PAs. Hospital systems seem more inclined to hire APNs.
- PAs are not recognized in Delaware as rendering providers so their services cannot be billed separately. As a result, their contribution to primary care can be overlooked.
- Although lower cost upfront, PAs and APNs may generate more referrals to specialists, increasing overall costs.
- PAs and APNs both would benefit from additional training after graduation, like a residency program, to ensure they are prepared to serve the complexity and diversity seen in primary care practice.
- The residency program at Christiana has been popular and is expanding.

RECOMMENDATIONS OF THE ROUNDTABLE PARTICIPANTS

Primary care physicians are adopting new practice models

- Create a PCMH certification in Delaware that is simpler and less expensive
- Address comprehensive insurance reform that targets the financial liabilities, unpredictability, and burdens that makes running a primary care practice unsustainable

Payment reform can increase investment in primary care

- Increase payments to primary care accounting for the administrative and care coordination work that is required in new models
- Standardize quality metrics across payers and ensure these metrics are clinically meaningful and associated with improving patient health

Few medical students want to enter primary care

- Consider loan repayment for new graduate PC providers to work in HPSA areas
- Provide training in medical school preparing student to run a business
- Increase primary care residency opportunities for foreign medical graduates

PAs and APNs face barriers in contributing to the primary care workforce

- Provide residency training opportunities for PAs and APNs
- Change state law to recognize PAs as "providers"

CONSUMER ROUNDTABLE

CONSUMER ROUNDTABLE

- A convening of consumer advocates to discuss the patient experience when seeking out and engaging with primary care providers
- June 19, 2018, 1:30 – 3:30 pm
- Attendees: A range of consumers, patient advocates, and stakeholders including representatives from:

Represented Organizations	
AARP of Delaware	Leukemia and Lymphoma Society
American Cancer Society, Primary Care Systems	Mental Health Association in Delaware
Christiana Care, Patient and Family Centered Care and Resource Management	Wilmington Health Planning Council
Delaware Center for Health Innovation	Patient Advocate
Delaware Health Care Commission	Delaware Division of Vocational Rehabilitation
Health Management Associates	University of Delaware

KEY THEMES: CONSUMER ROUNDTABLE – WHAT WE HEARD:

- It is difficult for patients to find a new primary care provider.
- Patients with complex conditions face additional barriers to primary care.
- Communication with primary care providers is inconsistent.
- Convenient care options like retail clinics and urgent care centers provide important access but can contribute to fragmented care.
- Many consumers fall outside the reach of the traditional health care system.

IT IS DIFFICULT FOR PATIENTS TO FIND A NEW PRIMARY CARE PROVIDER

- There is a shortage of primary care providers and geographic disparities in the distribution of providers.
  - Primary care is reimbursed too low to incentivize physicians to stay in practice.
  - APNs can serve as primary care providers.
- Many physicians are leaving practice, retiring, or switching to a concierge model – exacerbating the shortage and forcing more patients to search for a new provider.
- Patients with complex conditions have an even more difficult time finding a primary care provider.

PATIENTS WITH COMPLEX CONDITIONS FACE ADDITIONAL BARRIERS TO PRIMARY CARE

- Patients with mobility impairments lack access to facilities – including basics like scales and exam tables.
- Patients with communications barriers may lack services to ensure they receive appropriately translated care.
- Providers and staff are unsure how to interact with complex patients.
- The burden of coordinating complex care falls to the patient.
- Providers may be unable or unwilling to dedicate uncompensated time to educate themselves on rare complex conditions.

COMMUNICATION WITH PRIMARY CARE PROVIDERS IS INCONSISTENT

- Few primary care providers perform outreach to address gaps in care.
- It can be easier to speak with a provider afterhours than to get through during office hours.
- Most primary care providers have adopted EHRs, but many consumers do not or are not aware they can access their health records.

RETAIL CLINICS AND URGENT CARE CENTERS PROVIDE IMPORTANT ACCESS

- Many consumers are willing to pay more in order to have the convenience of accessing care in this way.
- Records of care are not transferred between retail clinics and primary care providers.
- There is some adoption of telehealth, but barriers include the lack of reimbursement from Medicare.

MANY CONSUMERS FALL OUTSIDE THE REACH OF THE TRADITIONAL HEALTH CARE SYSTEM

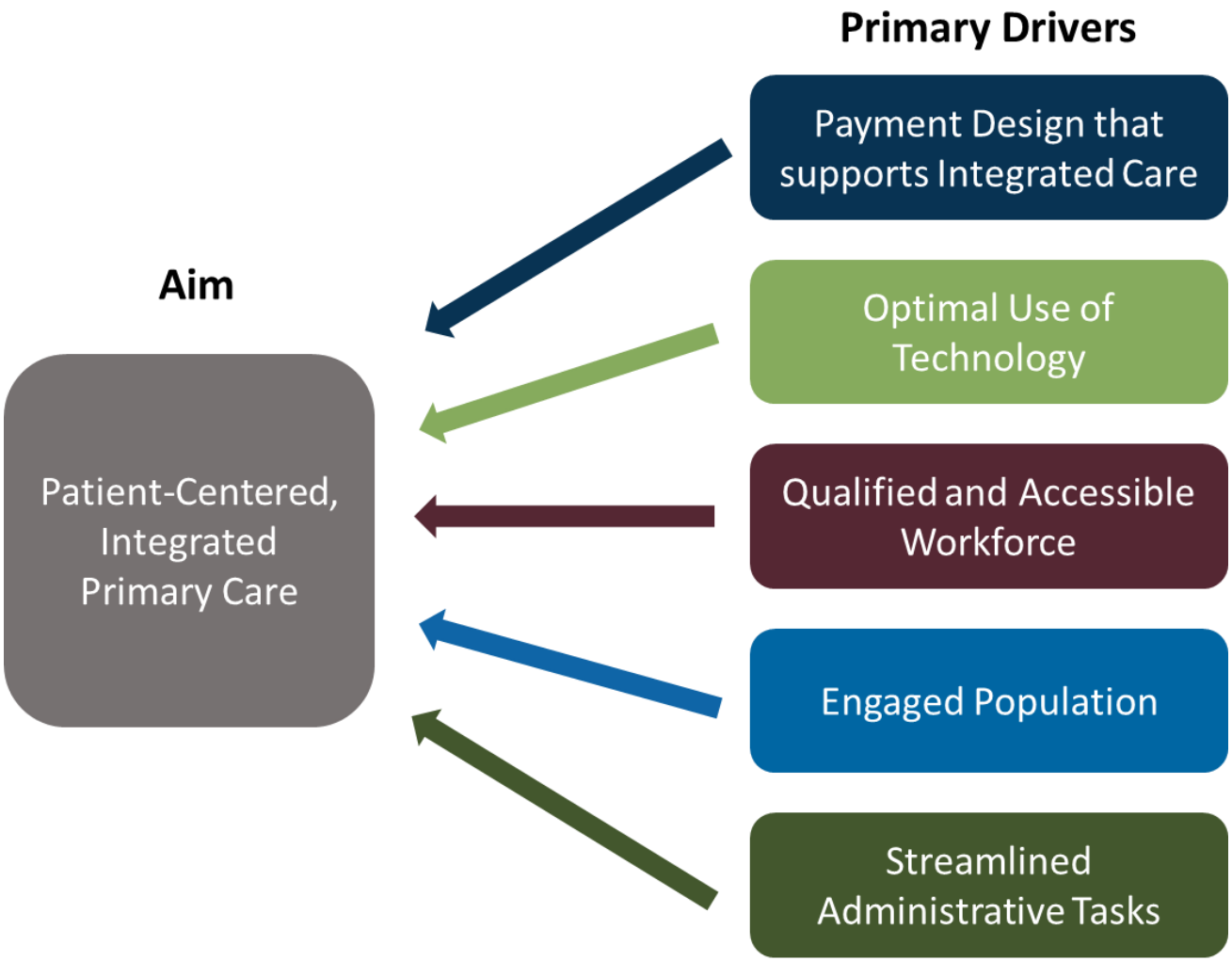
- Many people do not normally access health care at traditional sites of delivery.
- There are financial and structural barriers preventing people for accessing health care.
- Providing access to care that meets people where they are – like community centers – may expand access to health care services.
- Accessing mental health care can be an even greater challenge than accessing primary care.

COMMON THEMES FROM ROUNDTABLES

- Pay with models that support primary care
- Reduce administrative burden for PC providers
- Make it easier for people to practice in DE
- Integrate across the health care system
- Enhance the role of PAs & APNs

PRIMARY CARE DRIVER DIAGRAM

DRIVER DIAGRAM



PRACTICE TRANSFORMATION

DELAWARE PRACTICE TRANSFORMATION

- Under Delaware's SIM grant, practice transformation efforts provided practices with customized coaching and technical assistance
- Practice transformation coaching occurred from September 2016 to April 2018
- 112 practices participated encompassing 250 physicians and 100 mid-levels
- The average length of participation was 17.5 months
- Practices made progress on 9 milestones
  - 2016: 4.0 out of 9 on average
  - 2018: 7.4 out of 9 on average
- Reported barriers included:
  - Time and resources to dedicate to PT efforts
  - Adequate staffing
  - Leadership buy-in/ support
  - Leveraging data/ EHRs

PRACTICE TRANSFORMATION MILESTONES

- Participants were expected to make progress toward 9 practice transformation milestones that are representative of the elements of NCQA's PCMH recognition.

Share of Practices who have Passed PT Milestones, April 2018	
Milestone 1: Identify 5% of the panel that is at the highest risk and highest priority for care coordination	90.5%
Milestone 2: Provide same-day appointments and/or extended access to care	92.9%
Milestone 3: Implement a process of following-up after patient hospital discharge	86.9%
Milestone 4: Supply voice-to-voice coverage to panel members 24/7	96.4%
Milestone 5: Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan	82.1%
Milestone 6: Document plan to reduce emergency room utilization	91.7%
Milestone 7: Implement the process of contacting patients who did not receive appropriate preventive care	84.5%
Milestone 8: Implement a multi-disciplinary team working with highest-risk patients to develop care plans	66.7%
Milestone 9: Document plan for patients with behavioral health care needs	52.4%

BEHAVIORAL HEALTH INTEGRATION

BEHAVIORAL HEALTH INTEGRATION (BHI)

- **BHI work is IN PROGRESS until January 2019**
  - Practices include both primary care and behavioral health/substance use disorder sites and vary in size and complexity of services offered
- The BHI pilot program is divided into two cohorts of practices who receive technical assistance over a six-month period
  - The first cohort - Jan to June 2018 14 practices enrolled
  - The second cohort - July -Dec 2018 28 practices enrolled
    - 28 practices enrolled (all practices from cohort 1 asked to re-enroll)
- **Three tracks:**
  - Fully integrated PC/BH focused on the Collaborative Care model and co-location of services
  - Enhanced referrals- improving referral processes
  - Increasing PC services in BH practices
- Baseline Assessments indicate that 64 percent of the practices will require a high level of transformation efforts to achieve behavioral health/primary care integration

PRACTICE READINESS ASSESSMENT

Evaluation of current BH/PC integration

Practice/Org Leadership Understanding, commitment, involvement	**Practice Team Commitment** Awareness, commitment, confidence	**Practice Functions** e.g., trainings, EHR sophistication, QI experience
Level of Integration In comparison to chosen track	**Screening** Frequency, intensity and standardization of screening	**Treatment** Frequency, intensity, and standardization of treatment