

Medical Home

NEWS

Leveraging PCMH Evidence to Make the Case for Greater Investment in Primary Care

By Ann Greiner and Chris Adamec

The The Patient-Centered Primary Care Collaborative's mission is to promote primary care to achieve the quadruple aim. A key strategy to achieve this mission is the Patient-Centered Medical Home (PCMH) which has been widely adopted across the country. One in five primary care physicians practice in a PCMH where they engage in team-based, collaborative care. Building on our success in spreading the PCMH model, PCPCC is now focused on ensuring that PCMHs and other advanced primary care models have the necessary resources to transform healthcare and that patient barriers to high-value primary care are removed.

The PCPCC's vision of advanced primary care is embodied by the Shared Principles of Primary Care, supported by more than 280 organizations.¹ The Principles, developed in collaboration with Family Medicine for America's Health (FMAHealth), emphasize the need for care to be personal and family centered, continuous, comprehensive and equitable, team-based and collaborative, coordinated and integrated, accessible, and high-value. Achieving this future requires consensus on primary care goals, as well as appropriate payment, investment, training, workforce, and other resources.

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Using the Medical Home to Transform Primary Care Across the Largest Safety-Net Health System in the United States

By Rebecca Miller Dhruv Khullar Kaushal Challa Christina Jenkins Dave A. Chokshi

A strong primary care foundation is widely understood as important for high-value health care systems. Greater use of primary care has been associated with better patient satisfaction, lower costs, fewer hospitalizations, and lower mortality. Recent delivery system reform efforts, including accountable care organizations (ACOs), have focused on primary care transformation to ensure that care is more accessible, coordinated, continuous, and comprehensive.

While the need for a robust primary care foundation is increasingly evident, putting these principles into practice has proven challenging—particularly in safety-net health systems with limited resources. Clinicians and support staff often have engrained workflows, and implementing new initiatives can feel disruptive, unless clinical benefit is immediately apparent. Lack of core infrastructure—especially staff and technology—to support innovation across the entire system can mean many innovations remain local, short lived, or both. In safety-net health systems, high rates of turnover among frontline staff and program management can lead to institutional knowledge deficits and jeopardize program buy-in and sustainability. Finally, it can be difficult to implement separate (sometimes competing) initiatives simultaneously, even as fundamental and widespread changes are needed.

Developing, deploying, and diffusing new primary care initiatives requires coaching, training, investment, and change leadership. We present key challenges and lessons learned from ongoing primary care transformation efforts across NYC Health + Hospitals, the nation's largest public health care system.

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States often lead in tackling real-world problems – including strategies to make primary care more robust and patient centered. Oregon is one of the state innovators that provide crucial lessons to inform our national conversation about how to achieve patient-centered, team-based and high value primary care.

Oregon Tackles the Challenge of Underinvesting in Primary Care

Estimates indicate that the percentage of healthcare spending devoted to primary care in the United States ranges between 5.8 and 7.7 percent, with wide variation² and no standardized definition about how to calculate this investment. High-performing systems, both domestically and internationally, invest approximately double the U.S. estimate, and achieve better health outcomes. The UK is a case in point.

Oregon has strategically used evidence to make the case for promulgating PCMHs and increasing investment in primary care. Building upon past leadership by health leaders in Rhode Island, Oregon's work provides a path that could be emulated by states or the federal government.

Collaborating to Build and Spread the PCMH Model

In 2009, Oregon's legislature established the Patient-Centered Primary Care Home (PCPCH) program through a collaborative process that defined PCPCH attributes. The goals of the legislation were to encourage the development of Patient-Centered Primary Care Homes, measure what impact primary care homes have, and encourage Oregonians to use them.

In 2010, the program created a task force including clinicians, patients, public health, and healthcare delivery experts. The task force developed recommendations for broad implementation of the primary care home models, driving toward a goal of 75 percent of all Oregonians in primary care homes. Building on these recommendations, an institute was launched to "convene and broker resources, create a centralized learning system, and provide technical assistance to clinics ..." Value was created through the sharing of specialized training as well as through the promotion of best practices and featured clinician leadership strategies.

Compelling Evidence

In 2016, a final report was issued, "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings" by the Oregon Health Authority through a contract with Portland State University. Its goals were to understand exemplary clinics, estimate the impact of the program on healthcare utilization and expenditures, and assess the general consistency of scoring in evaluating performance. The report drew striking conclusions, leveraging data on more than a million individuals (half in PCPCH programs) including:

- A shift in organizational culture, increasing patient focus, patient goal-setting, shared-decision making, care coordination and data-driven decision making. It also found that this work had supported a shift toward population-based health strategies.
- Dramatic reductions in costs and utilization that totaled \$240 million in the first three years. It found that for every additional dollar spent on primary care, savings of \$13 were found in other services, such as specialty care, emergency department and inpatient care.
- A finding that PCPCH six program attributes collectively had a greater effect than any individual attribute with respect to cost and utilization measures – in other words, the whole is greater than the sum.

The study also identified some issues for further attention. It identified challenges in payment models and other financial arrangements that do not adequately support the medical home model. It also identified significant differences between PCPCH clinics and non-PCPCH clinics. PCPCH clinics tend to be younger, Medicaid-insured, and larger than non-PCPCH clinics or practices (perhaps reflecting the state's greater ability to influence those working with the Medicaid program.)⁴

Concurrent to the deployment of the PCPCH program, the Oregon Senate in 2015 passed legislation measuring primary care spending across the Oregon population. This data (both claims-based and non-claims based) is reported annually to the Legislature, and includes data from prominent commercial payers, Medicaid coordinated care organizations, and public employee organizations. It also created a public-private collaborative bringing together expertise and best practices. The collaborative developed and presented recommendations to the Oregon Health Policy Board in December 2016.

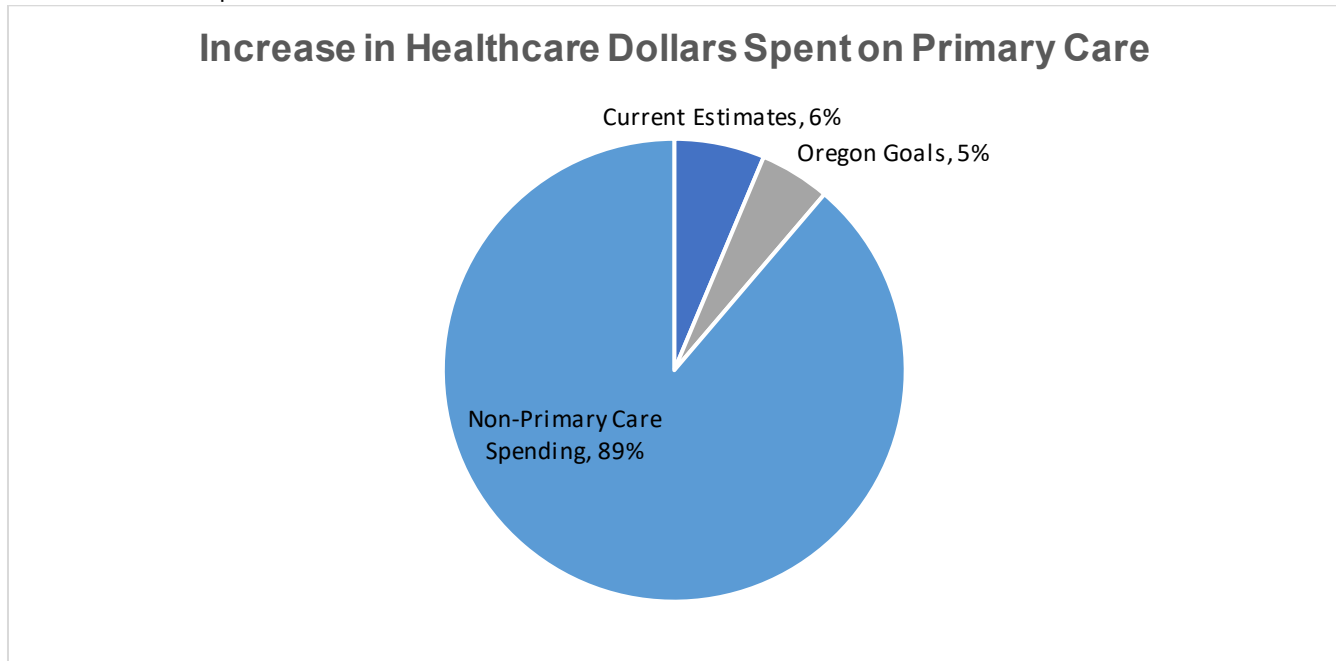
Making the Case for Further Investment

In 2017, based on the strong evidence of the PCPCH program and data collection infrastructure for primary care spending, Oregon took the next step by unanimously passing Senate Bill 934. This **legislation sets a minimum threshold for all payers – both commercial and public – to spend at least 12 percent of total medical expenditures on primary care.** The legislation also requires payers participating in the federal government's Comprehensive Primary Care Plus (CPC+) program to offer similar payment methodologies to all Oregon PCPCHs.⁵ Finally, it strengthened the role of the public-private collaborative with a requirement for an annual progress report to the State of Oregon and the legislature and encouraged the collaborative to continue supporting innovation in primary care. This includes improving reimbursement methods, such as by directing investments to address social determinants of health, behavioral health integration, and aligning reimbursement to support program goals through alternative and value-based payment methods.⁶

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"Working with all sizes and shapes of clinics across Oregon, I have had the opportunity to see many shining examples of transformation in care, as well as the improved health outcomes that can occur through robust implementation of the PCPCH model, said Evan Saulino, MD, PhD, Clinical Advisor to the PCPCH program. "At the same time, there are clearly significant barriers to sustain and continue improvement. If we can live up to the promise of SB934 and invest across our population in sustaining and expanding this innovative work, I believe we are just scratching the surface of what is possible in our state to achieve the Quadruple Aim."



Implications and Next Steps

Oregon has successfully moved to reform both primary care delivery and payment. Across the country healthcare policymakers have been more successful with the former than the latter. Consequently, many PCMHs are not adequately financed to deliver, spearhead or coordinate the array of comprehensive services envisioned in the Shared Principles for Primary Care.

Having considered the Oregon journey, a few lessons emerge for consideration:

- **Leverage Evidence** – Oregon's PCPCH program was able to realize compelling quality and cost outcomes. As described above, Oregon's progress was iterative, with each step building evidence to justify the next action and investment. A progression of steps, from advocacy for House Bill 2009 (in 2009), to Senate Bill 934 in 2017 has resulted in significant positive outcomes with more expected as the programs mature.
- **Engage all Stakeholders** – A key element of Oregon's success was its effort to engage a wide range of public and private stakeholders to design and implement a successful patient-centered medical home program. In addition, the Primary Care Payment Reform Collaborative built consensus across diverse payers and other stakeholders to ensure that efforts to increase investment in primary care, address the social determinants of health, and integrate behavioral health preemptively considered the concerns of all relevant parties.
- **Align with Multiple Payers** – A key element of Oregon's success is leveraging political leadership and collaborations to achieve alignment across payers. In many parts of the nation, PCMH's must contend with different requirements from different payers, undermining transformation. In Oregon, the legislature was able to align CPC+ and other PCMHs, while guiding efforts through its leadership. The state was also able to leverage its Medicaid program to drive widespread changes. This multi-payer support for the PCMH model created progress that a demonstration program supported by a single payer, public or private, cannot.

The Milbank Memorial Fund has been a champion for increasing investment in high value primary care. Fund President Christopher F. Koller said, "Other country's health systems deliver higher quality care at lower costs, in large part because they put a priority on the kind of primary care envisioned by PCPCC's Shared Principles. Oregon will continue to reap the benefits of their investment in primary care, and other states and the country can learn from their leadership."

The PCPCC is working with state innovators - such as Oregon - and national leaders across stakeholder groups to define a national standard for measuring primary care investment. Coupled with evidence about the value that PCMHs and other advanced primary care models deliver, we will be better positioned as a community to make the case for increased investment and to realize the vision of primary care embodied by the Shared Principles. Please join us at pcpcc.org.

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The Need To Jump Start New Initiatives To Transform The U.S. Healthcare System...continued from page 2

Value-based transformation in particular is not a new passion for me. It became a top priority for Secretary Mike Leavitt when I was working for him as deputy secretary of HHS, and it was taken seriously by President Obama's administration as well.

But it has been a frustrating process: Providers have been understandably reluctant to charge into a completely new payment paradigm. Massive new processes and data-gathering requirements have been instituted, without any fundamental changes to our delivery system. Results for the early stages of federal efforts to encourage accountable care organizations have been, to be honest, underwhelming.

But there is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us.

The four areas of emphasis are the following: giving consumers greater control over health information through interoperable and accessible health information technology; encouraging transparency from providers and payers; using experimental models in Medicare and Medicaid to drive value and quality throughout the entire system; and removing government burdens that impede this value-based transformation.

Putting the healthcare consumer in charge, letting them determine value, is a radical reorientation from the way that American healthcare has worked for the past century.

In fact, it will require some degree of federal intervention — perhaps even an uncomfortable degree. That may sound surprising coming from an administration that deeply believes in the power of markets and competition. But the status quo is far from a competitive free market in the economic sense of the term, and healthcare is such a complex system, that facilitating a competitive, value-based marketplace is going to be disruptive to existing actors.

In the years since we were talking about this very topic around Secretary Leavitt's conference room table, technology has advanced by leaps and bounds. The ubiquity of smartphones, cloud-based storage and computing power, and near-universal access to broadband internet has changed the way we keep and consume information.

In recent years, we've seen substantial advances in terms of adoption of electronic health records by providers, but all too often, this simply meant putting in electric form what had been on paper, at great expense and burden to the provider. Useful, but hardly realizing the promise of health IT. And this shift almost entirely left the patient out of the picture. It's not just that the benefits of health IT aren't always apparent to patients—it's that unless we put this technology in the hands of patients themselves, the real benefits will never arrive.

We already have the technological means to offer this power to patients, but it hasn't yet happened. The key to this administration's approach will not be micromanaging the standards and processes used.

We are much more interested in setting out simple goals: Patients ought to have control of their records in a useful format, period. When they arrive at a new provider, they should have a way of bringing their records, period. That's interoperability. The what, not the how.

Putting patients in charge of this information is a key priority. But if we're talking about trying to drive not just better outcomes, but lower costs, we also have to do a better job of informing patients about those costs.

That is where our emphasis on price transparency comes in. I believe you ought to have the right to know what a healthcare service will cost — and what it will really cost — before you get that service.

This is a pretty simple principle. We'll work with you to make it happen — and lay out more powerful incentives if it doesn't.

Some insurers and employers have created tools that show people what different local providers charge for a procedure. The information is correctly "grouped" together so you don't have to add together the doctor's charge, the hospital's charge, and the cost of other services. If you log in with your insurance information, it shows you how much you will pay out-of-pocket.

In both healthcare services and pharmaceuticals, the huge gaps between the list price and the actual price are notorious. It's like the gap between the \$500 rack rate on the back of the door in your Hampton Inn room and the \$100 you actually pay. This thicket of negotiated discounts makes it impossible to recognize and reward value, and too often generates profits for middlemen rather than savings for patients.

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