

# Practice Transformation Curriculum for Advanced Primary Care

## 1. Rationale

The current model of primary care in the United States is primarily driven by fee-for-service payments which have changed little since the 1960's when insurance plans expanded their reach to more Americans and CMS initiated the Medicare and Medicaid programs. Fee-for-service only rewards care done face to face, in a medical office, and the incentives drive the health system to create more utilization or intervention as the more that is done to a patient, the more reimbursement the provider or system receives. That reality coupled with primary care often being regarded as secondary or unimportant within tertiary care based health systems where other specialties generally have much higher revenues, and cost. This payment model has led to a very low investment in primary care in most states. The percentage of the health care services expenditure that goes towards primary care payments ranges from 4-6 percent in most states. This has effectively stifled the capacity of primary care clinics to offer more services to patients and restricted innovation. With the advent of the Patient Centered Medical Home, whose concepts were welcomed by patients and payers, attempts were made to transform practices with those ideals. However, without substantial increase in practice costs, staffing and time commitment needed to accomplish those ideals, most, if not all PCMH transformations have led to unsustainable care models with current FFS financing programs, even with a modicum of population-based incentives.

With the rise of direct payment to practices by patients and other payers (like self-insured employers), a number of pilots have demonstrated what we suspected would be true if the payment supported the essential functions of primary care. Family physicians, internists, and pediatrician have the broadest skill sets to manage patients in the primary care setting. Partnered with PA's and ARNP's, these physicians can assemble teams that can be highly effective in all of the key functions of primary care. These key functions, most embodied by family physicians in most medical systems, include:

- a. Caring for all people of all ages and health conditions.
- b. Be the reliable first contact for health concerns and directly address most health care needs, include acute conditions, chronic disease management and procedures.
- c. Develop enduring partnerships, to help patients prevent, understand, and manage illness, navigate the health system and set health goals.
- d. Adapt their care to the unique needs of their patients and communities using a multidisciplinary care team.
- e. Use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health.
- f. Be leaders of health care systems and partners for public health.

These pilots have demonstrated that a comprehensive primary care practice supported with 10-12 % of the total cost of care expenditure, can reduce the total cost of care by 15-30%. That is to say an additional investment of 5-7% of the healthcare dollar into primary care will yield an ROI of at least 3 times that amount.

## 2. Prerequisites

In order to truly transform a practice culture, at least 30% of a practice will need to be paid with a comprehensive primary care payment (i.e. \$60-80 PMPM for average risk patient for

example). The Calculator Tool developed by Family Medicine for America's Health can allow payers and practices develop an appropriate per member per month payment model to create incentives that are aligned with caring for the needs of a population with high value care. The more rapidly a practice moves all of its patients from FFS to a PMPM payment model, the less the incentives are conflicted between the two models which creates discordance for the providers and their care team staff. The care providers must be sufficiently well trained across a broad scope of care to, as a team, provide a comprehensive basket of services that are commonly attributed to primary care.

Another prerequisite is that the primary care practice must have competent generalist physicians at its core. The Entrustable Professional Activities developed by the leadership of family medicine in 2016 describe the essential functions of the broadest generalist specialty in the United States, that being family medicine. There are certainly other specialties that provide primary care, like internal medicine and pediatrics, but their training and practice does not cover the entire spectrum of our population.

### **3. Advanced Primary Care**

Once a practice has a new payment paradigm for its patient population, they will be free to innovate in ways that are not possible with fee for service. From these innovations, we have developed a definition of advance primary care practice, based on the Shared Principles of Primary Care and the commonly accepted characteristics of primary care (access, continuity, comprehensive, coordination of care).

Advanced primary care (APC) has the following characteristic which will be the focus of this curriculum:

1. Patient Engagement and Communications – Patient Advisory Committee, Patient Portal, Telemedicine – phone, Facetime, etc.
2. Access – Advanced access scheduling, longer, more comprehensive appointments, maximizing the visit, after hours care options.
3. Team based care – huddles, pre-visit prep, message management, pharmacy refill management, team meetings (various types – QI, CM, Practice management)
4. Comprehensive Care: Chronic disease, acute care management, primary care procedures – ensuring providers and clinical team are managing complex patients and common interventions to the top level of their training and experience. Referral network design and monitoring for patient care that is referred out.
5. Integrated Case Management – Well-defined role of CM RN on the team and effective methods of direct communications, rising-risk identification and intervention
6. Population Health – regular data reporting to team, leadership. Guiding CM and proactive outreach with Pop Health intelligence tools including social determinants of health.
7. Preventive Care - integrate preventive services in visit, proactive outreach to patients that need screenings or interventions completed.
8. Practice Improvement – quality improvement, enhancing clinical skills through CME, internal trainings, using data from practice to drive and monitor improvement

In the training sessions that this curriculum brings to a practice, we will explore each of these key characteristics in detail and while working with your team, devise strategies for your clinic or system to implement these strategies, monitor your progress, and continuously improve your deliver of primary care.



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