Bree Collaborative Primary Care Workgroup
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Executive Summary

Primary care access and quality impact all 329 million Americans. Geographic access varies significantly and is often lower in areas with a higher proportion of people of color, adding to health disparities.

Primary care, widely identified as the cornerstone of the health care system, is the usual source of health promotion, disease prevention, and care for a population’s acute and chronic health problems. The definition of primary care starts with a broad scope of services and general attributes and often described in contrast to health care services provided for urgent needs or within a hospital or surgical setting.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private healthcare stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous healthcare quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public healthcare purchasers for Washington State, private healthcare purchasers (employers and union trusts), health plans, physicians and other healthcare providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying healthcare services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each healthcare service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing healthcare providers or health carriers as to the price or specific level of reimbursement for healthcare services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private healthcare purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Healthcare Authority for review and approval. The Healthcare Authority (HCA) oversees Washington State's largest healthcare purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, healthcare service quality, and the affordability of healthcare for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

The Bree Collaborative elected to develop standards to develop a state-wide definition for primary care to support multi-payor payment reform. The workgroup met from January to XXX 2020 to recommend system- and individual-level changes to build a healthcare system that truly meetings the needs of a diverse population.

See **Appendix B** for the Primary Care Workgroup charter and a list of members.

See **Appendix C** for results of the guideline and systematic review search.

Background

Primary care, widely identified as the cornerstone of the health care system, is the usual source of health promotion, disease prevention, and care for a population's acute and chronic health problems.[1] Efforts to define primary care often start with a broad scope of services, general attributes in an outpatient or ambulatory care setting, and are often described in contrast to health care services provided for acute or urgent needs or within a hospital or surgical setting. The delivery of comprehensive primary care services is also frequently associated with certain types of providers that are trained to provide first contact, comprehensive, continuous, and coordinated care – the hallmarks of primary care.

Access and Outcomes

In a report from the Primary Care Collaborative, the authors note that "*consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs.*"[2] A lack of a sufficient primary care workforce is a growing issue that impacts accessibility in Washington State as well as nationally.[3]

Access to primary care depends on multiple factors: availability, accessibility or how close a delivery site is to where a person lives or works, convenience or the hours that the delivery site operates and the modes in which care is offered such as in-person or virtually, affordability or cost of care and acceptability or how well the care that is offered matches a person's individual needs and preferences such as through the availability of care in different languages.[4] Accessibility, physical proximity, is the most well studied factor associated with individual and population health, consistently showing a positive impact when compared with populations farther away from primary care.[5] Early studies in the 1990s found an association between a higher ratio of primary care physicians at a state-level and population-level health outcomes such as lower all-cause mortality and mortality from heart disease, cancer, stroke, as well as infant mortality.[6] Presence of primary care providers is also associated with increased life span, reduction in infant low birth weight, better overall patient experience, and a person's self-rated health.[7,8,9]

Access to regular, high-quality care is a challenge for many. Analysis of urban census tracts show lower levels of access to primary care for specific populations, such as areas with a higher proportion of Black Americans.[10] Those living in rural areas also have lower levels of access to primary care.[11] A primary care delivery site may be located in close geographic proximity but may not be of high quality, may have hours that render it inaccessible, or the providers may not be taking new patients.

These issues are influenced and compounded by low reimbursement for primary care compared to specialty care and hospital care, with the United States spending between 5-7% of total health care expenditure on primary care and Washington State spending between 4.4% to 5.6% of total expenditure on primary care.**Error! Bookmark not defined.**[,12] Low reimbursement leads to not enough time being spent with an individual patient in the visit. Many argue that there is not currently enough time in a clinical visit deliver all the services recommended by the US Preventive Services Task Force (USPSTF) to a complete panel of patients without reducing panel size by half.[13]

Compounding the issue of low reimbursement is the fact that many of the activities expected of a high-performing primary care practice are not reimbursed by traditional fee-for-service payment approaches. Examples of these activities that are frequently identified as features of high-performing or “advanced” models of primary care are included here:

- Proactive outreach to patients with upcoming or overdue preventive tests or screenings
- Ongoing engagement with patients who have complex or multiple chronic conditions to ensure adherence to agreed upon care plan
- Active management
- Daily team huddles that consider the needs of all patients– those on the visit schedule for the day as well as those not on the schedule
- Health IT implementations that support population and individual health analytics to properly resource and manage the patient panel while also meeting individual care needs.

Recommendation Framework

The workgroup's goal is to foster a common understanding of primary care to increase primary care accessibility and availability.

Defining Primary Care	Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider, but may exist in multiple care settings or be delivered in a variety of modes.
Measuring Primary Care	Based in claims, care delivered in an ambulatory setting by a predefined group of providers and team members including lab and drug costs
Components of Primary Care with Large Impact	• Care coordination • Integrated behavioral health • Disease prevention and screening • Chronic condition management • Medication management • Health promotion • Person-centered care that considers physical, emotional, and social needs

Stakeholder Checklists

Primary Care Site

Adapted from www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf and the HCA plan

Infrastructure

- ☐ Active patients are assigned or attributed to a primary care provider or team for advanced clinical judgment, the primary care team may/may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team
- ☐ Behavioral health provider(s) are part of the care team through coordinated, co-located, or integrated models
- ☐ *home as a setting of care, and home care workforce should be part of team and coordinated with (including mechanisms like information exchange to assist coordination)?*
- ☐ Primary care team is led by (as defined in RCW) (1) Doctor of Medicine – General practice, Family Practice, General Internal Medicine, General Geriatrics, General Pediatrics, Adolescent Medicine; (2) Doctor of Osteopathic Medicine - General practice, Family Practice, Internal Medicine, Geriatrics, Pediatrics, Adolescent Medicine; (3) Advance Registered Nurse Practitioner – Family, Adult, Pediatric, ~~Women's Health,~~ (4) Physician Assistant – Family, Adult, Pediatric, ~~Women's Health;~~ (4) Osteopathic Physician Assistant – Family, Adult, Pediatric, ~~Women's Health;~~ or a (5) Naturopath
- ☐ Team-based care strategies (huddles, care management meetings, high-risk patient panel review) are consistently used
- ☐ Forms and protocols (e.g., mission statement, employee materials) reflect that the delivery site has an open and affirming environment that includes non-discrimination in hiring practices
- ☐ Age-appropriate and culturally inclusive reading materials and audiovisual aids are available in the reception area and examination rooms

Access

- ☐ For physical and behavioral health the following are available:
  - ☐ Same day appointments
  - ☐ 24/7 e-health
  - ☐ Telephonic access
  - ☐ Communication through IT innovations
- ☐ At least one alternative to traditional office visits is offered (e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours in early mornings, evenings, and weekends)
- ☐ The site is physically accessible to those with mobility issues including entering/exiting, moving within the facility, during the clinical encounter such as seating within an exam room
- ☐ Translation services for languages common among the patient population are available. This can include providers who speak a patient and family's language, presence of a certified interpreter, or a telephonic interpreter. Family or friends are **not** used to translate during a clinical encounter.
- ☐ Patient-facing forms and information:
  - ☐ Are readable at an 8th grade reading level

  - ☐ Are available in languages that reflect the patient population
  - ☐ Are available in accessible formats (e.g., braille, large print, audio)
  - ☐ Use inclusive, non-stigmatizing language
  - ☐ Reaffirm the confidentiality of information

Information

- ☐ Health IT that supports management of the patient panel at a population health level, as well as supporting optimal care at the individual patient level is in place. To be effective, the primary care provider must be "connected" to the broader healthcare ecosystem through some mechanism that supports interoperability, such as a Health Information Exchange (HIE) that supports a longitudinal patient-centric record and near/real time alerts to support transitions in care
- ☐ Health record for each active patient contains at least the following and is updated as needed during a visit:
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Surgical history
  - ☐ Allergies
  - ☐ Race and ethnicity (if disclosed by the person)
  - ☐ Preferred language
  - ☐ Sexual orientation
  - ☐ Gender identity, chosen pronouns, and chosen name
  - ☐ BMI/BMI percentile/growth chart as appropriate
  - ☐ Immunization record
  - ☐ Parenting intention in the next year, if applicable
  - ☐ Advance directive or other advance care plan including goals, preferences, needs
- ☐ Care plan is documented and accessible to all members of the primary care team, regardless of their physical location or organizational affiliation
- ☐ Risk stratification process is in place for all empaneled patients that includes:
  - ☐ Medical need
  - ☐ Behavioral diagnoses
  - ☐ Health-related social needs
- ☐ At least every two years, site post-visit surveys to measure patient reported outcomes are sent to people who have accessed care including questions on access to care, provider or health team communication, coordination of care, and staff helpfulness
- ☐ Whole person needs are identified at a population level and develops processes to meet needs
- ☐ Quality and effectiveness of care improve over time
- ☐ Patient visits with assigned clinician or team are tracked and reported to health plans
- ☐ Capacity to query and use data to support clinical and business decisions.

Referrals

- ☐ Agreements or contracts among providers, plans, and other organizations to coordinate transitions are in place including:
    - ☐ Emergency department and inpatient visits
    - ☐ Residential and partial treatment facility stays
    - ☐ Stays at substance abuse treatment facilities
    - ☐ Community resources to support non-medical social needs that impede health improvement
- ☐ Referrals to offsite services are tracked (oral health?)
    - ☐ Overdue referrals prompt outreach to the patient
- ☐ Referral patterns are identified and adjusted to improve patient outcomes and reduce cost and unnecessary care
- ☐ Hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits are identified
    - ☐ Timeliness of notification and information transfer is assessed
- ☐ Opportunities to work with ACHs to improve community supports are identified
- ☐ Hospice, palliative care?

Content of Care

- ☐ Services that address the whole person (multiple organ systems) are regularly offered including:
    - ☐ Active management of chronic diseases
    - ☐ Acute care for minor illnesses and injuries
    - ☐ Office-based procedures and diagnostic tests
    - ☐ Preventive services including USPSTF recommended cancer screenings
    - ☐ Patient education
    - ☐ Self-management support
    - ☐ Medication management
    - ☐ Chronic condition management
    - ☐ Behavioral health support
- ☐ People are screened at least annually using a validated instrument for:
    - ☐ Depression
    - ☐ Anxiety
    - ☐ Suicidality
    - ☐ Tobacco use
    - ☐ Alcohol
    - ☐ Other drug use
        - → Process for follow-up of brief intervention, brief treatment or referral to treatment is documented
        - Any positive behavioral health screen follows an appropriate workflow that includes brief intervention, brief treatment, and/or referral to higher levels of care such as outlined in the Bree 2017 Behavioral Health Integration

recommendations, the 2018 Suicide Care recommendations, the 2015 Addiction and Dependence Treatment recommendations, and/or the USPSTF recommendations on tobacco

- ☐ Care is evidence-based or evidence informed
- ☐ During a clinical visit, patients and providers engage in:
    - ☐ Self-management support
    - ☐ Shared decision making
    - ☐ Motivational interviewing for behavior change

Patients and Family Members

- ☐ Select a primary care provider who meets your needs
- ☐ Think about your broad health and wellness-related goals and how your provider and care team might help you meet these goals
- ☐ In situations where different options are available, give your provider(s) information about your values and preferences, and discuss options, tradeoffs, and implications of a decision together
- ☐ Consider your primary care/team your first point of contact to the larger health system for all non-emergent care needs

Health Plans

- ☐ Members receive information about the value of primary care, how to access primary care within the network, and are asked or otherwise encouraged to select a primary care provider/team at enrollment
- ☐ Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism that is transparent to the purchaser (employer/union), as well as to the individual member.
- ☐ Members are notified when a primary care provider is held accountable for their care through a claims-based attribution process or other assignment mechanism. Members should be able to change this by notifying the health plan of their preferred primary care provider within the available network.
- ☐ Data from care delivery sites is collected and aggregated to understand variation in care and look for underlying issues such as disparities in access or services provided within and across:
    - Race and ethnicity
    - Language
    - Sex
    - Screening for relevant cancers of the sexual and reproductive health system
    - Prenatal care utilization
    - Perinatal care outcomes reported for those who are Black, indigenous, and people of color
- ☐ Health plan records accurately reflect a person’s gender, pronouns, and chosen name
  If gathered at a health plan level such as upon enrollment, this is communicated to care delivery sites with the required permissions to do so in place at the member/individual level

- ☐ Primary care is supported through a payment mechanism that supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation
    - Payment mechanisms are clearly articulated to employers with the stipulation that the qualifications for payment eligibility and the measures of success are clearly understood and openly shared

Employers

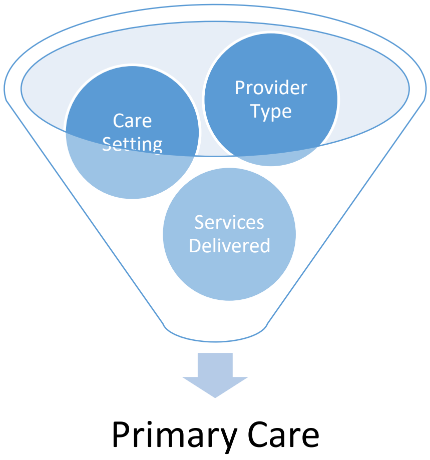
- ☐ Employees and covered family members receive information about the value of primary care, how to access primary care within the available plan options, and are asked or encouraged to select a primary care provider/team at enrollment
- ☐ Benefit designs are structured to encourage the use of primary care including Value-Based Insurance Design (VBID) mechanisms tied to primary care, such as:
    - $0 cost for specified services delivered by the individual's named primary care provider (that provider is named by the individual or assigned through an attribution or other mechanism) for in-person or virtual care
    - Lower out-of-pocket cost for specialty care accessed after seeing one's primary care provider/team
    - When qualified high deductible health plans with Health Savings Accounts (HSA's) are in place, the new rules allowing for first dollar coverage under an expanded definition of "preventive services" have been incorporated.
- ☐ Agree to support non-fee-for-service payment mechanisms for primary care. Non-fee-for-service forms of primary care payment must be clearly articulated by health plans and supported by employers with the stipulation that the qualifications for payment eligibility and the measures of success are also clearly understood and openly shared.
- ☐ Contracts with health plans and/or directly with delivery systems require:
    - Measurement of primary care spend
    - total cost of care
    - Measurement of quality of care
    - Measurement of disparities in care outcomes by race
    - Reporting of primary care spend
    - Targets for primary care spend
    - Requirement that consumers select or be paneled to a primary care provider or team
    - When individual selection is not in place, the primary care provider/team to whom the individual is assigned is clearly communicated and the individual has the ability to change that assignment
    - Penalties for indicators of not-managed and not-coordinated care, like avoidable hospital readmissions or avoidable ED

Defining Primary Care

The concept of primary care was first introduced in the 1920s and described by the Institute of Medicine (IOM) in 1978 as being "*accessible, comprehensive, coordinated, continuous, and accountable*."[14] Barbara Starfield further describes primary care as being characterized by first-contact care and being longitudinal and comprehensive.[15] Primary care can further be defined as including advocacy, taking place in the context of a community context and family, including goal-oriented care and health promotion, being integrated, and being based on a relationship.[16] In many studies, primary care is defined by four Cs: first-contact care that is comprehensive in addressing a wide variety of issues from sprains to behavioral health to prenatal care, is continuous with multiple touch-points over time, and is coordinated. In order to know whether primary care spend is increasing in the state, Washington must first develop an agreed upon definition of primary care that will allow for accurate measurement.

The IOM categorizes possible definitions into care provided by certain clinicians, a particular set of activities, a level or setting of care, the attributes themselves, or as a strategy for organizing a system.[17] More simply, primary care can be defined broadly as consisting of the care provided by a subgroup of medical providers, the set of functions that providers within and outside of that subgroup perform, and/or a general orientation of a health delivery system.[18] A family medicine physician may order a thyroid test which would be considered part of primary care while an endocrinologist ordering that same test may not necessarily be considered primary care. These provider, service, and system categories have been expanded by Millbank into:[19]

- Provider: All the services delivered by pre-defined primary care providers in an ambulatory setting.
- Service: Services that meet particular definitions including being: comprehensive, first-contact for a wide variety of (not limited) conditions, coordinated, and taking place over time (longitudinal).
- Service: All office visits and preventative services within a category independent of the provider type.
- Service and Provider: Based in claims, specific set of pre-defined services delivered by pre-defined primary care providers not limited to an ambulatory setting.
- Health systems: Primary care delivered at a system level, useful for capitated systems but most difficult to measure.



In Washington State, primary care provider is defined as "a general practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW."[20] The workgroup sought to operationalize the four C's described above to develop a standardized definition: Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of the health care services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time.

If primary care is yes to ALL of the following:

1. **Accountability** through a team and/or provider that includes physical health, behavioral health, and care coordination. Advanced clinical judgement for a person's care/panel of patients lies with one of the following:
   - Doctor of Medicine – General practice, Family Practice, Internal Medicine, Geriatrics, Pediatrics, Adolescent Medicine
   - Doctor of Osteopathic Medicine - General practice, Family Practice, Internal Medicine, Geriatrics, Pediatrics, Adolescent Medicine
   - Advance Registered Nurse Practitioner – Family, Adult, Pediatric, Women's Health
   - Physician Assistant – Family, Adult, Pediatric, Women's Health
   - Osteopathic Physician Assistant – Family, Adult, Pediatric, Women's Health
   - Naturopath

   Other team members can include but are not limited to: psychologist, psychiatrist, social worker, registered nurse, medical assistant, care coordinator, etc.
2. **First Contact** – Does the team assess, triage, and direct a person's health or health care issues as they arise?
3. **Comprehensive** – Does the team care for the whole person and provide services that address multiple organ systems including active management of chronic physical (e.g., COPD, diabetes) and behavioral health (e.g., depression, anxiety, substance use disorder) conditions as well as USPSTF recommended screening and preventive services?
4. **Continuous** – Does the team maintain or attempt to develop a longitudinal relationship?
5. **Coordinated** – Does the team take responsibility for a person's care through managing a care plan in coordination with a multidisciplinary team and/or with offsite referrals?
6. **Appropriate** – Does the team provide evidence-based, person-centered medicine that includes behavioral health?

Content of Care

Care Coordination

AHRQ defines the goal care coordination “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.”[21]

Integrated Behavioral Health

Mental illness and substance use disorders, together called behavioral health, are common, with an estimated 46% of adults experiencing mental illness or a substance abuse disorder at some point in their lifetime, 25% in a year.[22] Patients with chronic medical conditions and behavioral health issues have an estimated two to three times higher health care costs.[23] Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[24]

On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis, indicating potential to impact patient outcomes through treatment within the context of primary care.[25] Primary care providers have reported preferring integrated care, reporting more effective communication and lower stigma about mental health and substance use for patients.[26] Research has consistently shown healthier patients and populations including decreased depression, anxiety, and positive impacts on medical conditions including diabetes, increases in quality of life, and higher patient satisfaction.[27,28]

Disease Prevention and Screening

In addition to screening for common behavioral health issues, primary care practices should screen for disorders and infections that may be present in the patient population. Approximately 39.3% of people will be diagnosed with cancer in their lifetime.[29] The most common types of cancer are breast, lung and bronchus, prostate, colorectal, and melanoma and skin cancer. The US Preventive Service Task Force (USPSTF) recommends

- Breast “biennial screening mammography for women aged 50 to 74 years.”[30]
- Lung “annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.”[31]
- Prostate “For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision. Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction. In determining whether this service is appropriate in individual cases,

patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening."[32]

- Colorectal "starting at age 50 years and continuing until age 75 years. [33]
- Skin "current evidence is insufficient to assess the balance of benefits and harms of visual skin examination by a clinician to screen for skin cancer in adults."[34]
- Cervical "screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting)."[35]

Health Promotion

Health promotion within primary care is broad, including chronic care management, medication management, vaccinations against common diseases, and education on diet and exercise. Almost half of all Americans have a chronic disease such as heart disease, stroke, cancer, diabetes, respiratory conditions, and arthritis.[36]

Person-Centered Care

The person receiving care is at the heart of every care relationship. Shared decision making, where appropriate, is a key component of person-centered care. This is a, "*process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences*."[37] Motivational interviewing is behavioral change achieved through identifying patient values and motivators and using these to drive progress toward a desired health outcome.

Shared decision making for preference-sensitive conditions has been shown to help people gain knowledge about their health condition(s) and possible outcomes of care and to have more confidence in their decisions.[38,39] The process has also been associated with improved patient satisfaction with care, improved health outcomes, and with better appropriateness of care.[40,41]

Strengthening Primary Care with New Payment Models and Measurement of Spending

Various entities have proposed mechanisms to enhance the provision of primary care to a defined population including state Medicaid agencies, health plans, organizations representing private purchasers of healthcare, or employer purchaser organizations. To understand how these various mechanisms work, the Workgroup has organized the discussion around spending to include the following:

- A description of the range of payment types available, including the central features of each
- A discussion of initiatives under way across the country to change the primary care mechanism to inform efforts in Washington State. This discussion includes the identification of features central to these efforts, including practice transformation and patient attribution/assignment considerations.
- The implications for measurement based on the system as it is today (primarily fee-for-service) and as may be envisioned under a new payment model(s) that support the transformation of primary care in Washington state with non-fee-for service mechanisms.

Primary Care Payment Types

Like most other forms of health care delivered in Washington State and across the country, the predominant form of payment is fee-for-service. While there have been many efforts to enhance fee-for-service with various value-based incentives tied to cost and/or quality measures, the underlying payment for the services delivered to patients continues to be fee-for-service.

It has already been noted that many of the important components of primary care described in the previous section are not directly reimbursable through a fee-for-service payment mechanism. This represents an obstacle to strengthening primary care in the best of circumstances. The Workgroup writes these recommendations at a time when the impact of COVID-19 cannot be ignored – particularly as it relates to primary care. The Larry Green Center, in collaboration with the Primary Care Collaborative has been surveying primary care practices weekly to assess the impact that COVID-19 is having on primary care practices since mid-March. In the latest survey report published on their website, they state that *"The primary care platform is shrinking. The low level and time limited support offered through previous federal relief efforts are ill-matched with the magnitude of COVID-19 challenges."* Their survey results indicate that "2% of practices have closed, another 2% are considering bankruptcy, and 10% are unable to be certain of their solvency 4 weeks out" and that "1 in 5 clinicians are now considering leaving primary care and 13% could not answer that question either way." When basic services are not being delivered, primary care practices, that operate on thin margins in the best of circumstances, cannot survive. This also means that, in many cases, basic health care needs of individuals are not being met.

The range of primary care payment mechanisms available are described at a very high level in the table below. There are many iterations and variations within each of these categories. This table is intended to ground the discussion around measurement of primary care spending by describing the broad payment types included in this table and used as terms throughout this document

	Fee-for-Service	**Fee-for-Service-Based Incentives**	**Non-Fee-for-Service Prospective Payments**
What triggers payment?	Delivery of a Service	Achievement of threshold for cost, quality, experience measures	Matching a patient to a qualified provider
How is payment made?	A discrete payment made as services are delivered	In a variety of ways: enhanced ffs, lump sums, quarterly bonuses, etc.	Typically on a PMPM monthly basis, but may be quarterly
What is covered by the payment?	The actual services delivered	Performance on a wide range of quality measures – cost, clinical, experience	Enhanced or "advanced" components of primary care not covered by ffs
Does the payment reflect the intensity of the services delivered?	Yes, if FFS coding is accurate	Unknown	Yes, if risk adjusted accurately at the individual patient level

It is not within the scope of the Workgroup to recommend a specific payment type. However, the workgroup believes that noting the inadequacy of a fee-for-service payment mechanism to support the implementation of primary care as defined or envisioned by this workgroup. The workgroup strongly encourages the adoption of non-fee-for-service payment mechanisms in a manner that aligns key healthcare stakeholders – providers, payers, and purchasers. These recommendations are reflected in the Stakeholder Checklists.

Primary Care Payment Initiatives

The Centers for Medicare and Medicaid Services (CMS) launched Comprehensive Primary Care Plus (CPC+), a multi-payer primary care improvement initiative in 2017, the largest single primary care payment demonstration model in the US. CPC+ builds on the learnings derived from a smaller five-year Comprehensive Primary Care Plus (CPC) demonstration. Alignment across the commercial and Medicaid plans that voluntarily participate in CPC+ is an important point of emphasis in CPC+. The 18 CPC+ regions were selected based on the number and strength of private payers (commercial, Medicaid MCOs and Medicare Advantage) and state agencies willing to work together on a regional basis to do the following:

- Compensate primary care practices using prospective PMPM payment mechanisms (with or without fee-for-service; the specific approach is left to each organization and payment levels are not discussed across payers or specified by CMS/CMMI)
- Align with CMS and other payers in the region on quality measurement – both the identification of key metrics and to aggregate the data used for measurement and evaluation of participating primary care practices
- Work in collaboration with other payers in the region to support practice transformation through learning collaboratives, shared resources, such as practice transformation consultants, etc.

The evidence on how well CPC+ is working is mixed. CMS has retained Mathematica to conduct its evaluation of CPC+ based on its impact in the Medicare population (*need to insert specifics here as to those results which generally show some impact on quality and health, but no discernable impact on cost*). The impact on the lives covered by the private payers is not included in Mathematica's evaluation. The evidence for how well this is working in the private sector has been less robust but is starting to emerge. Recently, the most significant payer in the Arkansas region which has been a part of CPC and CPC+ published a white paper that reports significant savings in the total cost of care for patients whose primary care provider is in the CPC+ model vs. those that are not. Similar evidence from other regions is beginning to emerge in conference settings but has not yet been published.

Independently and prior to CPC+, the Oregon Health Authority developed and established the Patient Centered Primary Care Home Program due to state legislation in 2009. The program sets standards, certifies individual practices, and works to incentivize the population's use of the certified primary care homes.[42] Core attributes of the program include: access to care; accountability; comprehensive, whole-person care; continuity; and person and family-centered care with 11 must-pass standards such as offering advice through telephone and five possible tiers.[21] All of the following are able to become a certified primary care home: Physical health providers; Behavioral, addictions and mental health care providers with integrated primary care services; Solo practitioners; Group practices; Community mental health centers with integrated primary care services; Rural health clinics; Federally qualified health centers; and School-based health centers.

Key learnings from these and other primary care payment initiatives underscores the importance of non-fee-for-service payments and a multi-payer approach. Specific considerations around implementation of these models is best supported when there are common understandings and approaches to implementation across payers to support practice transformation.

Practice Transformation

The Knoster model for managing complex change argues that for a successful change to occur, a system needs vision, skills, incentives, resources, and an action plan.[43] The lack of any of these elements leads to confusion, anxiety, resistance, frustration, or false starts, respectively.

- Vision – Outlined in these Bree Collaborative recommendations (needed to overcome confusion)
- Skills – Already exist (needed to overcome anxiety)
- Incentives – Multi-Payer Approach to non-fee-for service payment, such as Transformation of Care Fee (needed to overcome resistance)
- Resources – Payor-agnostic resources to reduce the administrative burden placed on practices dealing with multiple payment mechanisms, misaligned quality incentives and/or data collection mechanisms (needed to overcome frustration)
- Action Plan – Outlined in these recommendations as Stakeholder Checklists (needed to overcome false starts)

Attribution

Decisions for attribution include: unit of analysis (patient versus episode of care); signal for responsibility (professional costs versus number of evaluation and management visits); number of physicians that can be assigned responsibility (single physician versus multiple); and minimum threshold for assigning responsibility (majority of visits or costs versus plurality of visits or costs).[44]

Measurement

Accurate measurement of primary care depends on availability of data and how primary care is defined. Claims data, derived from fee-for-service payment, has been used imperfectly to measure the attributes of four Cs (first contact, comprehensive, continuous, and coordinated). However, this framework is not necessarily reflected in codes that are billed. Further, the lack of a nationally accepted definition of primary care is a major impediment to assessing and increasing the primary care expenditures uniformly across states.

More information on healthcare cost data is available here.

In 2019, Washington State Office of Financial Management (OFM) was mandated by legislation to develop a report on primary care spend. The report notes that comparisons between Washington's percent expenditure and national averages or other states' averages depend on different definitions. Also, this 2019 report does not include non-claims-based care such care coordination activities. Reports from the states of Oregon and Rhode Island include non-claims care that may artificially lower Washington's numbers.[12]

To develop a proxy measure for primary care spend, groups have operated on various assumptions. If defining by provider, the assumption is that a group of subspecialists (i.e., family medicine) always offers primary care and that other groups of subspecialists never provide primary care (i.e., emergency medicine). This assumption holds true for some but not all disciplines. Advance registered nurse practitioners and physician assistants practice in a multitude of settings, including surgical care, which is not reflected in a claim. The 2019 OFM report adjusted the total claims from ARNPs and PAs by 41% and 34%, respectively.

The OFM report presents narrow and broad definitions of primary care, differing based the types of providers who are assumed to be providing primary care. The narrow definition only includes providers who are traditionally considered to perform primary care while the broad definition includes a wider range of provider taxonomy codes includes behavioral health providers, clinical nurse specialists, registered nurses, midwives, and a host of other providers who are not typically considered general practitioners.[12] The OFM stakeholder group also reviewed procedure codes and created both narrow and broad definitions of services qualifying as primary care. Only claims which met both the provider and service definitions of primary care were counted toward the state's total expenditure, with the narrow definition yielding 4.4% and the broad 5.6%.[12]

However, the OFM report noted that deficiencies inherent to the Washington All Payor Claims Database claims database, combined with lack of a firm definition for primary care, limit the report's accuracy in some regards. Claims data does not capture, for example, whether or not the location of services provided was a primary care clinic. As was mentioned earlier, Washington lacks a way to measure non-claims-based expenditures. The OFM report mentions a number of other systemic impediments to accurate measurement that may need to be addressed in order to calculate an accurate primary care expenditure percentage for the state.[12]

Appendix C: Guideline and Systematic Review Search Results

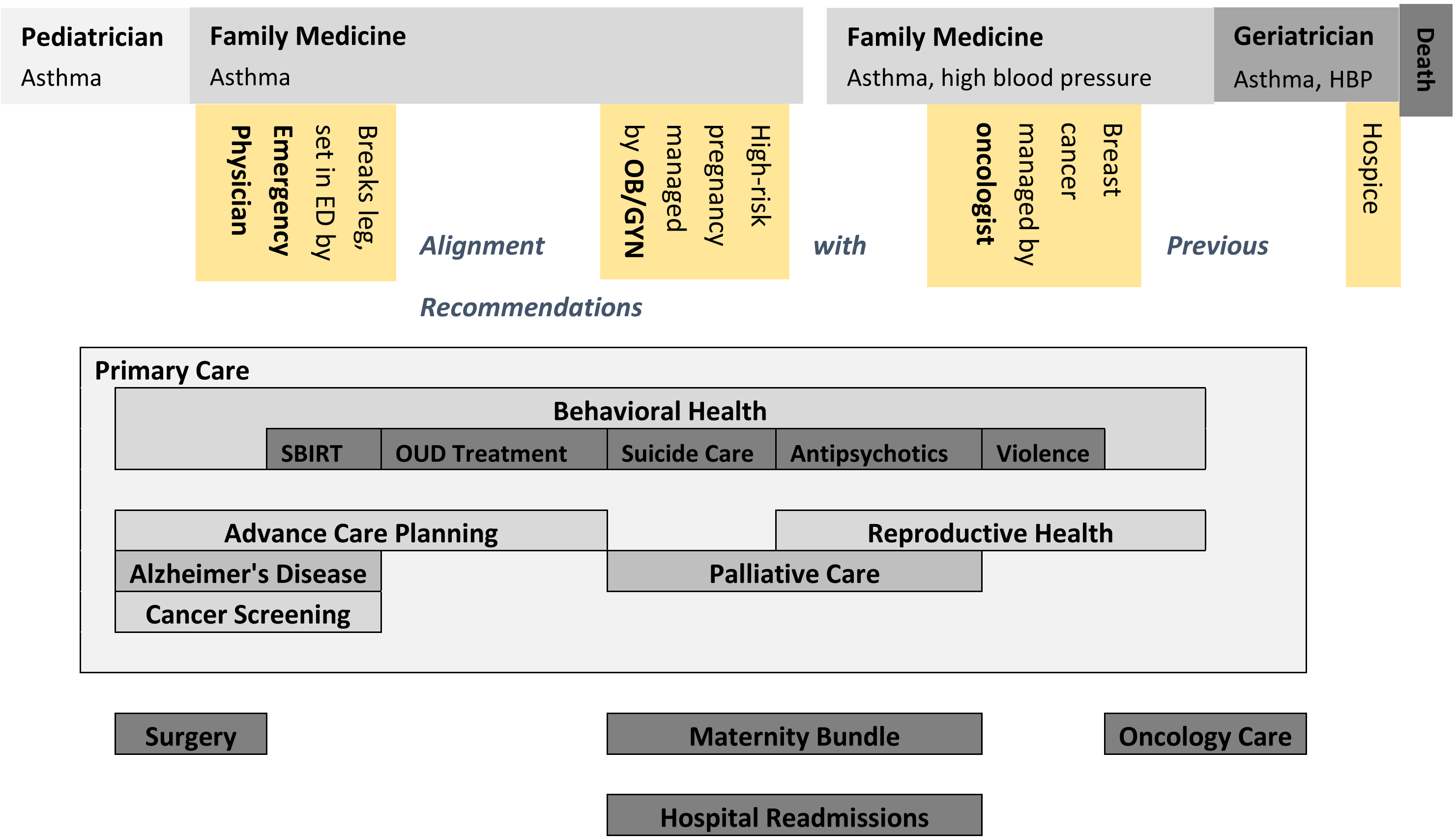
	Year	*Title*	*Summary or Findings*
AHRQ: Research Findings and Reports	2019	**Achieving Health Equity in Preventive Services**	No eligible studies evaluated effects of provider-specific barriers; 18 studies of population barriers provided low or insufficient evidence regarding insurance coverage, access, age, rural location, low income, language, low health literacy, country of origin, and attitudes. In 12 studies of clinician interventions, screening was higher for colorectal cancer with patient navigation, risk assessment and counseling, educational materials, and decision aids; breast and cervical cancer with reminders involving lay health workers; and cervical cancer with outreach and health education. Clinician-delivered interventions were effective for smoking cessation and weight loss. In 11 studies of health information technologies, automated reminders and electronic decision aids increased colorectal cancer screening, and web- or telephone-based self-monitoring improved weight loss, but other technologies were not effective. In 88 studies of health system interventions, evidence was strongest for patient navigation to increase screening for colorectal (risk ratio [RR] 1.64; 95% confidence interval [CI] 1.42 to 1.92; 22 trials), breast (RR 1.50; 95% CI 1.22 to 1.91; 10 trials), and cervical cancer (RR 1.11; 95% CI 1.05 to 1.19). Screening was also higher for colorectal cancer with telephone calls, prompts, other outreach methods, screening checklists, provider training, and community engagement; breast cancer with lay health workers, patient education, screening checklists, and community engagement; cervical cancer with telephone calls, prompts, and community engagement; and lung cancer with patient navigation. Trials of smoking cessation and obesity education and counseling had mixed results. In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2016	Improving Cultural Competence to Reduce Health Disparities	None of the included studies measured the effect of cultural competence interventions on health care disparities. Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols, empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates or commenting about efficacy in a meaningful or responsible way. The term "cultural competence" is not well defined for the LGBT and disability populations, and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.

Cochrane Collection	2012	Narrow band imaging versus conventional white light colonoscopy for the detection of colorectal polyps	We could not find convincing evidence that NBI is significantly better than high definition WLC for the detection of patients with colorectal polyps, or colorectal adenomas. We found evidence that NBI might be better than standard definition WLC and equal to high definition WLC for detection the patients with colorectal polyps, or colorectal adenomas.
	2016	Interventions to encourage uptake of cancer screening for people with severe mental illness	A comprehensive search showed that currently there is no RCT evidence for any method of encouraging cancer screening uptake in people with SMI. No specific approach can therefore be recommended. High-quality, large-scale RCTs are needed urgently to help address the disparity between people with SMI and others in cancer screening uptake.
	2019	Follow-up strategies for patients treated for non-metastatic colorectal cancer	The results of our review suggest that there is no overall survival benefit for intensifying the follow-up of patients after curative surgery for colorectal cancer. Although more participants were treated with salvage surgery with curative intent in the intensive follow-up groups, this was not associated with improved survival. Harms related to intensive follow-up and salvage therapy were not well reported.
	2013	Personalised risk communication for informed decision making about	There is strong evidence from three trials that personalised risk estimates incorporated within communication interventions for screening programmes enhance informed choices. However the evidence for increasing the uptake of such screening tests with similar interventions is weak, and it is not clear if this increase is associated with informed choices. Studies included a diverse range of screening programmes. Therefore, data from this review do not allow us to draw conclusions about the best interventions to deliver personalised risk communication for enhancing informed decisions. The results are dominated by findings

		taking screening tests	from the topic area of mammography and colorectal cancer. Caution is therefore required in generalising from these results, and particularly for clinical topics other than mammography and colorectal cancer screening.
	2017	Decision aids for people facing health treatment or screening decisions	Compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices. There are no adverse effects on health outcomes or satisfaction. New for this updated is evidence indicating improved knowledge and accurate risk perceptions when decision aids are used either within or in preparation for the consultation. Further research is needed on the effects on adherence with the chosen option, cost-effectiveness, and use with lower literacy populations.
Veterans Administration Evidence-based Synthesis Program	2019	What is the Optimal Panel Size in Primary Care? A Systematic Review	In 2009, the Veterans Health Administration Handbook 1101.02 established a baseline panel size of 1,200 patients for a full-time physician in a Patient Aligned Care Team (PACT). This number could be adjusted up or down based on availability of support staff, the number of examination rooms, and patient complexity. After adjustment for these factors, panels ranged from 1,000 to 1,400. Veterans Health Administration (VHA) Directive 1406 reaffirmed both the baseline panel numbers and adjustment parameters.
Health Technology Assessment Program	None		
Centers for Disease Control and Prevention	N/a		
Institute for Clinical and Economic Review	2008	Computed tomography (CT) colonography	Given the possible benefits of introducing a widely available minimally-invasive option for colorectal cancer screening, there is considerable interest in CTC.

Appendix D:

Figure 2: Care Provided Over the Course of a Person's Life: Doris



Alignment with Previous Recommendations

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