The Accountable Primary Care Model

Tom Doerr, MD
Director, Innovation Research, Lumeris Inc.
1. DEFINITION

• The Accountable Primary Care (APC) Model re-architects the way care is delivered at the practice level.

• The APC model offers a framework with workflows, metrics and strategies necessary to transition from volume-based to value-based care and achieve the Triple Aim Plus One:
  – Population health management
  – Cost-effective care
  – Patient experience of care
  – Physician satisfaction (Plus One)
1. Evolution of Accountable Care

Primary Care Model
- Primary Care Centers 1920
- Institute of Medicine 1978
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- Barbara Starfield 1992 4 C’s
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FFS Hamster Wheel Care
- Medicare RBRVS 1992
- "Toxic Reimbursement System"

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<table>
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<tr>
<th></th>
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<td>Fee For Service</td>
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**Table: Fee For Service vs. Models**

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**Legend:**
- ++: Poor
- +++: Fair
- ++++: Good
- +++++: Excellent
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- FFS Hamster Wheel Care
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- Medical Home
  - AAP 1967
  - 2007, 8, 11

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1. Evolution of Accountable Care

Accountable Primary Care
- Esse Health, late 1990’s
- Primary Care: 9 C’s, 2012

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<th>C8 Capacity/Expansion</th>
<th>C9 Career Satisfaction</th>
<th>Notes</th>
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<td>In FFS contracts, often ^ C1 and C4 by one +</td>
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1. Evolution of Accountable Care
**Accountable Delivery System**
- IDS or *virtually*-Integrated Delivery System
- Collaborative Payer Model (CPM, 2008)

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**ACOs 2006**

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</table>
2. ACCOUNTABLE 1° CARE MODEL VS FFS MEDICARE

2010 Encounters per thousand member years

<table>
<thead>
<tr>
<th>Category</th>
<th>APC</th>
<th>FFS</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>908</td>
<td>1,880</td>
<td>-52%</td>
</tr>
<tr>
<td>SNF</td>
<td>803</td>
<td>2,404</td>
<td>-67%</td>
</tr>
<tr>
<td>OP Hospital</td>
<td>12,902</td>
<td>14,627</td>
<td>-12%</td>
</tr>
<tr>
<td>OP Non-Hospital</td>
<td>11,483</td>
<td>32,474</td>
<td>-65%</td>
</tr>
<tr>
<td>Specialist</td>
<td>15,813</td>
<td>26,526</td>
<td>-40%</td>
</tr>
<tr>
<td>PCP</td>
<td>13,656</td>
<td>9,650</td>
<td>42%</td>
</tr>
<tr>
<td>Total</td>
<td>59,292</td>
<td>90,603</td>
<td>-35%</td>
</tr>
</tbody>
</table>
2.1 ACCOUNTABLE 1° CARE MODEL VS FFS MEDICARE

- The blue line is PMPY spending in 5% FFS by decile.
- The green dashes are Essence Healthcare’s spend by decile.
• APC model spends significantly less on the higher deciles of patient cost groups, compared with FFS.
APC spends significantly more on lower cost patients (the decile groups on the left) compared with its overall average 70% of FFS expenditure level.

In order to spend less overall, it is necessary to spend more than FFS does on healthier patients (e.g. the screening colonoscopy paradigm).
2.4 The APC Model excels in quality and patient satisfaction

- Star Ratings are 55 quality metrics relating to the Triple Aim in five domains:
  - Outcomes – health improvement as a result of provided care
  - Intermediate Outcomes – assesses care related to specific diseases
  - Patient Experience – measures patient perspective about care provided
  - Access – reflects barriers to patients receiving needed care
  - Process – how healthcare is provided

- APC Model rated 4.5 Stars in 2011 and 2012
  - Based on performance in 2010 and 2011
  - ~10% of health plans are rated 4.5 stars or higher
2.4 Doctors Can Afford to Spend More Time with their Patients

THE NINE C’S COMPONENTS

FFS plus incentives

- PA’s and Nurse Practitioners
- Panel Management Assistants¹
- Teamlets, health coaches²
- PCP leadership assessments and training³

Global risk contracting

- Virtual Visits: email and telephone care
- PCP organizations: frail elderly and disease management programs
- PCP orgs may employ: case managers, nutritionists, social workers, home health nurse, care coordinators, certified coders

• FFS-Plus methods and processes (on the left) may be used in global risk contracting.
• Global risk contracting methods and processes may not be feasible without substantial global gain-sharing.
• Methods and processes in blue italics are NOT in the NCQA Medical Home model.
• Different elements for different practices
C1: FIRST CONTACT AND ACCESS TO CARE

FFS Plus Incentives
(i.e. PCMH, MSSP, etc.)
- Patient education handouts to define expectations
- More same-day appointments
- On-call access on evenings and weekends
- Secure email for scheduling, communication
- Offices open until 8 pm, PCAT-AE #A1-A12

Global Risk Contracting
- Advanced Access Scheduling
- Virtual Visits: email and telephone care
- Outreach to new patients not seen

2008 Harris survey: 60% of adults have difficulty getting care on nights, weekends and holidays without going to the ER. ¹

In a nationally representative sample of over 20,000 episodes of care, episodes that began with visits to an individual's primary care clinician, as opposed to other sources of care, were associated with reductions in expenditures of 53% overall ($63 vs 134, P<.001). ²

¹ How SK et al Public Views on U.S. Health System Organization: A Call for New Directions Commonwealth Fund
³ Lei et al. Validating the Adult Primary Care Assessment Tool JFP 2001;50:161ff
C2: COMPREHENSIVE CARE

- **Proactive, Anticipatory Care**
- Chronic Disease Management
- Self-management support
- Community resources
- **Longer Office Visits**
  - thorough evaluation
  - documentation of high risk conditions
  - accurate coding
  - preventive care and immunizations
  - proactive care
  - disease management
  - teaching and assessing patients’ understanding
  - communication with families
  - phone calls with specialists

- **Expanded Role of PCPs**
  - "I am 80% of every specialist"
- **Greater range of procedures to serve the population**

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### Table 1 - Some Common Primary Care Office Procedures

<table>
<thead>
<tr>
<th>Dermatology</th>
<th>Cardiovascular and Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidermal cyst excision</td>
<td>Ankle brachial index</td>
</tr>
<tr>
<td>Foreign body removals</td>
<td>Electrocardiography</td>
</tr>
<tr>
<td>I&amp;D of abscess</td>
<td>Office spirometry</td>
</tr>
<tr>
<td>Ingrown toenail excision</td>
<td>Pacemaker checks¹</td>
</tr>
<tr>
<td>Keloid injection</td>
<td>Thoracentesis</td>
</tr>
<tr>
<td>Laceration suturing</td>
<td>Ultrasound of abdominal aorta</td>
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<tr>
<td>Lipoma excision</td>
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<tr>
<td>Mucocele removal</td>
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<tr>
<td>Nail avulsion</td>
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<td>Skin biopsy (punch, shave)</td>
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<tr>
<td>Subungual hematoma evaluation</td>
<td></td>
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<tr>
<td>Toenail trimming / grinding</td>
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<tr>
<td>Unna paste boot</td>
<td></td>
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<tr>
<td>Wart cryosurgery</td>
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<tr>
<td><strong>GI, GU</strong></td>
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<tr>
<td>Anoscopy</td>
<td>Arthrocentesis</td>
</tr>
<tr>
<td>Bladder catheterization</td>
<td>Greater trochanteric bursa injection</td>
</tr>
<tr>
<td>External hemorrhoid thrombosis excision</td>
<td>Bursa injections</td>
</tr>
<tr>
<td>Fecal disimpaction</td>
<td>DeQuervain’s tendonitis injection</td>
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<tr>
<td>Flexible sigmoidoscopy</td>
<td>Knee joint aspiration and injection</td>
</tr>
<tr>
<td>Pap smear</td>
<td>Lumbar puncture</td>
</tr>
<tr>
<td>Suprapubic bladder catheterization</td>
<td>Olecranon bursa aspiration and injection</td>
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<tr>
<td></td>
<td>Plantar fascia injection</td>
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<tr>
<td></td>
<td>Short arm cast</td>
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<td></td>
<td>Short leg cast</td>
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<td></td>
<td>Shoulder Injection</td>
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<td></td>
<td>Trigger finger Injection</td>
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<tr>
<td></td>
<td>Wrist ganglion cyst aspiration and injection</td>
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</table>

¹Pacemaker checks are performed by a technician from the device manufacturer. The physician does not charge for it. While these checks are usually performed in cardiologist offices, they may be accompanied by revenue-generating supply-sensitive interventions such as stress tests.
C3: CONTINUOUS, LONGITUDINAL, PERSON-FOCUSED CARE

- Advance care planning
- Patient activation with self-management
- Pre-visit work, post-visit work, between visit work

- Enduring, personal relationships PCAT-AE: metrics C2-9
- Following patients across care settings (inpatient, SNFs)
- Following patients into hospice
- Engaging the patient’s family

*Person-focused care includes discussing expectations, discerning preferences, setting priorities, engaging with family*, as well as the usual personalized prevention and screening goals and advance care planning.

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C4: COORDINATED CARE

• Active management of care transitions
• Patient care plans
• Medication reconciliations

• PCPs follow their patients across care settings
• Engagement in Referrals: Referral pre-work solves the specialist’s dilemma
• Low referral rates
• PCP orgs employ case managers and/or care coordinators
• Monitor, follow-up, adjust to changes and failures

After WWII:
A dozen categories of health professionals
A half dozen specialties

2013:
>200 categories of health professionals
>100 specialties
C5: CREDIBILITY

“If we don’t have credibility with patients, then we’re just referral clerks.”

- **PCP Credibility and Patient Trust**
  - Provision of the first four C’s
  - Address what patients care about, answer their questions thoroughly
  - Honoring the patient’s perspective
  - Timely follow up of test results

- **PCP Credibility and Patient Trust**
  - PCPs build credibility with specialists
  - Enduring, personal relationships. → beneficent persuasion
  - Management of Supply-Sensitive demands for care
  - PCP Sensitivity to Creating Expectations

---

1Swindell et al  Beneficent Persuasion: Techniques and Ethical Guidelines to Improve Patients’ Decisions  Ann Fam Med  2010;8:260-264
C6: COLLABORATIVE LEARNING

- Push care reminders into EHRs
- Outreach work list and scores
- Enhanced Encounters
- ACT documents, MOTDs
- Care consideration messages
- Computer-based educational programs
- Prevention and screening
- Panel management assistants

- Collaborative analytics wherein PCPs work on truing up shared payer database
- Collaborative learning across organizational boundaries and institutional barriers
C7: COST-EFFECTIVE

- Keep patients healthy
- Teach patients to call PCP first
- Hospice and Palliative Medicine

30% of $2.4T is waste

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Unnecessary services</td>
<td>$210</td>
</tr>
<tr>
<td>Inefficiently delivered</td>
<td>$130</td>
</tr>
<tr>
<td>Excess Admin costs</td>
<td>$190</td>
</tr>
<tr>
<td>Prices too high</td>
<td>$105</td>
</tr>
<tr>
<td>Missed prevention</td>
<td>$55</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75</td>
</tr>
<tr>
<td>Total</td>
<td>~$750</td>
</tr>
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</table>

“20 percent to 30 percent of health spending is waste that yields no benefit to patients... much is done that does not help patients at all, and many physicians know it.”

Donald Berwick


1 IOM Best Care at Lower Cost 2012
C8: CAPACITY EXPANSION

• PA’s and Nurse Practitioners
• Panel Management Assistants\(^1\)
• Teamlets, health coaches\(^2\)
• *PCP leadership assessments and training*\(^3\)

• *Virtual Visits: email and telephone care*
• *PCP organizations: frail elderly and disease management programs*
• *PCP orgs may employ: case managers, nutritionists, social workers, home health nurse, care coordinators, certified coders*

---
\(^1\) Bodenheimer T, Laing BY. The Teamlet Model of Primary Care Ann Fam Med 2007;5:457-461.
C9: CAREER SATISFACTION (PCPS)

- Drivers of Career Satisfaction:
  - Meaning in work/mindfulness
  - Control
  - Order
  - Work-Life balance
  - Financial compensation
- Volume-based with bonuses (for quality, process)
- How much gain sharing?

- Global Risk Contracting
  - Adequate compensation that enables longer visits
  - PCPs capture the value they create
  - Aligned incentives to decrease conflicts of interest
  - removes constraints on time, place, and manner of care, enabling innovation
3. Accountable Primary Care Model Playbook
1. Defines Activities by C and by Role
   – Administrator
   – Chief Medical Officer
   – Regional Medical Director
   – PCP/NP/PA

   ➢ One individual may perform several roles
   ➢ Activities distributed among individual roles

2. Defines Activities by Calendar by Role

3. Maps to ADSP
C1: First Contact
Explanation and description

First-contact care means that care is first sought from the primary care provider when a new health or medical need arises, except in the case of serious emergencies. The primary care provider either provides care directly or serves as a facilitator, directing patients to more appropriate sources of care at the appropriate time. (Starfield, 2008)\(^1\)

Dr. Starfield demonstrated that, for ambulatory conditions, when a patient’s entry into the health care system was through his/her PCP, the costs were 53% lower and the outcomes were better.\(^2\)

Additionally, in a survey published in JAMA, the zenith of managed care in 1999, Kevin Grumbach and colleagues found that 94% of patients valued the role of a primary care physician as a source of first-contact care and 89% as a coordinator of referrals. Depending on the specific medical problem, 75% to 90% of patients preferred to seek care initially from their primary care physicians rather than specialists.\(^3\)

You can expand access to care for your patients in several ways:

- Reserve more appointment slots for same-day visits.
- Provide telephone support after hours.
- Implement advanced access scheduling.
- Conduct telephonic or email care.

The failure of fee-for-service reimbursement to cover non-face-to-face care is a major barrier to many of these methods of expanding access.
# C1: First Contact

## Instructions for Implementation

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<th>Instructions</th>
<th>Role</th>
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<tbody>
<tr>
<td>1.</td>
<td>Review comparative benchmark</td>
<td>Health Plan/Market Director</td>
</tr>
<tr>
<td></td>
<td>Run Established Members last year. Each report 50% data. Refine to the AAPB Utilization Strategies stepwise for instructions on how to run and view the report. Review comparative component, prior year, and current year.  <strong>Focus!</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Include appropriate benchmark and key metrics to support data interpretation.  <strong>Focus!</strong></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Maintain and assess overall performance of activity metrics</td>
<td>Health Plan/Market Director</td>
</tr>
<tr>
<td></td>
<td>Include appropriate benchmark and key metrics to support data interpretation.  <strong>Focus!</strong></td>
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<tr>
<td>3.</td>
<td>Ensure appropriate staffing</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td>Ensure appropriate staffing numbers based on area of practice. Review the times and times until first appointment.</td>
<td></td>
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<tr>
<td>4.</td>
<td>Facilitate on-call support, scheduling, and same day/no same day with access to patient EHR</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td>Provide administrative capability for the drivers of access issues. Review case files from patients after hour. Review access with 24/7 access to ED, including ability to schedule new appointments. Integrate telephone triage protocols are optimal for appropriate patient visits and referral availability.  <strong>Focus!</strong></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Review after-hours message center, gaps in telephone of PEP/PN after hours</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td>Ensure that all messages received reflect the PEP/PN after-hours follow-up directly.</td>
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</tr>
<tr>
<td>6.</td>
<td>Ensure PEP/PN staffing</td>
<td>Administrator</td>
</tr>
<tr>
<td></td>
<td>Leverage impact of first contact on cost of care. Establish access to resource and procedures.  <strong>Focus!</strong></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Follow-up group established</td>
<td>Medical/Provider Summary Report</td>
</tr>
<tr>
<td></td>
<td>Ensure that all gaps in telephone of PEP/PN after hours are identified.</td>
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<tr>
<td>8.</td>
<td>Reduce access to care in external physician owners</td>
<td>Medical/Provider Summary Report</td>
</tr>
<tr>
<td></td>
<td>Provide access to care in external physicians.  <strong>Focus!</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** This document contains sensitive information and should be treated with confidentiality and respect.
<table>
<thead>
<tr>
<th>Timing:</th>
<th>Tactic:</th>
<th>Instruction:</th>
<th>C:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Attend CMO Monthly meeting/conference</td>
<td>Communicate pertinent information from Medical Group CMO meeting. (C6.5)</td>
<td>C6</td>
</tr>
<tr>
<td></td>
<td>Monthly Meeting with Regional PCPs – share comparative performance, discuss variation. Run reports by MG/Subgroup/PCP</td>
<td>Established Members not Seen Report</td>
<td>C1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utilization Management Summary Report YTD (ER Visit Rate, Generic Fill Rate)</td>
<td>C1, C7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PMPM Cost Comparison (Specialist cost and utilization; use of hospitalist)</td>
<td>C2, C3, C4, C7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measure Summary Table (Contract incentive performance)</td>
<td>C2, C7</td>
</tr>
<tr>
<td></td>
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<td>High Cost Members Report</td>
<td>C7</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Attend a JOC</td>
<td>Communicate findings to PCPs</td>
<td>C6</td>
</tr>
<tr>
<td>Annual</td>
<td>PCP Comp</td>
<td>EE Completion</td>
<td>C6</td>
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<tr>
<td></td>
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<td>ACT Document Completion</td>
<td>C6</td>
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<tr>
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<td>Gaps in Care completion</td>
<td>C6</td>
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<tr>
<td>Ongoing</td>
<td>Management Responsibilities</td>
<td>Discuss preferred specialist referrals best practices based on group preferences</td>
<td>C4</td>
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<tr>
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<td>Compare PCP Policies for notification of test results</td>
<td>C5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Share PGSR results and opportunities at Monthly meetings</td>
<td>C6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruit and train physician leaders</td>
<td>C9</td>
</tr>
</tbody>
</table>