Robert Wood Johnson Foundation

LEAVITT PARTNERS

Defining High-Value Primary Care Providers for ACO Partnerships

A leader's guide to potential partner assessment

As the health care industry moves toward population-based models of care, providers are seeking partnerships to help manage the continuum of services. Many will rely on existing partnerships while others will need to develop new relationships. The overall brief series is designed to give provider leadership guidance on how to begin that evaluation process in a time when performance data is scarce. This brief looks particularly at primary care providers and the specific considerations that should be included in a qualitative assessment of a potential primary care partner.

AN ESSENTIAL PARTNER

Building a network of high performing primary care providers (PCPs) is essential for effective population health management.[1,2] PCPs play an important role in every stage of the patient health care journey. Not only are PCPs the most common entry point into the health care system, but they also provide a majority of the care through frequent patient touchpoints along the way.[3] PCPs serve as the health system's main resource allocator, helping patients to identify and connect with other providers for their acute and post-acute care needs.[4]

OPPORTUNITIES FOR PRIMARY CARE IN AN ACO

Because PCPs are involved in so many stages of the care journey and represent a common connection to patients across all points of care,[5] they are best positioned to oversee the coordination of care between the various providers on the care team,[6] which is particularly important for patients with complex health needs. PCPs can ensure that patients are sent exclusively to high-value specialists and other provider partners by learning which providers are also committed to triple aim outcomes. PCPs can also ensure that crucial information from the specialist is brought back to the patient's personal health record and incorporated into the care plan for the sake of continuity.

EVALUATING PRIMARY CARE PROVIDERS

Due to their central role in accountable care, ACO leaders need to be very thoughtful in evaluating potential PCP partners. More than any other provider type, ACOs are often too quick to select PCP partners based on factors that are less relevant to long-term ACO success, like practice size and location. Any ACO seeking to develop its network of community PCPs should be methodical in its assessment of potential primary care partners to identify those most likely to culturally align with the goals of the ACO and become an engaged, long-term partner. Because PCPs are often used for patient attribution,[7] ACOs tend to over-partner with PCPs in order to accrue lives, but must later invest in costly practice transformation efforts that may never be successful. While strong, high-performing primary care can dictate the success of an ACO, poor performing PCPs can also be its biggest detriment.

When there is an abundance of primary care providers in a given market, initial screening steps may be necessary to create a more manageable pool of potential partners. Considering such factors as EHR adoption, referral activity, and prescribing patterns can eliminate organizations that are likely not ready for ACO partnership in the near-term. However, while these types of metrics can be used in preliminary stages, they should not be the ultimate criteria for a long-term partnership. Instead, ACO leaders should consider other qualitative attributes and indicators of high value.[8,9] The table below summarizes those key qualitative characteristics.

EXAMPLE HIGH-VALUE ATTRIBUTES

- **Demonstrates a willingness, even eagerness, to engage in all facets of transformation**
- **Proactively manages care according to patients' preferences and needs**
- **Collaborates with other provider to co-manage patient care**
- **Thoughtfully uses technology to improve clinical and business processes**
- **Prepared to prioritize long-term goals over immediate financial rewards**

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RESEARCH METHODOLOGY

Research findings represent an 18-month project which included: (1) Literature review of resources discussing high value in health care; (2) Expert panel meeting with 13 leaders from a variety of health care sectors to establish high-value domains and provider categories; (3) Interviews with ACOs and provider associations to field-test high-value criteria; and, (4) Transcript coding and qualitative analysis of interview findings.

"Primary care provider" definition: A provider who is specifically trained for comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem, organ system, or diagnosis.

Example settings:
- Ambulatory clinic
- FQHC
- Patient residence (home care)

Example clinicians:
- Physicians with generalist training (e.g., family medicine, internal medicine, pediatrics)
- Physician assistants
- Nurse practitioners

1. Primary Care And Why It Matters For U.S. Health System Reform; Health Affairs. **2.** Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform; NEJM. **3.** Disentangling the Linkage of Primary Care Features to Patient Outcomes: A Review of Current Literature, Data Sources, and Measurement Needs; Journal of General Internal Medicine. **4.** Trends in Physician Referrals in the United States, 1999-2009; JAMA Internal Medicine. **5.** Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans; American Journal of Public Health. **6.** Patient Experience with Coordination of Care: The Benefit of Continuity and Primary Care Physician as Referral Source; Journal of General Internal Medicine. **7.** Accelerating and Aligning Population-Based Payment Models: Patient Attribution; Health Care Payment Learning & Action Network. **8.** Lessons Learned From the Study of Primary Care Transformation; Annals of Family Medicine. **9.** The 10 Building Blocks of High-Performing Primary Care; Annals of Family Medicine

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HV DOMAIN	CHARACTERISTIC/ABILITIES	POTENTIAL CRITERIA
 Patient-centeredness	Proactively manages care according to patients' preferences and needs	• Do they incorporate patients' cultures/values/preferences in co-creating the care plan? • Do they have a process for identifying at-risk patients? Do they incorporate physical, mental, and social factors in that stratification? • Do they actively initiate end-of-life planning? Do they track these plans in a shareable format?
	Fosters meaningful relationships with patients beyond the point of care	• What is their patient attrition rate? • What are their strategies for patient outreach and engagement?
	Provides prompt and adequate access to care	• What are the average wait times for an appointment and once in office? • Do they have extended or weekend hours? Do they have same-day scheduling? • What have they done to address financial barriers to care?
 High Value Culture	Exhibits cultural compatibility with value-based care	• Do they have strong physician leaders who support the principles of value-driven care? • What are their motivations for partnering? Seeking true collaboration for care delivery transformation or just a financing mechanism? • Is there already some integration of clinical and administrative staff?
	Demonstrates a willingness, even eagerness, to engage in all facets of transformation	• Have they made any efforts to adapt to value prior to the ACO's interest in partnering (e.g., PCMH recognition, HIT or staff investments)? • Do they want to be involved in the ACO's governance structure? • Are they actively seeking information and feedback? Are they responsive when asked to make changes?
	Oversees the coordination of care	• Do they track and follow-up on all referrals, consultations, tests, and transitions? • Do they have systems for monitoring their patients' ED visits, hospital admissions, discharges, and transfers (e.g., regional or statewide HIE, direct interface with hospitals or SNFs)?
	Handles behavioral health needs with great care	• Do they regularly assess all patients' behavioral health needs? • What behavioral health resources do they suggest to patients? • Do they tend to simply treat behavioral health issues with psychotropic drugs?
 Team Based Care	Collaborates with other providers to co-manage patient care	• How often do they call other providers to discuss a shared patient's care plan? • Do they work with behavioral health providers for diagnostic and treatment support?
	Leverages an expanded, cohesive care team	• Do the physicians work closely with other clinical and administrative staff in innovative ways to efficiently manage patients' care (e.g., scribes)? • Do they have staff dedicated to identifying & addressing patients' needs (e.g., care managers)?
	All levels of staff share commitment to delivering high-quality, coordinated care	• Do all clinical and administrative staff meet together regularly for team meetings? • Do staff members enjoy their work environment? What is the employee turnover rate? Are staff members encouraged to report problems to practice leadership?
 System & Public Accountability	Assumes responsibility for identifying and selecting providers for value-driven referrals	• Do their referral patterns reflect careful attention to quality and cost considerations? • Do they communicate and enforce high-value expectations with specialists, hospitals, and post-acute care providers (e.g., commitment to shared care plan, timely data sharing)? • Do they incorporate patient experience into later referral decisions?
	Has a positive reputation within the community	• How do they advertise themselves? • How are they rated online? • What are the opinions of senior leaders who have practiced in the market for a long time?
 HIT Systems	Thoughtfully uses technology to improve care delivery	• Do they have a MU-certified EHR? Have they used the EHR to do things better or differently? • Do they maximize HIT's value (e.g., customizing templates, using reporting functions)? • Do they have HIT tools they don't use? Are they distracted by too many platforms?
	Systematically gathers data to inform clinical and business strategies	• Do they actively collect, combine, and analyze data from multiple sources (e.g., claims, EHR, patient survey, registries, physician notes)? • Do they assume responsibility for gathering and incorporating clinical information into the patient's health record following an interaction with another provider?
	Bi-directional data sharing capabilities	• Can they electronically share and receive important clinical information?
 Performance Improvement	Systematically tracks clinical quality, utilization, and experience data for ongoing improvement efforts	• Do they know the percentage of their patients who have had an annual wellness visit? • Do they have a thoughtful process for prioritizing improvement efforts based on greatest need and potential impact?
	Regularly shares quality information widely across the practice (as opposed to only during annual reporting)	• Are the physicians aware of the individual quality measures for which they're responsible? Do they know how to access the measure list and data? • Are physicians' quality scores transparent to their practice peers?
	Agrees to collaborate with other ACO providers in joint performance improvement activities	• Are they willing to participate in clinical collaboration committees for improvement planning? • Are they willing to take on new quality measures?
 Financial Readiness	Prepared to prioritize long-term goals over immediate financial rewards	• Have they already made investments that demonstrate their commitment to value? • Are they willing to invest, even a small amount, in practice transformation (e.g., ACO membership fee) to have some "skin in the game"?
	Aligned with the principles of value-based payment	• Do they have past experience with risk-based contracting (e.g., MA)? If so, successfully? • Do their internal financial rewards systems align with value (e.g., performance-based bonuses)?
	Has sufficient resources to invest in necessary population health efforts	• Do they have sufficient resources to hire new staff (e.g., case managers) even though part of their salary might not be paid-off until shared savings is achieved? • Do they have the capacity to quadruple their wellness visit rate?