Risk-Ready Primary Care

Risk-Ready Primary Care is a model developed and promoted by Health Management Associates. The model creates a clear path to clinical and organizational excellence that prepares primary care entities to compete in the evolving world of value-based payments. Primary care practices must be ready to succeed at hitting quality targets to optimize pay for performance revenue, and similarly ready to succeed in attracting and retaining patients. These three areas -- cost, quality, and experience -- are recognized as the pillars of accountable care.

HMA’s Risk Ready Primary Care team assists clients in assessing their system of care and prioritizing action steps towards improved readiness for financial risk, including achievement of Patient-Centered Medical Home (PCMH) recognition by an accrediting body. The HMA team includes medical and behavioral health clinicians, quality improvement professionals, several National Commission on Quality Assurance (NCQA) PCMH Certified Content Experts, a former graduate medical education program director, healthcare finance specialists, and managed care experts. This team has assisted public and private safety net health and hospital systems, residency-operated clinics, Federally Qualified Health Centers and others in their transition to an organization ready to thrive on value-based and population-based payments.

Two foundational elements of the model -- a functional and connected information technology ecosystem and a prepared workforce and leadership that is committed and capable of leading change -- are supported by our expertise and organizational strength in delivery system transformation.

We have found that understanding the four pillars of the Risk-Ready Primary Care helps our clients to make purposeful and strategic moves towards capacity-building. These pillars are: “Build Your Foundation,” “Capture Sure Wins,” “Focus on the Right Populations,” and “Make it All Work.” This model is depicted and described in more detail below.
Becoming a patient-centered medical home (PCMH) is a foundational transformation for succeeding in taking on risk. The Agency for Healthcare Research and Quality (AHRQ) defines PCMH as a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

The PCMH is the basic unit of an integrated delivery system. It is where patients develop long-term, continuous healing relationships with a primary care provider and medical home team. It is the first place a patient calls when they have a non-emergent health concern and it is the coordinating entity for all their care. A Patient-Centered Medical Home transformation is multi-faceted and requires system-redesign and engagement of staff at all levels. The PCMH model that has gained the most national attention is the National Committee on Quality Assurance's PCMH Recognition Program which has six standards described briefly below.

1. ACCESS AND COMMUNICATION
The practice has a written process and defined standards for providing access to appointments; access to clinical advice and continuity of medical record information at all times; and the ability to offer information and services to patients through a secure, electronic system.

2. TEAM-BASED CARE
The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches; has a process for informing patients and families about the role of the medical home; and uses a team to provide a range of patient care. The goal is to have ongoing interactions of team members to discuss roles, responsibilities, communication and patient hand-off, working together to provide and enhance patient care.

3. POPULATION HEALTH MANAGEMENT
The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

4. CARE MANAGEMENT
The practice systematically identifies patients that may benefit from care management; and works collaboratively with the patient to develop an individual care plan, and coordinates care among the practice team. The practice supports patient self-management.

5. COORDINATION AND TRANSITIONS
The practice systematically tracks tests and referrals, and coordinates transitions across specialty care, facility-based care, and community organizations. This includes integrating behavioral healthcare providers within the practice site.

6. PERFORMANCE IMPROVEMENT
The practice uses performance data to identify opportunities and improve clinical quality, efficiency, and patient experience.
These are targeted interventions that are highly likely to have a positive return. These are some examples of things that a system should take as first steps if they have entered into a shared savings arrangement. These are things to be most likely to result in savings while improving quality and satisfaction (not using service restriction as the mechanism of savings).

**REDUCTION OF LOW VALUE TESTS:**
Many studies have shown that physicians order more tests than are necessary. Some of these tests are very costly, have downstream costs from follow ups of abnormal results and/or are actually dangerous for patients. CT scan for a headache without “red flag” findings is a very good example of a low value test (negative value).

**POST-HOSPITAL TRANSITION CARE MANAGEMENT:**
This is care management done specifically to reduce re-admissions when a patient is being transitioned from inpatient to outpatient. This is very likely to be high yield but not as rock-solid as reduction of low value tests. In order to have a high return on investment, the care management efforts must be more intensive for the higher risk patients. Returns include the avoidance of Medicare penalties.

**ED DIVERSION:**
ED diversion generally means that patients that are intending to access the ED are diverted to a lower level of care if appropriate. The reason this results in savings is not because the ED is costly per se. It’s that when patients come to the ED they are treated as people coming in for an emergency, and are much more likely to receive low-value tests and referrals.

**USE OF GENERICS:**
This is a potential quick win but often full advantage of this has already been accomplished. However, if it has not, there are several avenues. First, when both generic and branded are available for a medicine, require generic. Within a class of medicines, first use medicines for which a generic equivalent is available. In a situation where various medication classes could be effective, first use the medication class in which generics are available.
Focus on the Right Population

Particular populations with high potential for improving health across the population, patient experience and reducing cost. Use panel data to determine the particular populations with potential to improve health outcomes and yield a return on investment, for example: frail elderly dual eligibles, disabled dual eligibles, individuals with serious mental illness, individuals with substance use disorders.

- **Primary Care Capability to Deliver Behavioral Health**  
  This refers to training and empowering primary care providers to treat depression, anxiety and more serious mental illnesses with the support of behavioral health providers within their primary care practice.

- **Behavioral Health Professionals on Primary Care Teams**  
  This may be one of several models. The outcome is that the behavioral health provider becomes part of the primary care team that works together on a plan of care for individual patients.

- **Primary Care Delivery in the Behavioral Health Setting**  
  This is a recognition that some people with serious mental illness or substance use disorder will only visit their behavioral health provider despite having significant primary care needs. Through various possible models, primary care can be brought, in whole or part, into the behavioral health setting. This is one model of a health home, though a behavioral health provider may provide a health home by coordinating with primary care delivered elsewhere.
The final pillar is intended to convey that the model won’t work without financial capacity and management control. Management control is the ability to monitor and affect the performance of the organization -- financial and other types of performance.

**Active Management of Utilization Patterns**
An organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care. It is the process of evaluating the medical necessity, appropriateness, and efficiency of health care services. An example in primary care is the use of evidence-based referral rules to ensure the appropriateness of sub-specialty referrals.

**Analytic Capacity or Capability**
The ability to take in the reams of data that are generated in the process of caring for a population and to analyze with the outputs allowing monitoring of expected outcomes, identification of opportunities, prediction of risk, etc. This is inclusive of software and human capabilities.

**Financial monitoring connected to patient-specific program intensity**
This refers to changing the intensity of effort around each patient based on their risk for avoidable high utilization or avoidable poor outcomes, and monitoring the cost and outcomes (the return on investment) related to the interventions.

**Contracting for Risk**
An important part of making it work is setting up contracts that allow the primary care provider to be rewarded for the right kind of success. HMA has specific capabilities in assisting primary care entities in defining and negotiating win-win contracts. These components of practice transformation will take time, energy, and leadership. They will lead to a practice that is prepared to succeed in the new paradigm of value-based payments. We are prepared to assist your organization take the right next steps in becoming a Risk Ready Primary Care practice.