SB 227 Primary Care Collaborative Meeting

Wednesday, November 7th, 2018
4:00 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:	**Email:**
Dr. Nancy Fan	nfanssmith@yahoo.com
Absent:	
Senator Bryan Townsend[1]	Bryan.Townsend@state.de.us
Representative David Bentz	David.Bentz@state.de.us
Staff:	
Juliann Emory	Juliann.Emory@state.de.us
Caitlin Del Collo	Caitlin.DelCollo@state.de.us

Attendees:	**Organization:**
Kathy Collison	Division of Public Health, DHSS
James Gill	FMA-Greenhill
Drew Wilson	Medical Society of Delaware/Morris James
Pam Price	Highmark
Megan Werner	Westside Family Healthcare
Art Jones	HMA
E. Woodford	DAPA
Cheryl Heiks	Connections CSP
Rosa Rivera	La Red Health Center
Shay Scott	Henrietta Johnson
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Dr. Christine Donohoe-Henry	Christiana Care Health Systems
Lolita Lopez	Westside Family Healthcare
Dr. Dan Elliott	eBright ACO
Tom Brown	Nanticoke Health Services
Dr. Bryan Villar	Bayhealth
Dr. Gary Siegelman	Bayhealth

[1] Senator Townsend was present for the opening of the meeting, but had to leave due to a caucus meeting. Representative Bentz also had a caucus meeting to attend, and therefore did not make this meeting.

The meeting was brought to order at 4:01pm.

Opening remarks from participants

Dr. Christine Donohoe-Henry, CMO – Christiana Care Health Systems

- We have been delivering high quality, but not necessarily high value care.
- We went on a process looking at care delivery and how it needs to change in the future because:
    - Access to primary care providers is extremely limited
    - Significant health disparities exist among ethnic minorities
    - There is a pressing need to decrease costs
    - It is stressful to be primary care clinician especially with EHR and patient visit volume expectations.
- We used a consultant to look at physician need by local geography. Currently patients may wait 2 or 3 months for a new patient appointment.
- Our strategies include:
    - Data is important tool. We need to follow quality metrics and utilization metrics.
    - We have leaned on Carelink CareNow. This is a nurse care management model that provides ongoing care management with social workers and pharmacists as well.
    - We are moving toward one electronic health record – transitioning all practices to the same EHR.
    - We are adopting virtual primary care options for employees and their dependents – via video, calls, and texting.
    - We have co-located and integrated behavioral health into primary care.
    - We have residency recruitment strategy that focuses on doctors who will likely choose to practice primary care and want to support new primary care clinicians.
    - We also have an NP residency transitioning to APC fellowship to support in first 6 months of practice.
- Team-based care:
    - We are also focused on team-based care and moving toward a teamlet model (PCP partnered with an APN within a care team), which include behavioral health and nutrition
    - There will be three teamlets per practice caring for approximately 10k patients.
- Linked specialty
    - We are engaging with specialty providers to repatriate patients who don't need to see specialists as often back into primary care while maintaining the electronic link to those specialists.
    - This helps to improve access to specialist by freeing up appointment times.

Lolita Lopez – Westside Family Healthcare Key point important to FQHCs

- The biggest challenge we have is recruiting and retaining qualified primary care providers to meet the demand.
- In collaboration with Christiana, we now have a residency program that trains at the FQHC site.
    - This has been a successful program. Residents are choosing Christiana for the opportunity to come to an FQHC.
    - They are introduced how to manage social determinants in a continuity setting.
    - We have two residents in each year meaning we have 6 residents at any given time. And we are looking to expand this work.
    - Research shows that doctors practice near where they serve their residency.

- Westside had always had NPs, in fact we were established to be a nurse-managed center. We have found NPs have inconsistent training and students graduate without a lot of primary care training. They need 3 to 6 months of support and training to get them up to speed.
    - We need help supporting APNs and PAs to expand usage of these providers.
- The administrative burden of enhanced care teams and EHR has made it difficult for providers in a community-based practice.
    - We are interested in enhanced payments to help address this challenge.
- We rely heavily on state and federal loan repayment program and would like to see this expanded and enhanced.
- We are always recruiting for primary care providers; we currently have 9 primary care provider vacancies; until we are fully staffed and have capacity, we cannot focus on generating savings in the system because primary care capacity is not sufficient to prevent ED use and sufficiently manage chronic conditions.

Dr. Megan Werner – Westside Family Healthcare

- We want enough primary care providers to take care of the patient population.
- The situation must to be desirable enough for people to want to practice primary care here in Delaware.
- We need to create a system where providers feel supported and can focus on helping patients rather than chasing after administrative work.

Shay Scott – Henrietta Johnson

- Care teams give providers the opportunity to focus on care and step away from the administrative work.
- We find it challenging to have enough primary care providers and are not operating at full capacity due to a PCP shortage. Recruiting APNs and PAs has not been sufficient.
- Our strategy has been to use care coordinators to relieve burden from the provider.
- With the EHR, we find that teaching a provider this new skill has been a burden that impacts our ability to operate at full capacity.

Dr. Dan Elliot – eBright ACO

- As a MSSP ACO, we have employed providers from all the major health systems and 12-15 private practices.
- We do not hire physicians to fill gaps but work to help each of these organizations orient to the value proposition. This includes looking at their own practice model and considering how to improve the value of the care they provide.
- We have a conversation with a group of providers and see that across these geographic areas, all are working to achieve the same ends. We ask - what can we do at scale that is more efficient than we can do individually?
- We have a shared commitment to work together on a few key things such as:
    - Sharing best practices;
    - Sharing investments that take advantage of scale like a data analytics system;
    - A care management program that creates a more supportive environment for PCPs.

- It is complicated work, and everyone must do it individually. These systems and practices are at different stages in adopting best practices. We can help them find the biggest bang for their buck.
- The ACO serves as an aggregator and as a collaborative engine. We help to guide action, assess the situation, and make strategic plans.

Tom Brown – Nanticoke Health Services

- We are a small rural hospital and health system with a service area of about 715,000 residents in the western part of Sussex County. We have a physician group of about 60 physicians. The hospital is financially stressed and threatened with closure.
- The plight of primary care is the same as small community hospitals.
- In rural areas, primary care is strongly linked to the community hospital. The payer mixes skews toward public coverage, not private sources. PCPs panels are composed of approximately 60% Medicaid and Medicare covered individuals. That patient mix increases to 83% for the hospital. The commercial share continues to decline.
- Additionally, the population is challenging due to the poor health risks in the population.
- This year alone we have lost 4 out of 30 primary care providers. That is a 15% decrease. We expect to lose another 20% next year. These providers are leaving due to age and financial liability.
- Nanticoke wants to keep independent physicians independent. Having an independent provider leave or seek employment at the hospital is not helpful to sustaining primary care access.
- There is only one primary care group that has hired in the last few years and Nanticoke has financially assisted (within Stark Law rules) in recruiting and hiring these primary care providers.
- We have helped primary care with the ACO. We have a single EHR and help affiliated independent PCPs access to that EHR, which removes a huge burden from independent who wish to join us.
- We don't choose where we locate our physicians in order to gain favorable market share. We want to maintain access.
- We employ 16 primary care physicians and 20 NPs. We have been employing primary care NPs for 8 years. They are treated as providers with their own panel. We also have other NPs under physician supervision. This is intended to relieve the burden on our physicians and our ED.
- By moving ED patients to primary care and keeping them out of the ED, we have saved the state money, although we are not reimbursed well for this success.
- We became PCMH certified. We hired care coordinators who worked with the high-risk patients regardless if the insurer pays for care coordination.
- We have also run a telemedicine behavioral health pilot working with Medicare population in the ACO.
- We participate in the eBright Medicare ACO.
- All these innovations and changes are at a loss to Nanticoke.
- We cross-subsidize the primary care physicians because the level of work does not match up with our reimbursement. We have to find a way to fund the shortfall in the long term.
- Primary care providers need to be paid adequately and appropriately for their role as health care QBs.
- Hospitals and primary care physicians are not all alike. The solution is not monolithic. There is no one public policy that will fix things for all practices. We have different problems and serve different populations. I would rather build a system that is sustainable, not patch the obvious holes in the current system.

Dr. Bryan Villar – Bayhealth

- When I graduated there were no jobs in Wilmington. As foreign grad on an H1 visa, I needed a job. In a small practice, we had 6 residents. Only 2 or 3 of the residents stayed in Delaware. Compensation here is not good so they leave for higher paying states.
- I worked for a private practice. It is a small business, and in a small group it was difficult to sustain our medical insurance. Comparatively, being a hospital resident was better compensated.
- Hospital employment of physicians makes it seem like the hospital is the enemy of the private practice because they are competing for the jobs and talent. In reality, by their ability to offer better salaries and benefits, they are helping to keep primary care physicians in Delaware.
- Bayhealth has sent in application to create internal medicine and family medicine residencies because we know there is a need for primary care doctors. But if other states pay more for primary care, they will not get enough interest.

Dr. Gary Siegelman – Bayhealth

- There are a number of similarities across these organizations.
- The goal is how to bring new providers to the state of Delaware and how to maintain and sustain their practice the once here.
- We applied for a practice transformation grant in 2015 – this was simultaneous with the SIM grant. With this grant from CMS for practice transformation, we provided training in quality improvement, data collection and analytics and practice transformation for 2,400 to 2,500 clinicians. Many of these cohorts of physicians have graduated from practice transformation and are better prepared for care. This included both specialists and primary care physicians.
- We have begun the process to beginning residency training. We plan in July of 2021 to have two programs – family medicine and internal medicine. In the following years we will add emergency medicine and general surgery.
- We think this will add new primary care trainees to the state. We have had preliminary discussions with Westside to work together on training.
- We want to add trainees to the state in the hopes that they will stay in the state.
- You see fewer private practices – we are saying that there is a strong role for private practices, but we recognize that that is not sufficient to sustain the needs of the population. There are very few private practices that are recruiting.
- We have provided forgivable loans to help primary care physicians to enter into private practice, but we have few takers.
- We also brought in two practices in the Milford area – these practices have been in the community for 20 years but couldn’t sustain a practice on their own. These practices that we brought in are doing well.
- We participate in the eBright ACO and are doing well on the quality metrics.

Rosa Rivera – La Red Health Center

- We have found that both recruiting and retention are hard, especially when competing with larger groups.
- We are able to use NPs more, but the type of patients seen at FQHCs are very complicated patients, so we are asking NPs to act more like physicians.
- The physicians have an increased workload because they need to mentor and assist NPs.

- The types of patients we see have changed. We have agreed that we need to meet our patients where they are, which increases the cost of operating.
- In Sussex, there are many barriers to patients seeking care, we need to reach out to meet them
- These stressors increase provider burn out. We are using care coordinators to relieve some of the stress.
- FQHCs provide services that we don't get paid for:
  - We provide translators and sometimes must send our translators out with patients to other providers because specialty care practices do not hire their own translators.
  - We also provide transportation to reduce no shows and increase compliance.
- IT is a both blessing and a nightmare. Having access to data is great, but it is a nightmare because it is expensive, requiring staff training and constant maintenance. Payers and governments constantly increase the number of data points they want us to collect. We still struggle to get the reports they want out of the IT system.
- Implementing care coordinators has been great; they help us keep on top us patient prevention and follow up.

Questions

Dr. Fan

- There seem to be some common themes across these organizations.
- Do you see any benefit in trying to push forward investment not just for reimbursement, but direct investment for instance in IT? Would it be helpful for payers to devote a block of money to IT investment? This is one of the strategies begin used in Rhode Island.
- And as we transition away from the current system, how do we build a team-based care model?

Tom Brown – Nanticoke Health Services

- All of our organizations have different ideas to improve care, but implementation is hindered by the uncertainty of the future.

Lolita Lopez – Westside Family Healthcare

- All providers are different. We all have care teams, but they are all a little bit different.
- The work that we do in between visits is not paid for. Even if we have enhanced payment (which FQHCs do get) there is still work between visits that is not reimbursed. Care management would be a good investment from payers.
- I am not sure how you structure it, but that piece of reimbursement is missing.

Dr. Megan Werner – Westside Family Healthcare

- It is no longer possible for physicians or NPs to address all the needs of their patients alone. As a result, we need to rely on care teams, but we are not paid to have care teams support the clinician. These teams provide follow up and medication management, but this is not reimbursed so it is difficult to find a way to pay for it.
- The payment should be flexible to acknowledge that each organization is doing care management differently.

Dr. Fan

- Connecticut is thinking of adopting a primary care bundled payment.
- There are different models of value-based payments. The MSSP ACO model provides a back end payment for value, rather than up front.
- How should value-based payments work?

Dr. Dan Elliot – eBright ACO

- We need upfront investment. We are trying to build smart investments. The issues are consistent across organizations.
- We need investment that pays for care management. This is a shared value across all providers.
- We need to understand what should be purchased at scale and what should be done locally. Then we can direct investment appropriately.
- We need to think through the immediate needs and more strategic investments. The ROI will be much longer than you expect. If you think you are investing in the right thing, you need to avoid placing a timeline on outcomes that is too short and could inhibit or jeopardize the work.

Shay Scott – Henrietta Johnson

- By participating in Aledade's Medicare ACO, we got two care coordinators who have made a huge difference. Figuring out how to pay for that was important, but it has been a great investment. The decision to do this ourselves was tough.
- A grant that supports organizations with flexibility is important – accounting for their unique readiness levels and putting it toward what they need most.

Dr. Fan

- How do you align cost containment with investment?

Dr. Gary Siegelman – Bayhealth

- It may be helpful to have aligned, stepwise goals that link the action and outcome to highlight why change is important.
- One thing that helped us with the practice transformation grant, but the physicians didn't internalize why they should care until the MIPS program provided a specific goal aligned with their practice transformation change.
- Organizations need help with predictability. There were some private insurers who helped the providers become PCMHs, but then that reimbursement was cut. The practices felt that the rug was pulled out from under them.

Rosa Rivera – La Red Health Center

- What is the trade off with this investment? Is it new money or is it a result of reductions elsewhere? We need to be able to put this investment to our most important things – and that probably won't be IT.

- Many services we provide are not reimbursable but make a difference for patients. How can we get paid for these services? All of this costs money. The additional services improve health and make staff happier.

Dr. Megan Werner – Westside Family Healthcare

- It is really important to think about investment in a long-term view. Primary care is the most cost-effective place to provide care, so investment makes our care more efficient in the long term, but not in the short term. I would expect a short-term increase in spending from providing more care, finding conditions, and treating them early. But over the long term it improves health, helps avoid complications, and improves the economy.

Dr. Dan Elliot – eBright ACO

- These concepts are important; we can learn from CPC+ model.
- To put resources in front of someone without accountability for outcomes is a mistake.
- How do we get all providers to participate? We need a glide path that allows for all providers to participate.
- There is a 5-year time horizon to move to downside risk in the Medicare models. This is a precedent that can start a discussion of how fast/how far we can expect adoption.
- The investment needs to be directed, but within a frame work that ensures all can benefit from it.

Dr. Fan

- What does value based payment mean to you?

Dr. Dan Elliot – eBright ACO

- Speaking on behalf of Christiana care, our leadership has been interested in moving forward with value-based payments.
- There is an aggressive posture in adopting and making it sustainable.

Tom Brown – Nanticoke Health Services

- We are stewards of the community's assets. When we take risks, it needs to be intelligent. I would like to think that in the next 5 years we have 100% value-based payments and some of that is includes downside risk.
- The investment of primary care must be seen in light of the change in primary care payment models.
- Asking about the ROI is not relevant if the bridge is going to fall down. We need to consider ROI from an appropriate baseline.
- We are not going to get value-based payment without physician capacity. Investment cannot only be linked to value-based payments because we need providers and resources.

Dr. Fan

- What do you think about 12% primary care investment as a share of total health care spending?

Tom Brown – Nanticoke Health Services

- That depends on what is measured and included in the numerator.
- We have to devote more resources to primary care, but I am reticent to say a certain number because we need specific details to support a number. Additionally, this is a monolithic fix and not helpful in overhauling the system.

Lolita Lopez – Westside Family Healthcare

- It depends are you taking the additional 9% from somewhere else. Is it a shift or a new investment?
- When I think of ROI, FQHCs offer a big return. There are studies on how much we save particularly for Medicare patients because we have always had care teams and one stop shopping to address the unique needs of our patient.
- For value-based payment, we want measurable quality outcomes, but it is difficult for medically underserve patients because there are many things we cannot impact. We really cannot take on downside risk because there is a limit on how much impact we can have. We can do upside risk.
- We have bundled payments (PPS encounter payment) for a long time, but it has not kept up with expenses and the needs of our patients.
- We want to increase prevention services, but we are not paid for this. Keeping up with the chronic and acute care needs requires so many resources that we cannot focus on the preventive side.

Dr. Fan

- Supporting the workforce continuum has been an important element in this conversation.
- Why does our Delaware attrition rate outpace our ability to support the workforce pipeline?

Dr. Gary Siegelman – Bayhealth

- There is a formula for high cost high utilizers and we need a focused approach to address these people.

Dr. Megan Werner – Westside Family Healthcare

- We need resources to help address social determinants.

Dr. Dan Elliot – eBright ACO

- My concern about spending thresholds is that it becomes like MLRs – a mess, where service categories get re-categorized.
- We need the funding to be directed in a way that is directed by the people who know the real need. We cannot just move money around.
- The institutions are subsidizing primary care. Primary care is not working financially for anyone.
- We care more about where that additional investment goes to rather than how much that investment should be.

Dr. Fan

- We need everyone onboard.
- Everyone has ideas for what is working.
- Our goal in phase one is increase reimbursement within our current model.
- The second phase asks how do we add investment that transforms the system?

Dr. Megan Werner – Westside Family Healthcare

- There is some adding dollars up front, then long-term shifting from low-value to high-value services. The ER spending can be invested in primary care when the people don't rely on the ER as much.
- There is lots of potential in value-based payment models. The question is what is value and to whom?
- The payer wants data for these things that are not clinically meaningful to me or the patient. The smaller your practice the less support you have to deal with this administrative burden.
- We need a common language. There should be accountability, but the burden on the providers to speak the insurers' language is not good.

Rosa Rivera – La Red Health Center

- We are responsible for so many things, but the real impact comes from the patient. The patient plays an important role.

Public comment

Dr. Susan Conaty Buck

- It is unfortunate you have not had any NP practice owners to speak to the Collaborative.
- NPs have a good track record. In Delaware, 100 have the ability to have independent practice, and others can apply for independent practice. Rhode Island and Connecticut both have independent practice. Like all primary care practices, they need support to overcome the same challenges.
- Maryland has been offering a sign on bonus to help establish NPs in their own practices.
- NPs want to practice at the top of their license. In other states, there is recognition that NPs successfully operate solo.
- We need to encourage organizations employing NPs to have them in primary roles, and placing them in places it's hard to get physicians.

Dr. Jim Gill

- I am impressed that everyone here is the same page that we all need all these types of practices.
- Question about how hospitals can support primary care in ways that has been done in other parts of the county. In other states, a hospital pays the salary of a physician in private practice.

- They charge a part of the practice revenue and the physicians develop a loyalty to the hospital. The primary care physician's salary is small compared to the revenue they generate for the hospital. Would the hospitals here consider this?

Tom Brown – Nanticoke Health Services

- The Stark laws are very prescriptive. Typically you have a 3-year period where you loan the money to the physician. NPs are excluded based in the federal law.
- For an individual physician this program can be a tremendous risk, but for a small group it is easier.
- I used to be able to sell this idea, but now the physician just would rather be hired because of the risk.

Jonathan Kurch

- I am hearing apocalypse and optimism. It strikes me that the system isn't broken but the system is operating exactly as designed.
- The social determinants is a phrase we hear over and over, but most of it has very little to do with physicians and medicine.

Dr. Gary Siegelman – Bayhealth

- I agree that the system is doing what it is designed to do.
- I give a lot of credit to CMS, they have been making significant strides in making changes 5 or 6 years ago. They have tried models to see what works. They have changed reimbursement and goals. The system is changing.

Dr. Dan Elliot – eBright ACO

- The issue is not necessarily whether we should go to risk because no one likes the way things are. The question is how with appropriate guiderails and goals.
- To the social determinants question – I tend to remind that we have a lot of work inside our clinical care that needs to be addressed before we can blame social determinants for adverse outcomes.

Caitlin DelCollo

- There is a lot you don't get reimbursed for, is that because payers make a choice? Is the state authorized to mandate these are reimbursed?

Pam - Highmark

- Telehealth is mandated by the state to be covered with parity to office visits. If it has a code, then it is reimbursed same as an office visit.
- In terms of care coordination, we have a program (True Performance) that pays for care coordination. Our fee for service programs don't have a payment for care coordination.

Dr. Gary Siegelman – Bayhealth

- There are quality metrics hurdles to get care coordination payments.
- Another option would be to gather a population of one payer's members and get a care coordinator from the payer.

Lolita Lopez – Westside Family Healthcare

- It's also different for every payer. Each payer approaches care coordination payments in a different way.