Investing in Primary Care: The Path Forward

A Report of the Minnesota Primary Care Stakeholders Group

April 2021

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Executive Summary

Greater investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. Despite current high levels of health care spending in the United States, the proportion spent on primary care is insufficient. A shift in resources to support greater access to comprehensive, coordinated primary care is imperative to achieving a stronger, higher-performing health care system.

Underinvestment in primary care gives rise to patient access and workforce issues. A significant financial incentive for physicians and other clinicians to choose other areas of specialty undermines primary care." – Primary Care Collaborative, 2020[1]

The health care system in the United States strained to the breaking point during the 2020 COVID-19 global pandemic, bringing to light longstanding issues involving access to care, health disparities, and poor outcomes despite the high cost of health care in the state and nation.

Primary care has served as the cornerstone for building a strong health care system that ensures positive health outcomes and health equity. According to the Institute of Medicine (IOM), "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[2]

[1] Primary Care Collaborative. (2020) Primary Care Investment. Retrieved from: https://www.pcpcc.org/topic/primary-care-investment?page=2&language=en

[2] Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra M. (2008, September 13). Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. *The Lancet,* 372(9642):917–927. Retrieved March 17, 2021, from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61402-6/fulltext

This definition established primary care as a function not fully captured by any single specialty. The IOM declared primary care the "logical foundation of an effective health care system" and "essential to achieving the objectives that together constitute value in health care."[3]

People who receive regular primary care can get preventive treatment earlier and before more severe problems develop. For people with chronic diseases, improved access to primary care improves health management and prevents or forestalls further complications. Higher levels of primary care in a geographic area are associated with lower mortality rates, trust, and treatment compliance. While primary care is not the solution to every health-related problem, few, if any, health-related problems can be adequately addressed without it.[4]

The Minnesota Primary Care Stakeholders Group calls upon the Minnesota Legislature to improve population health and health equity for all Minnesotans by rebalancing health care spending to strengthen the primary care infrastructure and workforce. This is not an easy task. It will require complex changes and take time, but it is imperative that we begin.

Introduction

Evidence consistently shows that primary care-oriented health systems achieve better results, are more equitable and have lower costs. Despite this, primary care is chronically under-funded in the United States (U.S.) and trending down over time. The average health care spend in other industrialized countries in 2019 was 14%, as opposed to 5-7% in the U.S.[5] As a result, primary care practices are unable to provide patients with the personal attention and scope of services that they

[3] Hall JJ, Taylor R. (2003, January 6). Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia,* 178(1):17–20. Retrieved March 17, 2021 from https://pubmed.ncbi.nlm.nih.gov/12492384/

[4] Phillips, Robert L. Jr, Bazemore, Andrew W. (2010, May 10). Primary Care and Why It Matters for U.S. Health System Reform. *Health Affairs 29, No. 5* (2010): 808-810. Retrieved March 17, 2021 from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0020

[5] Jabbarpour, Yalda; Greiner, Ann; Anuradha, Jetty; Coffman, Megan; Charles, Jose; Petterson, Stephen; Pivaral, Karen; Phillips, Robert; Bazemore, Andrew; Newmann Kane, Alyssa. (2019, July). Investing in Primary Care: A State Level Analysis. Executive Summary, p. 3. Retrieved from https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_es_2019%20%28002%29.pdf

want and need. Underinvestment in primary care is largely a result of the fee-for-service payment system, which rewards volume of services over improved health outcomes and prevention of chronic health conditions.

Since initiating the Statewide Quality Reporting Measurement System through legislation in 2008, Minnesota primary care clinics have demonstrated steady improvement in reducing chronic diseases such as asthma, diabetes, and hypertension with a concurrent decrease in hospitalization and emergency room visits. The Minnesota Department of Health's Health Care Homes (HCH) program helps primary care clinics to improve their practices by setting standards and certifying clinics that are delivering efficient, affordable, patient-centered, team-based care. The HCH program is voluntary and provides free learning and technical assistance to primary clinics that are seeking to improve the quality, outcomes, and cost of their care. Currently, 409 primary care clinics—approximately 60%—of Minnesota's primary care clinics are HCH-certified.

While the 2008 legislation laid the foundation for health system reform through the HCH program and Statewide Quality Reporting Measurement System, we still have significant challenges. Many Minnesotans do not have easy or equitable access to care. There is growing recognition of the impact of social factors influencing health and the importance of community partnerships to address them. Health care is fragmented and challenging to coordinate for both patients and health care providers. This poor coordination creates redundancy and waste across the health system, which further drives costs up and increases the administrative burden on providers. Technology limitations and health data privacy laws exacerbate the problem.

Perhaps most troubling is the orientation of our health care system toward treating illness and overinvesting in acute care. By shifting our focus, and our dollars, to prevention and whole person care that addresses physical and emotional well-being, along with social factors such as education, income, housing, and transportation, we can create a more accessible and equitable system to improve the health of all Minnesotans.

Background on the Minnesota Primary Care Stakeholders Group

The Minnesota Academy of Family Physicians, along with the Minnesota Department of Health's Health Care Homes Program and Office of Rural Health and Primary Care, convened a group of primary care stakeholders in January 2020 focused on increasing investment in primary care in Minnesota. The stakeholder group agreed on the following purpose:

> *Increase investment in primary care services that are equitable, person-centered, team-based, and community-aligned, and that will help achieve the goals of better health, better care, and lower costs.*

As the COVID-19 pandemic spread, the group met virtually throughout 2020 to gather input for a policy proposal for the 2021 legislative session. The COVID-19 pandemic reinforced our goal of increasing primary care investment in Minnesota but constrained our capacity to move on a legislative proposal in 2021.

This report captures the key primary care focus areas identified by the primary care stakeholder group and will serve as a basis for continued discussion of a legislative proposal and recommendations. Areas of strategic focus include:

Focus Area 1: Improve Population Health

- Shift the focus from individual to population health. Understand and optimize the health of the broader population and deliver better care at lower costs. Primary care clinics collect data to identify patients at greatest risk for more serious medical issues and hospitalization and employ more resources to coordinate care across a spectrum of physical, behavioral, and oral health, considering social factors such as income, education, housing stability and transportation. By focusing on those most at risk, patients have better health outcomes, and the total cost of care is reduced.

- Provide whole person, patient-centered care. Primary care should address the whole person, comprehensively, including preventive health, disease management, behavioral and mental health, oral health, social needs, wellness care and more.

- Increase access and advance health equity. Primary care should serve as the gateway to the health care system and be readily accessible to all Minnesotans regardless of socioeconomic or immigration status, spoken language, health literacy or cognitive or physical abilities. Care should be available when and where it is needed, and patients should have easy access to their health information.

- Measure health outcomes and results. Minnesota, through its Statewide Quality Reporting Measurement System, made a start at measuring critical health outcomes across patient populations. Financial and technical assistance are needed to support clinics in setting up efficient systems for quality measurement, aligning measures across different data collection systems, developing best practices, and ensuring greater transparency around data collection and sharing. Enhanced data collection must be accomplished without adding to administrative burden, and clinics should not be penalized for not reaching benchmarks if they are engaging in continuous improvement and showing steady progress overall.

Focus Area 2: Rethink Health Infrastructure

- Promote data sharing across the care continuum. Now is the time to foster a culture of electronically sharing information among a patient's care team. Secure information sharing is critical to ensure that health care providers have a complete view of a person's health and environment; that individuals and their families receive the care and services they need to be healthy; that care providers are paid for outcomes; and that communities are best prepared to address public health needs. To accomplish electronic information sharing, the members of the care team need to adopt and effectively use appropriate technology, standardize processes and workflows, and establish trust agreements with their "information trading" partners. This ensures that standards are in place for both technology and practices; mechanisms are in place to handle data according to an individual's preferences; and organizations can trust each other to be stewards of the information.

- Invest in telehealth and adopt telehealth policies that support positive health outcomes. Patients, providers, and payers pivoted quickly to telehealth, including telephone services,

during the COVID-19 pandemic, and overwhelmingly favor continuing this care option going forward. Telehealth policies must support the needs of patients, such as options for telephone-only appointments and the ability for patients to attend a telehealth appointment from their home, workplace, or wherever is convenient. Telehealth cannot hinge on patient access to technology and/or broadband service, and it also cannot be a substitute for in-person care. Payers must recognize parity in telehealth reimbursement as well as current and future innovations in technology for direct care and patient monitoring.

- Reform the payment structure to sustain primary care: Move away from fee-for-service to risk-based prospective payment. Insurers, including self-insured employer plans, should pay primary care clinicians and practices prospectively to care for patients (vs. retrospectively), so clinics can afford to keep their doors open. For the insurer, this should be budget neutral, as they would be paying based on the prior year.

Focus Area 3: Expand Payment for a Broad Range of Integrated Primary Care Services

- Behavioral health and dentistry. Recent studies indicate that mental health needs in the U.S. population are increasing because of the COVID-19 pandemic and its socioeconomic consequences. Individuals with chronic medical conditions are especially at risk for behavioral health conditions and poorer health outcomes overall. Integrated primary care and behavioral health can improve clinical outcomes.

  The Centers for Disease Control and Prevention recognized the potential in integrating primary care and oral health and, in 2018, launched an integration pilot. Minnesota should support this initiative and, in the meantime strengthen access by:

  - providing affordable dental care at Federally Qualified Health Centers (FQHCs)
  - expanding the adult dental benefit for Medicaid
  - supporting community partnerships with providers like Apple Tree Dental (offering free community clinics)
  - offering low-cost dental insurance through MNsure

- Telehealth – At the end of 2019, only one in four health care providers were using telehealth. By August 2020, nearly 40 percent of providers were using telehealth to provide care, including more than 60 percent of mental and behavioral health providers. A survey of Minnesota health care providers suggests that telehealth is working quite well for most types of clinical visits and patients.[6] But gaps remain among patients with limited English language skills, low-income patients who lack access to technology, and rural patients with unreliable internet access. Despite challenges, 90 percent of providers plan to continue using telehealth visits post-COVID, providing that temporary changes to reimbursement policies remain in place.

- Care coordination. The IOM identified care coordination as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the U.S. health care system. Care coordination promotes patient- and family-centered care by helping patients, caregivers and families effectively manage health conditions and navigate the health care system. The foundation of care coordination is a trusting relationship among the care team—patient, family, and care providers—as they work together to plan and monitor care that meets the patient's health and social needs while respecting cultural beliefs and preferences.

  Care coordination ensures patients have their medications, schedule their follow-up appointments, and understand any other critical pieces of health information. By improving the coordination of care, health care institutions and their community partners can work together to prevent serious health conditions, reduce avoidable emergency room visits and hospitalizations, improve compliance, and keep patients healthy.

  Well-designed, targeted care coordination can improve outcomes for everyone: patients, providers, and payers. In the primary care environment, all patients receive some level of care coordination, but greater support is needed for patients most at risk of serious health complications and hospitalization. While there is nominal reimbursement for care coordination

[6] Minnesota Department of Health, Office of Rural Health and Primary Care. (2020, December 11). *Spotlight on Telemedicine*. Retrieved March 17, 2020 from https://content.govdelivery.com/accounts/MNMDH/bulletins/2b00d77

services, it is far too low to meet patient needs and ensure clinic financial sustainability. There are also barriers to sharing information across health and community providers that result in inefficiencies and contribute to rising costs across the system.

Focus Area 4: Strengthen the Primary Care Workforce

- Enhance incentives for entering primary care. There is a current and growing need for primary care physicians and other primary care providers such as Advanced Practice Registered Nurses and Physician Assistants. According to data published in July 2020 by the Association of American Medical Colleges (AAMC), the U.S. could see an estimated shortage of between 21,400 and 55,200 primary care physicians by 2033.[7] This is partly due to the lower pay and longer hours associated with primary care (compared to other medical specialties). Primary care services remain undervalued, with reimbursement hovering at around half of their specialist counterparts. The pipeline for primary care can be strengthened by increasing incentives to enter the primary care workforce by addressing the imbalance between medical school debt and salaries for primary care physicians and providers, providing loan forgiveness for medical students entering primary care practice, and adding incentives for primary care preceptors.

- Increase the primary care workforce in rural Minnesota. Access to primary care in Greater Minnesota can be challenging, especially in remote or sparsely populated areas. In addition to telehealth and increased incentives to enter primary care, additional incentives are needed to encourage primary care clinicians to work in Greater Minnesota. The Minnesota Office of Rural Health and Primary Care and Minnesota Academy of Family Physicians are partnering to advance legislation to:
    - create rural learning tracks that feed the pipeline for primary care in rural areas
    - enhance loan forgiveness for medical students who begin their practice in greater Minnesota

[7] Association of American Medical Colleges. (2020, June 26) New AAMC Report Confirms Growing Physician Shortage. Retrieved from https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage

  - support the use of community health workers, community paramedics and dental therapists to close the gap between clinical care and community-based services.

- Expand primary care services into the community with community health workers, community paramedics, and dental therapists. There are many barriers to receiving primary care in Minnesota. In addition to a physician shortage in Greater Minnesota, patients are challenged by social factors influencing health, including transportation, language, and culture. At the same time, there is growing recognition that only a small percentage of health care happens in the clinic. To help fill gaps in health care services, the Minnesota Department of Health is working to develop and monitor the impact of community health workers, community paramedics, and dental therapists (including advanced dental therapists). These emerging professions can be supported by expanding clinical and training opportunities and supporting recruitment of a diverse student population with financial support and mentorships.

- Increase team-based, collaborative care, in partnership with community-based providers and local public health. The Primary Care Collaborative in its "Shared Principles for Primary Care"[8] espouses interdisciplinary care teams, including patients and families, working together collaboratively toward common goals. This requires that health care professionals work together, proactively communicating across the spectrum of care providers, including patients and their families or caregivers in decision-making. An important role for primary care is helping patients and families navigate and coordinate the care they are receiving from other clinicians and care providers, while honoring the wishes of patients and families.

Conclusion

The declining trend found in primary care's already low proportion of national healthcare spending from 2017 to 2019, along with widespread disparities in primary care access caused by the COVID-19 pandemic, are a clear call to action for health care leaders, purchasers, payers, and policymakers.

[8] Primary Care Collaborative. Shared Principles of Primary Care (2020, December) Retrieved from https://www.pcpcc.org/about/shared-principles

Reorienting the U.S. healthcare system toward primary care will involve greater investment in primary care driven by a focus on population health, rethinking the health care infrastructure, expanding payment for a broad range of integrated primary care services, and strengthening the primary care work force. Such policies can be leveraged to support patient centered, team-based, technology-enabled, comprehensive care models that encourage high-value primary care and prevention.

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Blue Cross Blue Shield Minnesota

Consumers

Community Health Worker Alliance

Guidepoint Pharmacy

HealthPartners

Hennepin Healthcare

Leisure Education for Exceptional People (LEEP)

Metro Alliance for Healthy Families

Minnesota Academy of Family Practice

Minnesota Advance Practice Registered Nurse (APRN) Coalition

Minnesota Board of Nursing

Minnesota Chamber of Commerce

Minnesota Council of Health Plans

Minnesota Association of Community Health Centers

Minnesota Board of Medical Practice

Minnesota Chapter – American Academy of Pediatrics

Minnesota Chapter - American College of Physicians

Minnesota Department of Health, Community Health Division

Minnesota Department of Health, Health Care Homes Program

Minnesota Department of Health, Health Policy Division

Minnesota Department of Health, Health Promotion and Chronic Disease Prevention

Minnesota Department of Health, Office of Rural Health and Primary Care

Minnesota Department of Human Services

Minnesota Farmers Union

Minnesota Health Leadership Council

Minnesota Hospital Association

Minnesota Medical Association

Minnesota Nurses Association

Minnesota Nurse Practitioners

Minnesota Nursing Community Policy Forum

Minnesota Rural Health Association

O'Connell Consulting

Prime West

SoLaHmo Partnership (Health for Somali, Latino and Hmong)

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References

Association of American Medical Colleges. (2020, June 26) New AAMC Report Confirms Growing Physician Shortage. Retrieved from https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage

Hall JJ, Taylor R. (2003, January 6). Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia,* 178(1):17–20. Retrieved March 17, 2021 from https://pubmed.ncbi.nlm.nih.gov/12492384/

Jabbarpour, Yalda; Greiner, Ann; Anuradha, Jetty; Coffman, Megan; Charles, Jose; Petterson, Stephen; Pivaral, Karen; Phillips, Robert; Bazemore, Andrew; Newmann Kane, Alyssa. (2019, July). Investing in Primary Care: A State Level Analysis. Executive Summary, p. 3. Retrieved from https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_es_2019%20%28002%29.pdf

Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra M. (2008, September 13). Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. *The Lancet,* 372(9642):917–927. Retrieved March 17, 2021, from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61402-6/fulltext

Minnesota Department of Health, Office of Rural Health and Primary Care. (2020, December 11). *Spotlight on Telemedicine*. Retrieved March 17, 2020 from https://content.govdelivery.com/accounts/MNMDH/bulletins/2b00d77

Phillips, Robert L. Jr, Bazemore, Andrew W. (2010, May 10). Primary Care and Why It Matters for U.S. Health System Reform. *Health Affairs 29, No. 5* (2010): 808-810. Retrieved March 17, 2021 from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0020

Primary Care Collaborative. (2020) Primary Care Investment. Retrieved from: https://www.pcpcc.org/topic/primary-care-investment?page=2&language=en

Primary Care Collaborative. Shared Principles of Primary Care (2020, December) Retrieved from https://www.pcpcc.org/about/shared-principles