State Policy Levers for Advancing Quality Improvements in Primary Care

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Introduction

States are major purchasers of health care services through coverage programs, including Medicaid and state employee health plans, departments of health and corrections, and more. As such, state agencies have a compelling interest to lower costs and improve efficiency of care delivered to individuals by closing the gaps between research evidence and primary care clinical practices in a timely fashion.

To help facilitate primary care quality improvement and the adoption of evidence, the Agency for Healthcare Research and Quality (AHRQ) established EvidenceNOW, a $112 million initiative in seven regional cooperatives working in 12 states. Launched in 2015 and running through 2019, EvidenceNOW was designed to help small to mid-sized primary care practices improve their ability to integrate clinical evidence more quickly and effectively into patient care. EvidenceNOW focused on heart disease prevention and the ABCS of heart health – aspirin in high-risk individuals, blood pressure control, cholesterol management, and smoking cessation. These four, evidence-based interventions are proven to prevent heart attacks and strokes, the number one cause of death in the United States. Promoting the adoption of evidence in primary care is important to both federal and state agencies, not only as a means to direct better investment of health care dollars, but also to improve the quality of care delivered to patients. Multiple states have implemented initiatives to promote quality improvement through either practice facilitation, implementation support, and/or academic detailing. Studies show that investments in primary care can enhance population health, reduce costs, improve efficiency, and patients' experiences.[1]

EvidenceNOW and the Heart of Virginia Healthcare Cooperative

The Agency for Healthcare Research and Quality EvidenceNOW initiative was a significant federal investment to advance evidence-based cardiovascular disease prevention in primary care through seven regional cooperatives reaching 1500 practices nationwide. The National Academy for State Health Policy collaborated with the Virginia Cooperative, known as the Heart of Virginia Healthcare (HVH), to share relevant insights for state health policymakers.

The Virginia-based EvidenceNOW collaborative, called the Heart of Virginia Healthcare (HVH), consisted of three cohorts of practices that launched in 2016 and concluded in August 2017. HVH was unique among EvidenceNOW cooperatives because it recognized the need to "restore joy in practice" as an essential prerequisite to overcome provider burnout and build capacity for quality improvement efforts.

HVH's approach to restoring joy in practice is based on the work of Tom and Christine Sinsky, MDs. The Sinskys define joy in practice as "a high level of physician work life satisfaction, a low level of burnout, and a feeling that

medical practice is fulfilling." HVH practice coaches worked with more than 220 Virginia-based primary care practice teams with the dual aims of transformation to restore joy in practice and quality improvement in cardiovascular disease prevention.

Health outcomes of the ABCS heart health intervention showed statistically significant improvements in aspirin and statin use to reduce the risk of heart attack and stroke. Although blood pressure control and smoking cessation did not demonstrate statistically significant improvements, both indicators were moving in the right direction after the initiative. Other EvidenceNOW cooperatives saw similarly mixed results as HVH.[2] Even with a commitment to quality improvement based on evidence, HVH's efforts uncovered a number of challenges within primary care practices that likely affected the initiative's overall success.

Challenges to Quality Improvement

As previously reported by the National Academy for State Health Policy (NASHP) in collaboration with HVH, burnout, electronic health records (EHRs), and staff turnover were major challenges to quality improvement efforts. From the initial stages of practice recruitment, HVH found primary care practices had a limited bandwidth to take on more responsibility than they have already assumed and there is evidence from a systematic review demonstrating that provider burnout threatens patient safety outcomes.[3] While there is a promise of efficiency in implementing a functioning EHR, it can be challenging to launch and connect into a broader system that allows for the extraction of useful data. Multiple HVH practice facilitators identified data collection and management as one of their biggest challenges. HVH also identified staff turnover in practices as adding to the existing challenges and further complicating quality improvement efforts. High turnover and lack of continuity in practice staff makes it difficult to pursue ongoing improvements that require multiple steps and demand rapid new staff education. However, lessons and results from HVH's EvidenceNow efforts can be used to inform others about how states can play a role in enabling quality improvement initiatives in the future.

State Policy Levers that Spur Quality Improvements

States have the ability to play a significant role in enabling the adoption of quality improvement efforts among primary care providers (PCPs). Uniquely positioned to monitor statewide trends and needs, states can target resources toward advancement of policy initiatives and infrastructure investments that will promote efficiencies in health care delivery.

Using Data to Support Quality Improvement

States play an important role in supporting and promulgating the data infrastructure needed for quality improvement initiatives, including EHR adoption. Data is critical for the advancement of any quality improvement initiative as it enables providers to measure their progress toward quality goals. However, adopting the EHR technology necessary for data collection is especially challenging for PCPs. Small or independent practices often lack the financial resources required to implement and maintain EHR systems.[4] Furthermore, due to the integrative nature of primary care, lack of interoperability across EHR systems may decrease the value of EHRs, as they provide minimal utility if they are unable to interact with the systems of various hospitals, specialists, or other providers that interact with patients served by the PCP.

Many states have invested in fostering utilization and interoperability of EHR systems. All states currently provide Medicaid incentive payments to support adoption, implementation, meaningful use, and interoperability of EHR technology through the Centers for Medicare & Medicaid Services' (CMS) Promoting Interoperability Programs.[5] Minnesota is a leading example in promoting EHR adoption. In 2007, Minnesota became the first state to adopt an interoperability mandate, requiring all providers to adopt interoperable

EHRs by 2015.[6] Through its e-Health Initiative, Minnesota has advanced many additional milestones toward improved utilization of health information technology (IT), including the creation of training materials and resources for providers to support utilization of technology including an annual summit to "provide quality education about emerging national and state e-Health initiatives."[7]

Implementing New Care Models to Promote Efficiency

In addition to data investments, states play a major role in advancing new models of care delivery that enable more efficient use of PCPs. As the United States faces an escalating shortage of primary care physicians,[8] it is imperative to ensure that PCPs are used resourcefully. This includes better utilization of health care professionals that support PCPs, such as community health workers who work to promote patient adoption of healthy behaviors and connection to community resources. Integrating these types of professionals into primary care settings may alleviate the need for PCPs to perform care coordination and management functions, which allow them to spend more time focusing on acute and unique needs of their patients. Similarly, adoption of coordinated care models that enable a team-based approach to care (e.g., primary care medical homes) reduce provider burden by delegating certain duties to clinical staff, such as nurses or certified medical assistants.

As health care purchasers, states can support these models directly by employing alternative payment models (APMs) in their Medicaid or state employee programs. States may use federal waivers to design and implement Medicaid reimbursement models that support team-based care (e.g., bundled or per member per month payments).[9] APMs may also be structured to provide direct compensation for care management services or health care professionals, such as community health workers.[10] States may require insurers to implement similar models through any state-based contracts, such as for state employee coverage or health plans that are certified to offer coverage on state health insurance marketplaces (qualified health plans). This is the case in Arkansas, where both the state and public school employee health plans and qualified health plans participate in the Arkansas Payment Improvement Initiative, which is designed to support primary care medical homes in the state.[11]

Supporting coordinated care models that enable these practice efficiencies can also yield cost savings. Oregon's efforts to reform primary care through evidence-based Patient-Centered Primary Care Homes reduced service expenditures by 4.2 percent or approximately $41 per person per quarter. For every $1 increase in primary care expenditure, there was a $13 savings in other service areas, such as specialty, emergency department, and inpatient care.[12] Evidence-based primary care can improve outcomes and reduce states' health care expenditures.

Supporting Workforce Initiatives

States can directly address the issue of primary care shortages by providing greater support to entice PCPs to practice in their states. One method is "support channels" that lead to training primary care physicians in the state, such as Michigan and Tennessee, which dedicate funding through their Medicaid Graduate Medical Education (GME) programs specifically toward primary care residency programs. Expanding on the National Health Service Corps Model, the states of Massachusetts, Michigan, and New York have instituted their own loan repayment programs for primary care professionals who commit to serving in underserved communities in their states.

States may also use their scope-of-practice laws to enable certain types of health care providers to more easily practice at the top of their license, meaning they can leverage the full extent of their professional training. While scope-of-practice laws provide important standards for insuring that health care professionals meet minimum requirements to provide quality care for consumers, they also lead to real and perceived barriers that prohibit some professionals from fully leveraging their skills to serve primary care needs.[13] Current scope-of-practice laws vary greatly across states.[14] Twenty-three states allow nurse practitioners to function as full PCPs who can independently diagnose, treat, and prescribe drugs to patients, whereas other states allow nurse practitioners to perform these functions only under physician supervision, which means less time for physicians to serve patients

directly.[15] Even when practitioners are permitted to practice at the top of their licenses, concerns over lack of clarity of state law and liability issues may prohibit some practices from fully leveraging scope-of-practice flexibilities. States can use their authority to provide health care practices with additional training and support to yield better benefits from laws designed to maximize scope of practice.

Facilitating Practice Transformation through Physician Engagement

In addition to leveraging their roles as health care investors, purchasers, and regulators, states can employ their unique role as agency leaders and conveners to support the advancement of quality initiatives. As part of implementation of its State Innovation Model (SIM), Vermont invested heavily in implementation of various learning collaboratives designed to facilitate provider adoption of coordinated care models, including the implementation of accountable care models in the state. These collaboratives included trainings and discussions hosted across provider-types, including community-based providers and services. Vermont also instituted a series of regional collaborations – leaders from its existing primary care medical homes and accountable care organizations (ACOs) met to review quality measures and develop guidance for medical home and community health teams to promote a statewide ACO model. These efforts helped ensure that providers had the training and resources necessary to adopt APMs, while also enabling better communication across its care initiatives so that they were not duplicating efforts.

In a similar vein, state policymakers can engage key clinical leaders to be part of state-led task forces or advisory committees that aim to transform primary care practice. By including clinician voices, a state can cultivate relationships with clinical leaders who can help champion quality improvement initiatives while also understanding key barriers and needs that may prohibit successful implementation of desired quality initiatives. By engaging providers early in these conversations, states may ultimately mitigate provider confusion or burnout attributed to the implementation of overly burdensome or duplicative reforms.

Notes

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Heart of Virginia Healthcare
Restoring the joy in primary care

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