December 2022

Advanced Primary Care Request for Information 1.1

Purchaser Business Group on Health

Introduction

Purchaser Business Group on Health (PBGH) members include the largest public and private purchasers of health care in the U.S. Collectively, these organizations spend roughly $350 billion annually buying health care for employees and families.

For the past two years PBGH members have come together to develop consensus standards for advanced primary care. Working with providers, plans and national experts, the group clearly articulated what purchasers expect from the market in a Common Purchasing Agreement, which is endorsed by employers and describes employer priorities, objectives and accountability standards for primary care that can lead to better care at a lower cost.

Because care varies by region and one size does not fit all, in the PBGH Common Purchasing Agreement, employers aimed to be clear and concise but also intentionally flexible to respect regional and other differences in care delivery. However, when PBGH members shared these expectations and principles with their health plan and direct contracting partners, many indicated the need for further specificity about employers' expectations. In response, PBGH and its members have developed a request for information (RFI), which more fully articulates what employers expect and want to pay for.

This Advanced Primary Care RFI builds off the principles outlined in the PBGH Common Purchasing Agreement and is intended to be used by purchasers interested in making advanced primary care available for their employees.

PBGH Common Purchaser Agreement Principles
Near-term transition to flexible and prospective, population-based payment to enable practices to transition to advanced primary care
Removing payment barriers to the integration of mental health care for mild-to-moderate conditions
Resources to build and support advanced primary care
Resources to acquire data and information to manage patient care
Payment that supports resources needed to avoid unnecessary and low-value care
Payment to collect and transparently share patient-reported outcome and experience measures with purchasers and patients
Payment models that promote and enable equitable access and outcomes
Primary care should be equipped to leverage community and employer resources to address social determinants of health (SDOH)

How to Use this RFI

Unlike traditional RFIs and RFPs, this survey focuses on and assesses provider-level outcomes. The outcome metrics requested in this RFI will help us assess the quality-of-care practices are delivering to patients. High-performing practices and provider organizations achieving 90th percentile NCQA PPO performance as identified via the clinical quality measures in question 2.2.2 below, need only respond to the following sections:

Section 1: Whole-Person Health and Well-Being

Section 2: Health Outcomes

Section 3: Behavioral Health Integration

Section 4: Health Equity

Section 5: Payment Structure and Performance-based Payment

Section 6: Access – After Hours, Weekends and Virtual Care Options

Section 7: Informed Referrals (Specialty Network, Hospital Services and Prescription Drug Management)

Section 8: Health Information Technology and Data Sharing

All responses should ideally reflect total commercial (non-Medicare or Medicaid) patient population unless otherwise noted in the question.

Table of Contents

Mandatory sections

Sections for organizations scoring below 90th percentile of APC clinical quality measures

Instructions

Activities must be in place by the date of submission or clearly noted that it is a future activity that will be implemented on specific date noted in your response.

Complete as **Attachment 1** the Attestation of Accuracy and Commitment form with the signature of CEO and/or responsible person for completion of this questionnaire.

Contact and Organization Information

Complete/duplicate the table below for the individuals specified and lead contacts. Please also include a list of your leadership names, title, specialty and years in role or practice as **Attachment 2**. Include CEO, Chief Medical Officer, Network Management/ Provider Contracting Lead, Clinical Quality Director, Performance Measurement Lead, Employer Relationship Manager.

Name	
Title	
Number of years in this role	
Organization	
Date Organization Founded	
Tax ID	
Email	
Telephone	
Website address	

Specify a zip code file for the regions represented by this response and submit as **Attachment 3**. Describe geographic areas and identify any zip code exclusions.

For the regions specified above provide as **Attachment 4** a "heat map" showing the geographic location and concentration of your primary care practices and number of providers associated with each practice. Provide as **Attachment 5** a listing of clinic addresses, by market, physicians and ancillary providers, including:

- National Provider Identifier (NPI)
- Practice name or Tax ID (if unique)
- Provider First Name
- Provider Last Name
- Primary Care or Specialist, or both
- Accepting new patients (Y/N)
- Specialty 1
- Specialty 2
- Board Certification
- Years in Practice
- Gender
- Race/Ethnicity
- Language(s) spoken
- Office Zip Code
- Telehealth availability (Y/N)
- Behavioral health availability (Y/N)
- Number of patients assigned or attributed (for primary care physicians)
- Please indicate if the behavioral health clinician is co-located and if so, for how many hours per week.
- If accredited, indicate if the provider/practice using the categories listed below

Accreditation

Please review the following third-party certifications/ accreditations and **select those that apply and are still current at time of submission of response. Please note # unique practices that have at least one of the accreditations you selected,** and submit as **Attachment 6.**

PBGH does not seek to duplicate requirements of other certification programs and will honor the designations below to the extent that they reflect member priorities. We will also honor regional certification programs that include similar performance metrics.

	# Unique practices with selected accreditations	# Physicians with selected accreditations
1. AAAHC (American Association for Ambulatory Health Care) Accreditation for Primary Care		
2. AAHC Medical Home On-Site Certification		
3. AAHC Medical Home Accreditation		
4. NCQA PCMH Level 1		
5. NCQA PCMH Level 2		
6. NCQA PCMH Level 3		
7. NCQA ACO Level 1		
8. NCQA ACO Level 2		
9. NCQA ACO Level 3		
10. Other (describe):[Unlimited]		
11. None of the above		

Organizational Composition, Demographics and Network

Please provide an overview (500 words or less) of the organization responding to this assessment — e.g., number of primary care practices within organization, other groups, hospitals, geography, if organization is a direct primary care entity, etc.

# Primary care practices in organization	
Average size of primary care practice (MDs), including Nurse Practitioner and Physician Assistant staffing	
# Primary care physicians in organization	
# Primary care ancillary staff or extenders (Nurse Practitioners, Physician Assistants)	
Overview of your organization	
Ownership of organization, including investor relationships	
Percentage of primary care physicians employed	
Percentage of primary care physicians contracted	
Number of specialist providers in referral network	
List primary supplier(s) for laboratory services	
List primary supplier(s) for routine radiology and advanced imaging	
List primary hospitals with which the organization is affiliated (and specify market for each affiliation)	
List commercial health plans with which the organization is contracted	
List health plans or payers with which the organization has shared risk arrangements (upside or downside)	
List health plans or payers with which the organization has risk arrangements for total cost of care (please specify if pharmacy is included)	
Describe your payer mix (Commercial, Medicare FFS, Medicare Advantage, Medicaid FFS, Medicaid Managed Care)	

Please complete the following information regarding your services and capabilities

Feature		Answer
Markets: current (list markets with existing clinics)		
Markets: planned (list markets where you are expanding and timing)		
Eligible patients: Employer sponsored only or open to the community		
APC Structure includes:	Integrated Mental Health, embedded resource(s) (Yes/No)	
	Referral to high quality specialists (brief description of process)	
	On-demand access (outside of traditional hours) (Yes/No)	
	Care-team approach (Providers, NPs, PAs, Medical Assistants) (Yes/No)	
	Integrated with Community Resources, embedded resource (Yes/No)	
	Integrated Pharmacist as part of team (Yes/No)	
	Pharmacy on-site (Yes/No)	
	Member App for easy access to care team (Yes/No)	
	Offer multiple pathways to care (in-person, phone, virtual, digital) – specify limitations	
	EHR system (provide system name)	
	Language capabilities (specify what languages are spoken by care team)	
	Staff diversity training (Yes/No)	
	Staff motivational interviewing training (Yes/No)	
	% of Providers who are Employed	
	% of Providers who are Contracted	

Continued from previous page

Feature		Answer
APC Services includes:	All preventive care (Yes/No)	
	On-site lab draw (Yes/No)	
	Care for minor injuries (Yes/No)	
	Mental health (Yes/No)	
	Vaccines/immunizations (Yes/No)	
	Women's Health (specify any limitations) (Yes/No)	
	Pediatric care (Yes/No)	
	Physical Therapy (Yes/No)	
	Other (please describe)	
Affiliations with health plans (please specify)		
Outcome data: can report on health outcomes and access (Yes/No)		
Financial:	Can process claims (Yes/No)	
	Can support a capitated approach (Yes/No)	
	Membership fee applies (Yes/No – indicate amount)	
	Ability to share risk (Yes/No – brief description of approach)	
	Can support HDHP members (Yes/No)	
Expertise: brief description of what your clinics are known for, how you differentiate from your competitors		

1.0 Whole-Person Health and Well-Being

Patients receive care and services with a view towards whole person health and well-being. Screening and care for behavioral and social needs is integrated into their primary care visit. The provider offers support to address lifestyle issues or stressors that impact overall well-being and can coordinate with the resources offered through the employer and/or health plan. Care teams identify anticipated care needs, offer additional support and identify community resources for those patients at high or rising risk.

1.0
What is your model for overall health and well-being improvement? Also discuss the extent to which your organization works within the community to augment access, improve the health of the community and coordinate with public health agencies. How do you measure change and improvement? Discuss use and results of overall well-being assessments or patient-reported outcomes (e.g, WHO-5 Quality of Life, PROMIS Mental/Physical Health functioning, optimism or resilience scales, Cantrell Index, etc.)

1.1
Do you integrate with health plans or employers' digital solutions for well-being or behavioral health? If so, which ones? What is that process of integration?

1.2
What are your strategies and approaches for re-engaging with individuals who have dis-engaged with their well-being goals?

1.3
For the USPSTF (United States Preventive Services Task Force) A and B recommended preventive services, which services are monitored?

		Describe
Confirm if all USPSTF (United States Preventive Services Task Force) A and B recommended preventive services are monitored at the physician level.	Yes/No	
List any USPSTF A or B preventive services that are not routinely monitored		
How frequently is performance information and benchmarking on preventive care measures provided to primary care providers?	1. Annually 2. Quarterly 3. Monthly 4. On demand 5. Other	

1.4
Indicate which of the lifestyle behaviors and risk factor reduction programs you offer and engage patients in to improve overall health and well-being.

	1. Education 2. Web-based self-service information 3. Push messaging 4. Online engagement and tracking tools 5. Coaching	Describe how members access services and metrics in use to monitor engagement
Pre-Diabetes or metabolic syndrome		
Physical activity		
Nutrition		
Weight loss		
Smoking cessation		
Substance use		
Stress reduction and management		
Self-efficacy		
Self-management		
Mental health		
Loneliness and social isolation		

2.0 Health Outcomes

Purchasers desire high performance clinical outcomes and a seamless patient experience. The Advanced Primary Care Measure set is designed to focus on a parsimonious set of metrics where high performance reflects a whole-person health strategy, patient access, effective patient engagement and deployment of care coordination resources, use of a high performing referral network and supportive investments in health information technology.

Practice Performance and Measurement

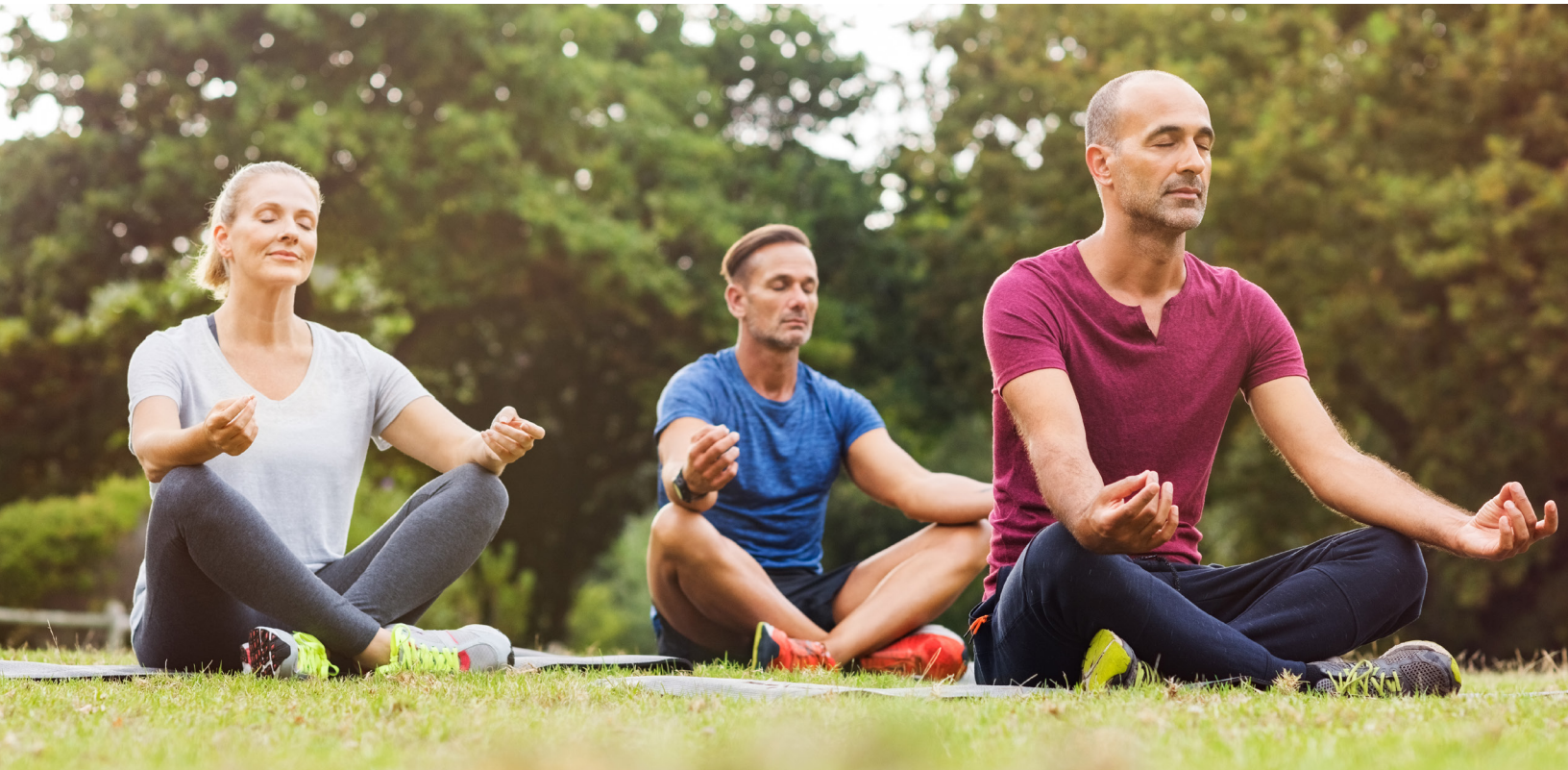
2.1
Please include a copy of your organization's roadmap for overall performance improvement and managing total cost of care (TCOC) and trend as **Attachment 7**.

If you do not have an organizational roadmap, please attach an annual QI report, dashboard or other relevant documents as **Attachment 7A, 7B**, etc.

If you do not have access to total cost of care data, do you have plans to gain access to manage TCOC.

Clinical Outcomes and Patient Experience

2.2.1
Please describe your observed impact (with some numbers if possible) on multiple sources of downstream costs (e.g., observed reduction/ increase in hospitalizations, behavioral health and other specialty cost, ER visits, drugs) and detail which metrics of impact on downstream costs you include in your employer contracting arrangements. Directionally and quantifiable. Include any helpful reports and studies if available.



2.2.2

For commercial patients in your organization/practice, for the previous year, please provide your results for the following measures and stratify.

If you use other measures of performance instead of/in addition to some/all of those requested below, please attach these with your results, noting how you benchmark these results as Attachment 8.

For those respondents representing markets in the State of Washington, you may submit results for the Washington Health Care Authority Common Measure Set as a substitute for the **Advanced Primary Care Measure Set/Women's Health below. Additionally, please provide results for the Utilization Measures as described in Section 2.23 below.**

Advanced Primary Care Measure Set/Women's Health	Percent Rate (range – lowest to highest)	Please explain
Asthma Medication Ratio		
Childhood Immunization Status (Combo 10)		
Colorectal Cancer Screening		
Controlling High Blood Pressure		
Diabetes HbA1c Poor Control (>9%)		
Immunizations for Adolescents		
Depression Screening Rate for attributed commercial population (if organization is unable to report remission rate below)		
Depression Remission at 6 months		
Concurrent Use of Opioids and Benzodiazepines		
Patient Experience (CG-CAHPS)		
Breast Cancer Screening		
Cervical Cancer Screening		
Social Need Screen and Intervention (SNS-E)*		

Note: All metrics should be stratified to ensure equitable outcomes (see health equity section).
* Baseline reporting for initial measurement year.

2.2.3
Please provide the following utilization information for the previous year.

If you use other measures of performance instead of/ in addition to some/all of those requested below, please attach these with your results, noting how you benchmark these results as Attachment 9.

For those respondents representing markets in the State of Washington, please provide results for the Inpatient Utilization/Acute Hospital Utilization and Total Cost of Care measures below.

For those respondents representing markets in St. Louis, MO, you may submit Midwest Health Initiative's REACH Total Cost of Care Measure.

	Rate (range)	Please explain why if NA
Emergency Department Visits		
Inpatient Utilization/Acute Hospital Utilization (days/1000)		
Total Cost of Care		

2.2.4
Please provide the following utilization information on potential waste and avoidable services for the previous year.

	Percent	Explanation and description of targeted improve
NYU – Potentially avoidable ED visits		
NCQA – Overuse of antibiotics of concern out of all antibiotic use		
Use of Imaging Studies for Low Back Pain		
Vitamin D Screening		
EKG testing and other cardiac testing for low-risk surgery (e.g., cataract, endoscopy)		
Describe any other assessment and feedback provided to reduce duplication of services or waste.		

2.2.5
What actions are taken with patients with high rates of avoidable specialty care utilization or who have frequent and/or avoidable ED visits?

2.2.6
What actions are taken with providers with high rates of specialty referral and outlier costs?

3.0 Behavioral Health Integration

Patients' physical, mental and social needs are communicated across their primary care team and with other care providers and settings. Health information and care activities outside of the primary care team are integrated into patients' care plans.

3.1
For the region(s) specified in **Attachment 3**, describe your behavioral health referral network.

	Number embedded (co-located) with primary care practice	Number contracted or employed	Percentage accepting new patients
Child & Adolescent Psychiatrists			
Psychiatrists			
Psychologists			
Licensed social workers			
Behavioral Health consultants			
Behavioral Health, NPs and PAs			
Addiction specialist			
Autism specialist			
Other behavioral health specialists			

3.2
Describe your approach to assure consistency of behavioral health integration in your primary care network with respect to patient screening, identification, follow-up and management.

3.3

Please provide the following information about behavioral health screening for your commercial patients (non-Medicare and non-Medicaid) and how is access to behavioral health care monitored?

	Commercial Population
Number of attributed patients for your organization	
Number of unique patients seen in the previous year	
What percent of patients with an office visit in the previous year also received a PHQ-2 or PHQ-9 or behavioral health assessment?	
What percent of attributed patients received a PHQ-2 or PHQ-9 or behavioral health assessment in the previous year?	
Among patients screening positive, what percent of attributed patients received a follow-up PHQ-2 or PHQ-9 in the previous year?	
What percent of attributed patients received a GAD-7 in the previous year?	
What percent of attributed patients received an alcohol or substance use screening in the previous year?	
% Patients (of those seen) where an internal consult (co-located/within practice) for behavioral health occurred in the previous year	
% Patients (of those seen) where a consult (within provider organization) for behavioral health occurred in the previous year	
% Patients (of those seen) where a virtual consult (with 3rd party, e.g., Concert Health or Telehealth vendor) for behavioral health occurred in the previous year	

3.4

For your commercial book of business, indicate the number of claims that were billed in previous calendar year and paid for the following codes related to psychiatric collaborative care management, behavioral health integration, Substance Use Screening and Brief Intervention and interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional. **The intent of this question is to assess the breadth and depth of behavioral health integration. If your organization does not submit claims, please use estimate the number of encounters where such services are performed and/or describe your provision of psychiatric collaborative care management, behavioral health integration, Substance Use Screening and Brief Intervention and interprofessional telephone/Internet assessment and management service.**

CPT (G) Codes		Total # of Billed Claims or encounters in 2021	Percent of primary care practices billing these codes	Of claims you billed in 2021, # claims that were paid	Total payment
CPT 99408 and 99409	Substance Use Screening and Brief Intervention codes				
CPT 99446	Inter-Professional Telephone/ Inernet/EHR consult with Consulting Psychiatrist: 5-10 mins				
CPT 99447	Inter-Professional Telephone/ Internet/EHR consult with Consulting Psychiatrist: 11-20 mins				
CPT 99448	Inter-Professional Telephone/ Internet/EHR consult with Consulting Psychiatrist: 21-30 mins				
CPT 99449	Inter-Professional Telephone/ Internet/EHR consult with Consulting Psychiatrist: 31 mins/>				
CPT codes 99492-99494	Collaborative Care Management (CoCM) codes				
CPT 96127	CPT II codes: G8510/G8431 (Brief Emotional/BH Assessment)				

Code Description Source: License for Use of Current Procedural Terminology, Fourth Edition (CPT) | CMS

3.5

If your organization does not bill claims on behalf of providers, indicate the number of patients receiving these services and the number of physicians (or ancillary team members) providing these services.

CPT (G) Codes		Total # of patients receiving these services	Total # of practitioners providing these services
CPT 99408 and 99409	Substance Use Screening and Brief Intervention codes		
CPT 99446	Inter-Professional Telephone/Inernet/EHR consult with Consulting Psychiatrist: 5-10 mins		
CPT 99447	Inter-Professional Telephone/Internet/EHR consult with Consulting Psychiatrist: 11-20 mins		
CPT 99448	Inter-Professional Telephone/Internet/EHR consult with Consulting Psychiatrist: 21-30 mins		
CPT 99449	Inter-Professional Telephone/Internet/EHR consult with Consulting Psychiatrist: 31 mins/>		
CPT codes 99492-99494	Collaborative Care Management (CoCM) codes		
CPT 96127	CPT II codes: G8510/G8431 (Brief Emotional/BH Assessment)		

Code Description Source: License for Use of Current Procedural Terminology, Fourth Edition (CPT) | CMS

4.0 Health Equity

Patients receive and experience care services and health outcomes that do not vary in quality or access due to personal characteristics, such as gender, race, ethnicity, language, socioeconomic status or sexual orientation/gender identity. Primary care teams proactively monitor their care to identify, eliminate and prevent care and health disparities and ensure they practice care with cultural humility.

4.1
Describe your organization's approach to improving health equity and reduction of care disparities (500 words)

4.2
Complete the table below with respect to how information captured for your patients.

How is information captured for your patients	Check all that apply
Race, ethnicity and/or language data (REAL)	1. Self-report 2. Staff assignment 3. Imputed through zip code or surname analysis 4. Other (describe)
Sexual orientation and gender identify (SOGI)	1. Self-report 2. Staff assignment 3. Other (describe)
For what percentage of your patients is REAL data documented in the medical record?	
For what percentage of your patients is SOGI data documented in the medical record?	
For what percentage of your patients is race data documented in the medical record?	
For what percent of your patients is ethnicity documented in the medical record?	
For what percent of your patients is language documented in the medical record?	
For what percent of your patients is sexual orientation documented in the medical record?	
For what percent of your patients is gender identity documented in the medical record?	%

4.3

For commercial patients in your organization/practice, please provide your results for the following measures for the previous year.

If you use other measures of performance instead of/in addition to some/all of those requested below, please attach these with your results, noting how you benchmark these results as Attachment 10.

Advanced Primary Care Measure Set/Women's Health	Indicate if results are stratified by race/ethnicity (yes/no)	Percent Rate (range – lowest to highest)	Describe any specific interventions to reduce performance gaps
Asthma Medication Ratio			
Childhood Immunization Status (Combo 10)			
Colorectal Cancer Screening			
Controlling High Blood Pressure			
Diabetes HbA1c Poor Control (>9)			
Immunizations for Adolescents			
Depression Screening Rate for attributed commercial population (if organization is unable to report remission rate below)			
Depression Remission at 6 months			
Concurrent Use of Opioids and Benzodiazepines			
Patient Experience (CG-CAHPS)			
Breast Cancer Screening			
Cervical Cancer Screening			

4.4
Do you screen for social determinants of health? If yes, indicate the screening instruments in use and identify factors that are documented in the patient's medical record (financial, housing, food, social isolation, etc.).

4.5
Report the rates below for specific categories of needs identified (NCQA Social Need Screening and Intervention (SNS-E) based on the previous year.

	Current Results	Planned Service Enhancements
What percentage of patients (of those seen) are screened for social determinants of health?		
Food screening: The percentage of members who were screened for unmet food needs		
Food intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs		
Housing screening: The percentage of members who were screened for unmet housing needs		
Housing intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs		
Transportation screening: The percentage of members who were screened for unmet transportation needs		
Transportation intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs		

4.6
Do you publicly share your providers' race, ethnicity, gender, sexual orientation and languages spoken for provider selection? Please indicate if information provided on your website or is subject to patient inquiry or request.

4.7
Please report the diversity and cultural representation of the provider group and each practice's (primary care physicians and ancillary providers) match of the community's demographics by geography.

	Geography (repeat rows as needed)	Percentage by Gender or Gender Identity	Percentage Distribution
White			
Black or African American			
American Indian or Alaska Native			
Asian			
Native Hawaiian or Other Pacific Islander			
Other (describe)			

4.8
What are your plans to ensure your practice culturally represents the community in which you serve?

4.9
What additional equity improvement efforts have been implemented to improve equitable care, experiences and outcomes? Do you have targeted efforts to support women's health (e.g., referral to doulas or midwifery practices)?

4.10
Describe any performance-based payments tied to disparities reduction.

5.0 Payment Structure and Performance-based Payment

Purchasers expect provider organizations to manage the total cost of care. Purchasers also want to support payment strategies that flexibly meet patient needs and maintain affordable access for their employees and families by promoting alternative payment models and population-based payments that enable high-value care. Purchasers also desire that the portion of payment directed to primary care is adequate to support integrated delivery of care, including behavioral health support, care coordination and health equity.

5.1
For the different contractual arrangements involving your total commercial (non-Medicare, non-Medicaid) patients in your organization/practice, please provide the requested information on prevalence in your practice. Only arrangements that are currently in place should be considered

Payment Innovation Model/Method	Availability	% of Primary Care Payment	% Organizational Revenue	Details
Population-based payment such as global budgets or percentage of premium (full risk for total cost of care, indicate if there are any carve-out elements under details)				
Population-based payment that is condition-specific				
Primary care capitation				
Shared risk arrangements/contracts using FFS architecture with downside risk (i.e., penalties apply if trend or total cost of care target not met)				
Shared risk arrangements/contracts using FFS architecture with upside only				
Alternative Payment Models using FFS architecture (e.g., Bundled payments/episode-based payments; describe elements of bundle in last column)				
FFS payments with care coordination fees				
FFS payments with link to quality or value outcomes such as P4P contracts				
FFS payments with payment linked to quality or value reporting				
FFS payments with no link to quality or value				
Salary				
Population-based payment such as global budgets or percentage of premium				
Other				

5.2
For your commercial (non-Medicare, non-Medicaid) patients, what is total cost of care (TCC - defined as global spending for the care and treatment of your patients calculated on a PMPY basis). Your calculation can be based on whatever resource you might have access to that allows for an estimated amount or an actual amount based on financial transactional data – paid claims. Tell us how you got information (source).

If you do not have total cost of care for entire commercial population, please provide as Attachment 11 the cost of care under 3 contract scenarios with associated populations and a PMPY – shared risk, shared savings and capitated arrangements. Please provide 3 business cases that illustrate your impact on Total Cost of Care, for example did you achieve savings, better outcomes, higher quality/lower cost shifts in utilization, etc..

Time frame is for calendar year (12 months)

	Two Years Prior	Prior Year	
	Response	Response	Resource(s) used for calculation
Total cost of care – commercial patients			
Total cost of primary care – commercial patients			
Total number of commercial patients (same time period as above)			
PMPY (TCC)			
PMPY (primary care)			

5.3
For your commercial (non-Medicare, non-Medicaid) patients, please summarize your prior performance including the type of arrangement and savings earned by year (2018 to present).

5.4
For your commercial (non-Medicare, non-Medicaid) patients, please describe your approach to risk sharing. Please include what percentage of fees you are willing to put at risk and based on what measures of success.

6.0 Access — After Hours Access and Virtual Care Options

Patients get the right care, at the right time with a care team that is familiar with their needs. Accessible care includes same-day care for urgent needs through in-person and virtual services with their care team, care provider availability after appointment hours, secure messaging with the team and an online medical record.

6.1
Please detail if you have standards for wait times for urgent and routine/non-urgent appointments and if you monitor these wait times.

Type of appointment	Standards set for wait times	Average time to appointment	Range of wait times (shortest and longest)
Urgent Medical appointment			
Urgent behavioral health (MH/SUD) appointment			
Routine Medical appointment (New Patient)			
Routine Medical appointment (Existing Patient)			
Routine behavioral health (MH/SUD) appointment			

6.2
Please respond regarding the use and virtual care options for primary care services.

Percentage of patient visits are with their designated primary care provider	
Percentage of patient visits are provided via video or telehealth visits	
If a primary care practice uses near-site or remote providers to provide digital first primary care services, describe your requirements for credentialing, access and availability. Indicate if providers are required to obtain licensure in 50 states and/or if patients are directed to select providers based on geographic location.	
What tools are used to measure access?	

6.3

Please provide information about current access to care within your organization/practice.

Service available to patients	Current Availability	Percent of primary care practices offering	Details such as standard response time, what are the extended hours, conditions for group visits, languages, planned expansion, etc.
Same day virtual (video or phone) appointments			
Same day appointments			
Walk-ins			
Phone consultations			
Other (virtual consultation) with in-house team (not outsourced)			
Other (virtual consultation) to external specialists (list which in last column)			
Group office visits on care management or chronic condition(s)			
Extended weekday hours (after 5 pm)			
Weekend hours			
Home health visit			
After hours call back by clinical care team member			
Secure E-mail or messaging through patient portal for lab results, prescription refills, etc.			
Other			

6.4

To what extent and via which communication channels would participants engage with “live” practitioners either in real-time or asynchronously?

7.0 Informed Referrals (Specialty Network, Hospital Services and Prescription Drug Management)

Practices refer to specialists based on their quality and patient experience. Data is shared between primary care and specialty providers. Patients are guided through care transitions between hospitals, emergency care, specialty care and their primary care teams. Patients can navigate across settings with established referral pathways to high-value specialist providers, with which the primary care team exchanges information and coordinates care.

7.1 Specialty Network

7.1.1.
Describe the selection criteria for your specialty referral network (250 words). How do you ensure referrals to a high-performance specialty network that manages both cost and quality? Indicate clinical quality outcomes measures in use for specialty provider selection.

7.1.2.
Do you use a third-party analytic vendor or consultant for specialty provider curation? If yes, please list organizations and describe measures used and methodology.

7.1.3
For referrals to specialists, please answer the following questions about sources used for referrals and protocols for continuation/coordination of care.

		Name(s) of third-party accreditation source(s) used/description of criteria
Sources of information used for selection	1. Information from health plan 2. Information from CMS Compare 3. Information from third-party accreditation source e.g., NCQA, etc. (name sources in last column) 4. Information from Medical Society 5. Defined list from third-party such as business coalition or IPA, etc. 6. Data collected by provider organization 7. Data provided by the specialist 8. Other (describe in text box in cell)	

7.1.4
Indicate the percentage of referrals that are made to:

	Percent In-network
1. Providers in your preferred specialty network (non-behavioral health)	
2. Providers in your preferred specialty network (adult behavioral health)	
3. Providers in your preferred specialty network (adolescent behavioral health)	

7.1.5
What processes do you have in place to comply with health plan authorization and utilization management protocols?

7.1.6
How do you facilitate patient access to second opinion services?

7.1.7
If a patient is referred to a specialist or Center of Excellence, how is care coordinated with and/or transitioned back to the primary care practice?

7.2 Hospital Services

7.2.1
For the region(s) specified above in Attachment 3, indicate your preferred admitting hospitals. List hospitals. Indicate if inpatient care is provided by hospitalists and/or whether your primary care physicians conduct rounds.

7.2.2
For referrals to hospital networks, please indicate which of the following are considered in selection and contracting.

		Name(s) of third-party whose quality information you use
Sources of information used for selection	1. Information from health plan, 2. CMS Hospital Compare, 3. Leapfrog Group Hospital Safety Score, 4. Third-party hospital quality information such as PA PHC4 (name(s) in last column), 5. Defined list from third-party such as business coalition, quality vendor, etc. 6. Data provided by the hospital 7. Joint Commission accreditation 8. Joint Commission accreditation or certification for specific specialty services such as joint replacement, cardiovascular, etc. 9. Other (describe)	250 words

7.2.3
Does your provider organization have select hospital relationships or work with designated Center of Excellence hospitals? If yes, describe what services, designation criteria and how patients may access Centers of Excellence (250 words).

7.3
Prescription Drug Management

7.3.1
Describe the organization's approach to medication reconciliation. Describe the potential triggers for medication review, including data assets to support issue identification (e.g., volume of prescriptions, medication interaction, patient safety, other).

	Percent
1. Generic substitution rate	
2. Biosimilar adoption rate	

7.3.2
Does the organization employ any of the following strategies (defined below) to address cost management or appropriateness of utilization?

	Yes/No	Describe
Therapeutic Interchange, (substitution of therapeutic equivalent, including use of biosimilars)		
Prior Authorization (e.g., prescribing criteria specified in EMR)		
Step Therapy (e.g., use of a generic or lower-cost alternative prior to Brand or non-preferred brand)		
Dose Optimization (e.g., single dose-alternatives be used instead of multiple doses per day)		
Pill Splitting		
Partial fill dispensing for specialty medications with patient follow-up		
Site of care management for infusion services		
On-site Pharmacist to support providers with prescribing practices/guidelines		
Other (describe)		

7.3.3
Does the organization have access to 340B pricing? If yes, confirm if pricing and acquisition savings are passed through to the purchaser and patient.

7.3.4
Does the organization accept financial risk for prescription drug management?

	Yes/No
1. Standalone prescription drug budget target	
2. Prescription drug management is part of targeted Total Cost of Care goal	
3. Other (explain, 100 words)	

8.0 Health Information Technology and Data Sharing

Purchasers expect providers to leverage health information technology and electronic medical records to exchange standardized data with health plans and ancillary service providers to deliver timely, coordinated care that is high-value and non-duplicative. These tools should also provide information to patients (and caregivers, as appropriate) to facilitate self-care and follow-up.

8.1
For your contracted providers, please respond to the following questions below.

	Response	How is this monitored and managed?
What % of your primary care physicians use an electronic medical record?	Percent. From 0 to 100.	
What % of your specialty physicians use an electronic medical record?		

8.1.1
If an electronic medical record is used, please provide the name of the system.

8.2

For your contracted providers, please respond to the following questions below.

	Response	
What information does your organization receive from the health plan and with what frequency?	1. Medical claims data 2. Prescription drug claims data 3. Specialty drug and biologics 4. Emergency Department admission 5. Inpatient admission 6. Health screening information (PHQ-9, GAD-7, other) 7. Patient-reported outcomes measures 8. Specialty care claims utilization 9. In-network claims utilization 10. Out-of-network claims utilization 11. Gaps in care reporting (missed preventive screenings or diagnostic testing for chronic condition management)	Real-time Weekly Monthly Quarterly Other
For which of the data and reporting areas listed above does your organization conduct further analysis to identify practice variation and benchmark performance at the practice or physician level?		
What information does your organization provide to contracted health plans or third-party administrators?	1. Medical claims data 2. Prescription drug claims data 3. Specialty drug and biologics 4. Emergency Department admission 5. Inpatient admission 6. Health screening information (PHQ-9, GAD-7, other) 7. Patient-reported outcomes measures 8. In-network claims utilization 9. Out-of-network claims utilization	Real-time Weekly Monthly Quarterly Other
Describe the extent to which your organization integrates claims information with EMR-based clinical screening and outcomes information.		
Are you part of a Regional Health Information Organization or other health information exchange? If yes, please list.		
Do you exchange data with local providers? (e.g., patient safety information, lab and radiology data, opioid utilization)		Frequency
Do you exchange data with the primary hospital where your providers have admitting privileges?		Frequency

8.3

For your patient population, please respond to the following questions below.

	Response	How is this monitored and managed?
What % of members have access to online appointment scheduling in the previous year?		
What % of your patient records are in an electronic medical record?		
What % patients (whose records are in EMR) can access their EMR to update/review prior to their appointment?		
What % of your patients have 24/7 access to a care team practitioner that has access to their medical record within your practice?		
Do you receive electronic notification about ED visit in the practice and what is timeframe of notification (e.g., real time, etc.)?		
Do you receive discharge summaries and/or other clinical information related to ED visits?		
After receiving radiology or lab test results, how are patients informed of results? If email or text notification, indicate if you track whether the email has been opened and whether the patient accesses your EMR portal to view the result.	1. Telephone call 2. Text message 3. Email 4. Email or text notification to sign into medical record 5. Other (detail below)	
After receiving labs, tests, etc., what is the standard for turnaround time to notify patients?	1. Upon receipt 2. Within 24 hours 3. Within 48 hours 4. No standard 5. Other (detail below)	

8.3.1

Do patients have access to a patient application? If yes, please describe the key features.

If your provider organization achieves 90th percentile NCQA PPO performance in clinical health outcomes in question 2.2.2 you do not need to fill out the rest of the RFI.

9.0 Employee/Patient Engagement and Activation

Care is designed around the needs and priorities of patients and families, encourages patient and family participation in improvement efforts and incorporates feedback. Patients share preferences and goals of treatment, engage in shared decision making with their care team and feel their choices are respected, integrated into care plans and takes into account community-based resources.

9.1 Primary Care Selection

What percentage of commercial patients attributed to the provider organization have been engaged?

Percent with at least one visit in the first year after attributed to practice or provider	
Percent with at least one visit in two years after attributed to practice or provider	
Percent with any visit, telehealth or email encounter among all patients attributed to practice or provider	

9.1.2

Describe if and how you identify and outreach to (a) covered individual and (b) patients who have not incurred a claim or been seen by a PCP in the last year. **Please include in your description any data and operational workflows in place to proactively identify covered individuals in an employer's population who have primary care impactable conditions and outreach to engage them in primary care.**

	Description of outreach	Percent engaged after outreach
Covered individuals who have not engaged with practice (no record on file)		
Patients who have not engaged with practice in the past 12 months		

9.1.3

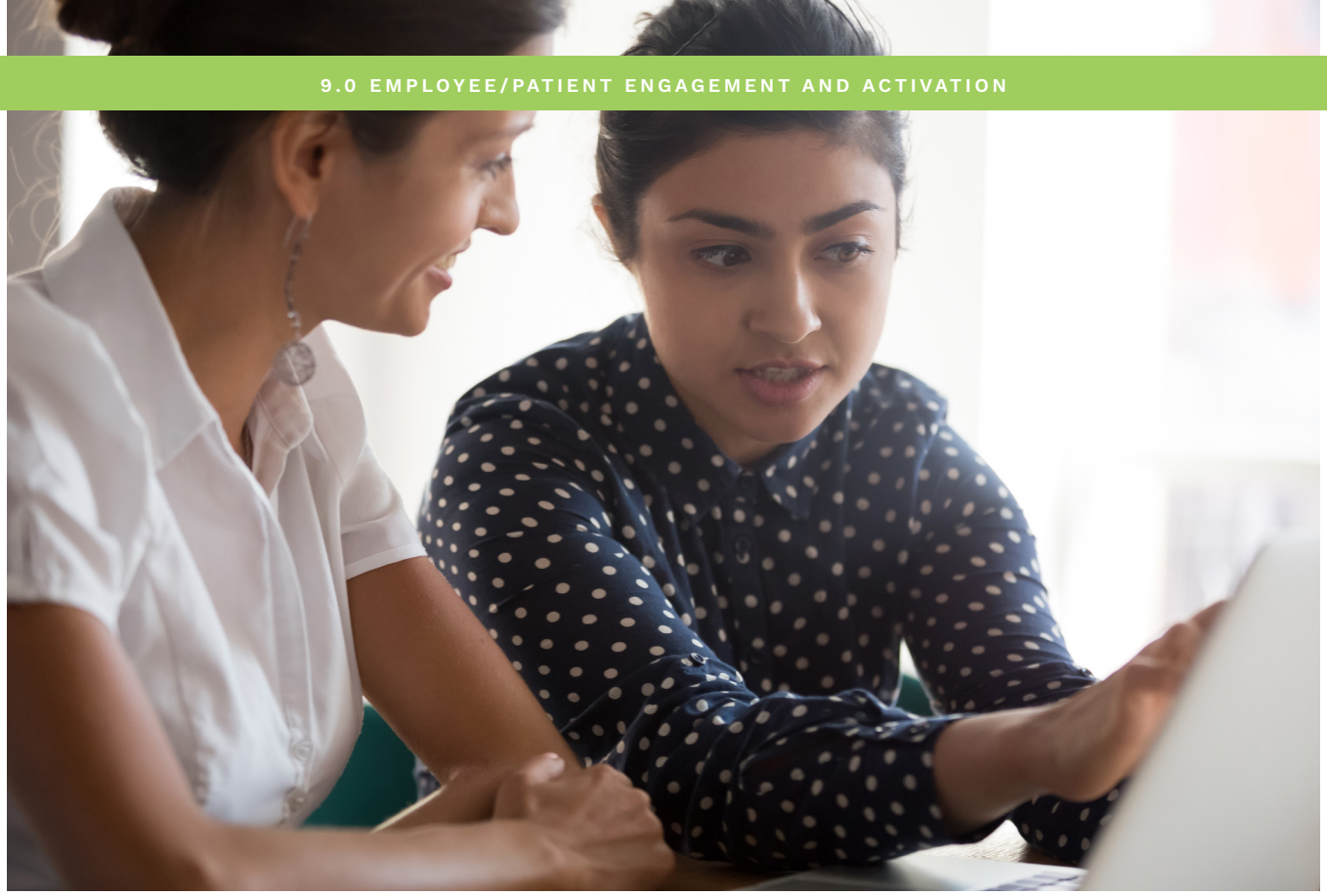
Describe frequency and process to validate that a primary care physician is accepting new patients. Describe what indicators are used to assess the need for clinic expansion.

9.2
Shared Decision-Making

It is important that the patient is engaged in education and shared decision making, please indicate the operational requirements for delivery of shared decision making support with the patient.

Shared decision-making practices with patients

Portion of attributed commercial patients with documented review of treatment options and/or shared decision-making support	Percent
1. Elicit member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.)	
2. Use of patient-decision aid with patient	
3. Walk through an online tool or phone app with patient (describe which you use)	
4. Walk through patient's insurer's decision-support/treatment option support tool with them	
5. Provide patient with link and/or name of app for them to use (describe which one(s))	
6. Discuss treatment/condition, i.e., symptoms, stages of disease and expectations/trade-offs from treatment	
7. Review information about what the decision factors are with their condition and/or circumstance	
8. Review benefits and risks of proposed treatment	
9. Review of alternative treatment options	
10. Review likely condition/quality of life if no treatment	
11. Walk through patient's insurer's cost calculator with them	
12. Review potential costs	
13. Call patient's health plan to review details while patient is in the office	
14. Discuss patient's or caregivers' role or responsibilities, including consent on care plan	
15. Provide other patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision	
16. Provide patient with questions or discussion points to address with their health plan/insurer	
17. Review medication list and potential contraindications or side effects	
18. Other (describe)	
19. What percentage of providers (including ancillary staff) have undergone training on shared decision making?	



9.3
Motivational Interviewing

It is important that the patient is engaged in self-care and encouraged to identify goals that are personally relevant. Please indicate the operational requirements for delivery of motivational interviewing support with the patient.

Motivational interviewing practices with patients

Portion of attributed commercial patients with documented goals based on motivational interviewing	Percent
1. Elicit patient goals (e.g., personal wishes, health goals linkage to self-care or condition management, etc.),	
2. Prioritization of patient goals based on relative impact on risk reduction	
3. Prioritization of patient goals based on patient's readiness to change	
4. Tools for patient to self-monitor and report on goal achievement status	
5. Documentation of progress towards goal	
6. Documentation of goal attainment	
7. Integration of patient-reported goals with care plan	
8. Other	

9.4
Care Plan

What requirements are in place for design and delivery of an individualized treatment/care plan for a patient?
Please include a blinded/blank sample of care plan used as Attachment 12

Do you require practices to produce a patient-centered personalized Care Plan for each patient?	1. Yes 2. No
What is the reading level of the care plan?	
In what language(s) can the care plan be produced for non-English-speaking patients?	
What % of your commercial patients have a care plan?	
How frequently is the care plan reviewed with the patient?	1. Every visit 2. Once a month 3. At agreed-upon dates between patient and practice 4. Upon patient request 5. Other (detail below)
How is adherence to the care plan monitored?	
What follow-up steps are taken if a patient has difficulty following the care plan?	
Does care plan document avoidable Emergency Department use and recommended alternative action?	

10.0 Coordinated Care, Risk Stratification and Care Management

Patients know and receive care from a primary care provider who is supported by members of an interdisciplinary care team, such as a medical assistant, nurse, pharmacist, psychiatrist, health coach or community health worker. Under the direction of the primary care provider, care team members communicate and coordinate across the team to address patients' needs and provide care appropriate to their training and expertise.

10.1
Please provide the following information about your commercial patients (non-Medicare and non-Medicaid)?

	Commercial Population
Number of attributed patients for your organization	
Number of unique patients seen in the previous year	
Percentage of your patient population stratified as high-risk	
Percentage of your patient population stratified as moderate-risk	
What is frequency of stratification?	

10.2

Please describe how you perform the following population health management functions and whether functions are performed by the provider organization or by the individual practices.

Population Health Management	Provider Organization	Practice Level
Risk Stratification (Describe analytic tools and sources of data)		
List screening instruments		
Use of mental or physical health function scores and/or social drivers of risk to refine risk or as risk score multipliers		
High risk case management or care coordination for high-cost patients		
Health coaching (for chronic care management, psychosocial issues)		
Patient activation assessment		
Clinical registry management		
Patient reminders and follow-up		
Outreach to at-risk patients		
Comprehensive medication management and reconciliation		
Medication adherence/Rx fill rate		
Care coordination and follow-up with referral completion		

10.3

What processes or systems do you have in place to support patients who require care coordination, navigational support or emotional and psycho-social support? Please select all responses that apply.

Activity	Support provided	Details (frequency, utilization rate, etc.)
Proactive care team outreach to assess the member's compliance to prescribed regimen		
Scheduled outbound calls to member (note frequency in last column)		
24/7 Telephonic clinical support on-call line for incoming call (Describe type of responding clinician and note utilization rate in last column. If an answering service is used, indicate average time to response.)		
Outbound emails to member on a fixed schedule		
Mobile application text inbound messaging support		
Mobile application outbound text messaging		
Group texting, chat room or moderated peer-to-peer engagement		
Other (describe in last column)		

10.4

If your organization does not bill claims on behalf of providers, indicate the number of patients receiving these services and the number of physicians (or ancillary team members) providing these services.

CPT (G) Codes		Total # of patients receiving these services	Total # of practitioners providing these services
CPT 99490, CPT 99487, CPT 99489	Chronic Care Management (CCM) Codes)		
CPT 99492 (G0502)	1st Psych Collab Care Mgmt		
CPT 99493 (G0503)	Subsequent Psych Collab Care Mgmt		
CPT 99494 (G0504)	1st/Subsequent Psych Collab Care Mgmt		
CPT 99484 (G0507)	Care Mgmt Service BH Condition		

Code Description Source: License for Use of Current Procedural Terminology, Fourth Edition (CPT) | CMS

10.5

Please describe if and how feedback with respect to quality improvement (QI) is provided within the organization or practice and the content of the feedback reports that is provided to assist in QI. Respondents can also attach description of their QI process, plan, annual evaluation, participation in quality improvement collaborative(s) (including named organizations), etc. as **Attachment 13.**

		Details
Does organization/practice have a process for QI where feedback is provided? If yes, detail method e.g., are there group meetings with peer-to-peer benchmarking, does the department chair or medical director talk with each provider, etc.? Is there a regular QI process and staff to address systemic issues and improve performance?	1. Yes, details of method/process in last column) 2. Yes, see attachment 3. No 4. Other (describe in text box in cell)	
Content of feedback QI report	1. Meeting access standards 2. Meeting quality threshold 3. Quality improvement over time 4. Equitable improvement over time 5. Quality compared to peers 6. Equitable quality compared to peers 7. Reducing waste/inappropriate use 8. Longitudinal efficiency relative to target and/or peers 9. Application of specific APC practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel) 10. Patient experience 11. Equitable experiences compared to peers 12. Financial results 13. Utilization results 14. Equitable utilization compared to peers 15. Pharmacy management 16. Behavioral health integration and outcomes 17. Equitable behavioral health integration and outcomes 18. Care coordination 19. Other (provide in attachment)	

10.6

Describe process for care coordination after hospital discharge or Emergency Department visit. Indicate what type of notification is routinely provided and the timeliness of provision of discharge summaries to primary care physicians.

	What % patients receive follow-up within the time-period noted above for ED?	Details
How is notification provided for ED visits?		
How is notification provided for hospital admissions?		
Is outreach conducted within 24, 48, 7 days of hospital admission or ED visit. Explain how outreach is prioritized.		

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We would like to thank the members of PBGH who have contributed their time and talents to develop new standards for advanced primary care and address barriers to their achievement. Special thanks to Linda Brady of Boeing for leading this effort.

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PBGH would like to thank the following reviewers and contributors to this work:

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