

Value-Based Primary Care Providers Try New Strategies to Improve Population Health

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Cognitive concerns frequently show up in primary care as adults age, although not all memory loss will progress to the dysfunction of dementia. However, the number of Americans with diagnosed Alzheimer disease (AD) could grow to nearly 14 million by 2060, up from 6.5 million currently.¹

To halt that trend, much of the recent focus has been on the success or failure of drugs to slow the progression of this devastating neurological disease, most notably the FDA's controversial 2021 approval of aducanumab, a monoclonal antibody, or results of lecanemab, another biologic, which slowed cognitive decline for patients in the early stage of disease but, as with aducanumab, was linked with brain swelling and bleeding.²

If no viable disease-modifying treatment options appear, the time-starved primary care provider (PCP) will continue to see these patients and families first as AD cases surge in coming decades.

This quandary and one organization's efforts to ease the challenges of AD for both PCPs and their patients and caregivers was the topic of a session at an Institute for Value-Based Medicine® (IVBM) population health event in Portland, Oregon. This session of IVBM, hosted by *The American Journal of Managed Care*®, took place November 16, 2022. The other value-based population health initiatives showcased that evening included a multispecialty quality improvement effort to control blood pressure and a transitional care model that aims to reduce superutilization. A panel discussion at the end of the evening featuring several of the presenters wove the sessions together.

One of the cochairs of the event, which was held in partnership with Optum and Vancouver Clinic, said he hoped attendees would absorb 1 key takeaway: "that there really is no relation between cost of care and quality of care."

"If anything, there's an inverse relationship," said Ken Cohen, MD. "At some point, the more care that is delivered to a patient, the worse the outcomes."

Deploying Evidence-Based Medicine, Data, and Technology to Optimize Care

To illustrate his points, Cohen, executive director of translational research for Optum Care, provided numerous examples of low-value, high-cost care that does not lead to better patient outcomes. Topping the list is lumbar spine surgery, which represents \$6 billion of the estimated \$10 billion Medicare spends on health care services that provide little to no benefit each year, he said.

Optum manages cases of chronic low back pain—which accounts for \$90 billion in US health care spending each year—through its Optimal Care model, which combines evidence-based medicine with data and technology. Instead of turning first to prescription drugs and surgery, low back pain is coordinated through the PCP, a physical therapist, or chiropractic care. If back pain is unabated, it is escalated to the 2 drug therapies with proven benefit, meaning nonsteroidal anti-inflammatory drugs and the antidepressant duloxetine; rehabilitative services; and cognitive behavioral therapy for pain management.

Referral to surgery is a last step, Cohen said, and happens only after engaging in shared decision-making based on the results of a lumbar fusion calculator, which considers various patient characteristics to predict the chance of a successful outcome, as well as discussions about lumbar fusion or spinal decompression without fusion, the choice of surgeon, and where to have the surgery.

However, Cohen stressed, most patients do not need surgery. "If they do need surgery, then it's the physiatrist

that's choosing the spine surgeon based on their experience," he said.

Easing the Toll of Dementia and AD in Primary Care

In contrast to the many chronic conditions seen in primary care and treated with low-value services, most cases of dementia are not diagnosed at all, noted Martin Levine, MD, MBA, chief medical officer at The Polyclinic, a group of primary care providers and specialists that is part of Optum in Seattle, Washington.

The prevalence of dementia ranges from 10% of adults 65 years or older to 50% in those 95 years or older, but families and physicians dance around the topic in office visits, trying to explain symptoms away by citing the aging process.

"Alzheimer is not a word that means severity," he noted; the disease is named for the doctor who published a paper about it in 1910. "It's a very common part of the day in primary care."

"We do have pills, but I'm not going to talk about the pills tonight," said Levine, an internist and geriatric specialist by training.

The biggest impact in AD care stems from something else, he said.

"The interventions that really make the biggest difference are working with families, so that they understand what's happening, and they take advantage of services in the community, they get greater self-understanding, self-efficacy, so that you can plan, and actually we can make a difference in people's lives if we provide those services to them."

The reasons why dementia is not diagnosed are complicated, he said, and can include PCPs not feeling confident in knowing how to diagnose it, or feeling like they do not have the time to do so—or as Levine put it, not wanting to open a "can of worms" when their office staff has no one equipped to handle and refer all of the subsequent psychosocial needs of the patient and family members.

However, there are also problems with not addressing dementia, Levine stressed. "These are missed opportunities to improve the quality of people's lives. That's what this is about. That's the problem that we saw in our team."

This year, to address that need, The Polyclinic and another Optum clinic, Evergreen, created a program called Memory Loss and Caregiver Support for patients with Medicare Advantage (MA). It's enabled by a change CMS made in 2020 to add dementia to the Medicare Part C risk adjuster; each diagnosis amounts to about \$2900 in revenue, and those funds are funneled back to pay for clinic social work services.

However, the program does more than add social workers into the mix. Levine said physicians are required to do 3 things to make a social work referral:

- Undergo training to evaluate patients for dementia using standardized cognitive and functional tools
- Make the diagnosis
- Inform the patient and the family of the diagnosis

Then, the PCP can refer the patient for social work services. The social workers, who began working in the program at the end of June 2022, relieve the PCPs of the nonmedical aspects of caring for a patient with dementia, some of which can be fraught with tension among provider, patient, and family—for instance, lengthy, emotional discussions about giving up driving.

"So, the doctor does not have to tell the person, 'You don't get to drive a car anymore.' Docs, we're going to take it off your back," Levine said.

Other aspects of care social workers manage include educating the patient and family, staging the level of dementia, providing referrals to community resources, conducting screenings for safety and behavioral problems, assessing for interest in drug therapy, and more.

Best practices, including improving the cognitive screening tool used in the annual wellness visit, are operationalized in the electronic medical record workflow—Polyclinic uses Epic—which will enable the creation of population-based metrics.

So far, virtually all 270 of The Polyclinic's PCPs have been trained and are participating in the program, and they are supported by a 7-part video series about dementia. In just a few months, the program has increased dementia diagnosis while building revenue.

In December 2021, The Polyclinic and another Optum clinic (The Everett Clinic) had 1658 patients with a diagnosis of dementia, a prevalence rate of 6.3%, out of an MA population of 26,436.

At the end of October 2022, there were 408 new cases of dementia out of an MA population of 32,284, for a prevalence rate of 6.4%. With the CMS risk adjustment, the 408 cases translate to \$1.18 million in revenue.

What also stands out, said Levine, is the increase in the risk adjustment factor (RAF) score; for all hierarchical chronic conditions, the RAF rose 11% this year, whereas for dementia, it rose 25%.

"So, the lesson of this is, when we marry a clinical service that is meaningful with the coding...we do way better. And that's really driving our business case and our opportunity to keep funding and developing new services," Levine said.

Innovation Spurred by Downstream Risk, Data—Could It Expand?

Fee-for-service models only allow for the payment of the immediate health or medical service, with no room or budget for anything else, said Cohen, as he kicked off the panel

discussion that ended the evening. He was joined by Levine; event cochair Craig Riley, MD, medical director of population health and medical education at Vancouver Clinic; Kyle Lamb, MD, Vancouver Clinic's associate medical director of population health; Stan Bower, Vancouver Clinic's director of clinical operations; and Michael Paull, MD, Vancouver Clinic's medical director of primary/urgent care and continuous improvement.

One audience member asked whether the panelists thought the concept behind MA could be expanded to other populations, if it works so well.

"I think we really, as a society, have to figure out how to do value-based care for all ages," said Levine.

Riley, who earlier had cited the takeaways from a notable health care hotspotting study focusing on patients with high care utilization³ when discussing the experiences of the

Vancouver Clinic's transitional care clinic model for complex, high-need patients, agreed.

"I think we are using the same approach—in general, can we prove this as a proof of concept in this population, so that we can ultimately convince our payers that it makes sense for them to invest in it across the board," he said.

REFERENCES

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