

## Background

Primary care is widely identified as the cornerstone of the health care system, serving as a usual source of care that is focused on acute and chronic disease detection, management, treatment, and prevention.<sup>1</sup> In a report from the Primary Care Collaborative, the authors note that “consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs”.<sup>2</sup> And, while provision of primary care has been shown to contribute to population-level reductions in morbidity and mortality, access to regular, high-quality care is a challenge for many people in Washington State.<sup>3</sup> Further, reimbursement for primary care is low compared to specialty care, with the United States spending between 5-7% of total health care expenditure on primary care and Washington between 4.4% to 5.6% of total expenditure.<sup>2,4</sup>

While much work has been done, particularly by the Office of Financial Management (OFM), to accurately measure primary care expenditures in Washington state, the lack of a nationally accepted definition of primary care is a major impediment to assessing and increasing the state’s overall primary care expenditures. The OFM report notes that comparisons between Washington’s percent expenditure and either the national average or states’ own reported expenditures are likely misleading due to differing definitions of primary care. For example, Washington does not currently include non-claims-based expenditures in its measure of primary care, but Oregon and Rhode Island do; this may artificially lower Washington’s numbers.<sup>4</sup>

### *Past Efforts at Definition and Measurement*

In order to know whether primary care spend is increasing in the state, Washington must first develop an agreed upon definition of primary care that will allow for accurate measurement. The 2018 OFM report employed both narrow and broad definitions of primary care. The broad definition included a wider range of provider taxonomy codes that included behavioral health providers, clinical nurse specialists, registered nurses, midwives, and a host of other providers who are not typically considered general practitioners.<sup>4</sup> The OFM stakeholder group also reviewed procedure codes and created both narrow and broad definitions of services qualifying as primary care. Only claims which met both the provider and service definitions of primary care were counted toward the state’s total expenditure, with the narrow definition yielding 4.4% and the broad 5.6%.<sup>4</sup>

However, the OFM report noted that deficiencies inherent to the WA-APCD claims database, combined with lack of a firm definition for primary care, limit the report’s accuracy in some regards. Claims data does not capture, for example, whether or not the location of services provided was a primary care clinic. There is also no roster of primary care providers for the state, which would be helpful for identifying whether nurse practitioners and physician assistants—who can work in primary care or specialist settings—are performing primary care. And, as was mentioned earlier, Washington lacks a way to measure non-claims-based expenditures. The OFM report mentions a number of other systemic

impediments to accurate measurement that may need to be addressed in order to calculate an accurate primary care expenditure percentage for the state.<sup>4</sup>

## Recommendation Framework

The workgroup's goal is to foster a common understanding of primary care in order to increase primary care accessibility and availability.

- A common definition, current and aspirational, for primary care services including behavioral health (i.e., providers of, components of, locations of service)
- Components of primary care with the largest impact on individual and population health
- A mechanism for measuring primary care spend

### *Examples from Shared Decision Making Report*

#### *Patients and Family Members*

- Think about your broad health and wellness-related goals (e.g., being able to attend an upcoming family wedding).
- Where different options are available, like the areas noted in this document, give your provider(s) information about your values and preferences and discuss options, tradeoffs, and implications of a decision together.
- Ask about whether a patient decision aid is available.
- Ask your care provider about the test or treatment options available, including the option of “doing nothing” or “watchful waiting.”

#### *Health Care Delivery Organizations and Systems*

- Work with your clinical champion(s) to educate providers about the value of shared decision making and how to have a good conversation that uses the patient decision aid or references the patient decision aid if the aid will be distributed to patients prior to the visit.
- Select one of the 10 clinical areas to pilot (e.g., breast cancer screening).

#### *Providers*

- Participate in skills training. Shared decision making is a learned skill-set that is supported by patient decision aids.

#### *Health Plans and/or Professional Liability Carriers*

- Incorporate shared decision making requirements as standards for value-based models (e.g., Centers of Excellence).

#### *Employers*

- Incorporate shared decision making requirements as standards for value-based contracting (e.g., Centers of Excellence, Accountable Care Organizations).
- Talk to your health plan about the importance of shared decision making and how to report on use of shared decision making including how to ensure appropriate reimbursement.

#### *Washington State Health Care Authority*

- Encourage the patient decision aid developer community to develop patient decision aids for the ten priority areas publicly available at no cost.

## ***Examples from Shared Decision Making Report***

Options for tracking shared decision making are below including those aligning with value-based reimbursement models from the Bree Collaborative and Federal programs:

- **Shared Decision Making Process**

Steward: Massachusetts General Hospital

NQF #2962

*This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of seven common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.*

- **Informed, Patient-Centered Hip and Knee Replacement Surgery**

NQF #2958

Steward: Massachusetts General Hospital

*The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis.*

## Appendix C: Guideline and Systematic Review Search Results

	Year	Title	Summary or Findings
AHRQ: Research Findings and Reports	2019	<a href="#">Achieving Health Equity in Preventive Services</a>	No eligible studies evaluated effects of provider-specific barriers; 18 studies of population barriers provided low or insufficient evidence regarding insurance coverage, access, age, rural location, low income, language, low health literacy, country of origin, and attitudes. In 12 studies of clinician interventions, screening was higher for colorectal cancer with patient navigation, risk assessment and counseling, educational materials, and decision aids; breast and cervical cancer with reminders involving lay health workers; and cervical cancer with outreach and health education. Clinician-delivered interventions were effective for smoking cessation and weight loss. In 11 studies of health information technologies, automated reminders and electronic decision aids increased colorectal cancer screening, and web- or telephone-based self-monitoring improved weight loss, but other technologies were not effective. In 88 studies of health system interventions, evidence was strongest for patient navigation to increase screening for colorectal (risk ratio [RR] 1.64; 95% confidence interval [CI] 1.42 to 1.92; 22 trials), breast (RR 1.50; 95% CI 1.22 to 1.91; 10 trials), and cervical cancer (RR 1.11; 95% CI 1.05 to 1.19). Screening was also higher for colorectal cancer with telephone calls, prompts, other outreach methods, screening checklists, provider training, and community engagement; breast cancer with lay health workers, patient education, screening checklists, and community engagement; cervical cancer with telephone calls, prompts, and community engagement; and lung cancer with patient navigation. Trials of smoking cessation and obesity education and counseling had mixed results. In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2016	<a href="#">Improving Cultural Competence to Reduce Health Disparities</a>	None of the included studies measured the effect of cultural competence interventions on health care disparities. Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols, empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates or commenting about efficacy in a meaningful or responsible way. The term "cultural competence" is not well defined for the LGBT and disability populations, and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.

2012	<a href="#">Narrow band imaging versus conventional white light colonoscopy for the detection of colorectal polyps</a>	We could not find convincing evidence that NBI is significantly better than high definition WLC for the detection of patients with colorectal polyps, or colorectal adenomas. We found evidence that NBI might be better than standard definition WLC and equal to high definition WLC for detection the patients with colorectal polyps, or colorectal adenomas.
2016	<a href="#">Interventions to encourage uptake of cancer screening for people with severe mental illness</a>	A comprehensive search showed that currently there is no RCT evidence for any method of encouraging cancer screening uptake in people with SMI. No specific approach can therefore be recommended. High-quality, large-scale RCTs are needed urgently to help address the disparity between people with SMI and others in cancer screening uptake.
2019	<a href="#">Follow-up strategies for patients treated for non-metastatic colorectal cancer</a>	The results of our review suggest that there is no overall survival benefit for intensifying the follow-up of patients after curative surgery for colorectal cancer. Although more participants were treated with salvage surgery with curative intent in the intensive follow-up groups, this was not associated with improved survival. Harms related to intensive follow-up and salvage therapy were not well reported.
2013	<a href="#">Personalised risk communication for informed decision making about</a>	There is strong evidence from three trials that personalised risk estimates incorporated within communication interventions for screening programmes enhance informed choices. However the evidence for increasing the uptake of such screening tests with similar interventions is weak, and it is not clear if this increase is associated with informed choices. Studies included a diverse range of screening programmes. Therefore, data from this review do not allow us to draw conclusions about the best interventions to deliver personalised risk communication for enhancing informed decisions. The results are dominated by findings

[taking screening tests](#)

from the topic area of mammography and colorectal cancer. Caution is therefore required in generalising from these results, and particularly for clinical topics other than mammography and colorectal cancer screening.

2017 [Decision aids for people facing health treatment or screening decisions](#) Compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices. There are no adverse effects on health outcomes or satisfaction. New for this updated is evidence indicating improved knowledge and accurate risk perceptions when decision aids are used either within or in preparation for the consultation. Further research is needed on the effects on adherence with the chosen option, cost-effectiveness, and use with lower literacy populations.

*Veterans Administration Evidence-based Synthesis Program*

2014 The Effects of Shared Decision Making on Cancer Screening The ideal SDM intervention would enhance Decision Quality (ie, increase knowledge and values clarity) and Impact (ie, increase satisfaction, reduce decision conflict, and have minimal impact on service utilization). The desired impact on Decision Action depends on the screening decision. For decisions about how to screen (such as colorectal cancer screening), the ideal SDM intervention would exert the desired effects on Decision Quality and Impact without reducing measures of Decision Action such as screening intention and behavior. For decisions about whether to screen (such as breast, cervical, and prostate cancer in some age groups and risk categories), the goal is to facilitate personalized decision making based on values and preferences. Hence, there are no desired effects on Decision Action per se in this context.

*Health Technology Assessment Program*

None

*Centers for Disease Control and Prevention*

N/a

*Institute for Clinical and Economic Review*

2008 Computed tomography (CT) colonography Given the possible benefits of introducing a widely available minimally-invasive option for colorectal cancer screening, there is considerable interest in CTC.

## References

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- <sup>1</sup> Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med.* 2008;23(9):1354–1360. doi:10.1007/s11606-008-0659-0 When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services
- <sup>2</sup> Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. <https://www.pcpcc.org/resource/evidence2019>
- <sup>3</sup> Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.
- <sup>4</sup> Washington State Office of Financial Management. Primary Care Expenditures Report Summary of current primary care expenditures and investment in Washington. December 2019.