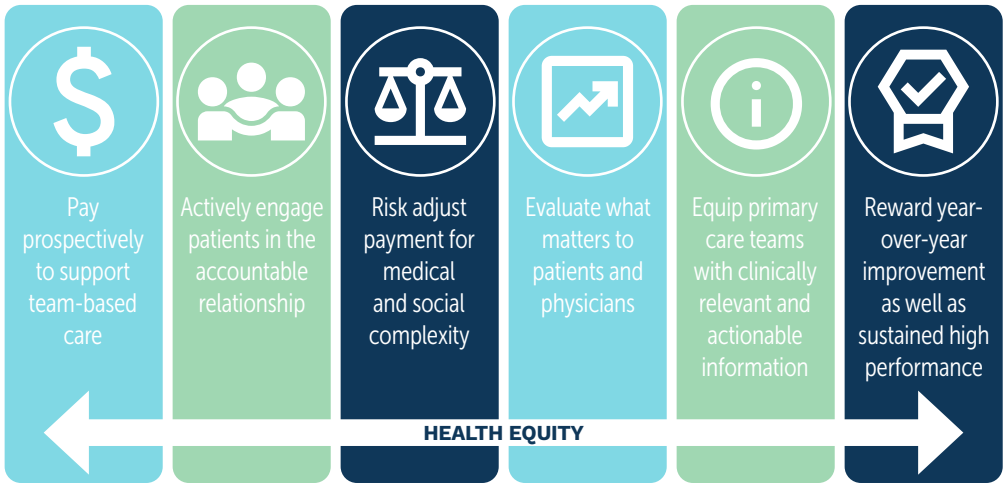
PRIMARY CARE INFORMATION BLUEPRINT

INTRODUCTION



Primary care is broadly recognized as the foundation of a high-performing health system. Family physicians are the cornerstone of community-based primary care, making up 40% of the primary care physician workforce,[1] followed by general internists and general pediatricians. The nation's shifting demographics and the increasing prevalence of chronic disease necessitate a robust primary care workforce. However, the pipeline of primary care physicians is shrinking due to a payment system that persists in underfunding and overburdening primary care physicians.[1] Fundamentally reforming primary care payment is essential to reversing this trend.

Building on its guiding principles for value-based payment, the American Academy of Family Physicians issued a series of position papers to describe how stakeholders can play a role in supporting primary care's essential function in successful value-based care delivery. In the information sharing call-to-action brief, the AAFP details actions that key stakeholders can take to facilitate a more effective information-sharing ecosystem. The Primary Care Information Blueprint addresses the following recommendations from the brief[2]:

- Ensure value-based payment agreements include a minimum viable description of the type, frequency and form of information that will be shared, including clear delineation of the information-sharing responsibilities of each engaged party
- Enable minimum health information-sharing requirements that reflect actual primary care information needs in place of narrowly defined compliance standards

These recommendations are applicable to a broad cross section of stakeholders, including public policymakers, health plans, purchasers (i.e., employers and union trusts), owners of primary care practices (including large health systems), health information technology vendors and health information exchange organizations.

THE PRIMARY CARE INFORMATION BLUEPRINT

As part of its efforts to support an information-sharing environment that enables value-based primary care, the AAFP conducted a series of interviews with family physicians. It also convened an advisory group comprised of family physicians and industry leaders representing payers, health IT organizations and academics for a series of discussions to inform the foundation of the Primary Care Information Blueprint. The advisory group was tasked with answering the following questions:

- What do successful value-based primary care teams do that is different than traditional, fee-for-service-oriented primary care?
- What information do primary care physicians and their teams need to be successful?
- How is that information used by the primary care physician and/or team?
- How easy (or hard) is it to gain access to the information they need in today's environment?

The purpose of the blueprint is to "set the table" for conversations between key stakeholders who want to ensure primary care physicians have the information needed to successfully meet the needs of their patients and meet the performance expectations under value-based payment arrangements. It is designed to facilitate changes that will improve both the comprehensiveness of the information available and the ease with which data can be ingested into a primary care practice system of record, whether that is an electronic health record or a stand-alone population health tool.

The AAFP's goal is to support "information in action," not just delivery of data. Importantly, the blueprint is not intended to be a technical resource or an implementation guide for specific technologies or data standards.

The Primary Care Information Blueprint emphasizes that information flows must be bidirectional to support primary care physicians' success in VBP models by reducing many of the current burdens associated with data collection and reporting requirements. Bidirectional data flow is best facilitated using a payer- and physician-agnostic data intermediary that provides much-needed data governance and security functions for various sources of health data. Data intermediaries include health information exchanges, (HIEs) or health data utilities (HDUs). These entities are essential to the creation of a person-centered data and information resource to support coordinated, comprehensive primary care.

The amount of health data available is expansive and growing quickly,[3] but despite the ever-increasing amount of data, only a small percentage is actually used.[4] The advisory group was instrumental in identifying the **essential data** needed to enable and support primary care success within an accountable, value-based environment.

ESSENTIAL DATA

- **Accurate, comprehensive patient lists** (key demographic data, benefits/coverage, contact information, known care preferences, etc.)
- **Medical history**
- **Patient health status (risk level)**
- **Transitions of care (alerts and notifications)**
- **Medication adherence data**
- **Cost and quality information to inform high-value referrals**
- **VBP contract-specific performance information**

HOW TO USE THE PRIMARY CARE INFORMATION BLUEPRINT

The blueprint is designed to support all parties to a VBP arrangement, including organizations holding essential data elements, data intermediaries (e.g., HIEs, HDUs), health IT vendors and other data networks. It can be useful in many ways, including the following:

- **Advising key health IT ecosystem stakeholders** to ensure that the components and capabilities of EHRs, data analytics platforms, and state/federal HIEs and agencies include the essential data and prioritize the flow of information that allows primary care organizations to be successful in VBP agreements at an attainable price point. The blueprint can guide their development into an HDU that offers multidirectional information exchange, providing clinical data and nonclinical health-related and transactional data to support multiple stakeholders and cross-sector needs.
- **Aligning payers, physicians, provider organizations** and others involved in contract negotiations to ensure bidirectional data flow supports high-value, person-centered care. Payers could also expect more primary care physicians to engage in value-based care models and have greater success (e.g., improved Healthcare Effectiveness Data and Information Set [HEDIS] measurement, lower costs, improved patient outcomes) if all the essential data were more easily accessible and available at the point of care.
- **Advocating for change** by helping policymakers and their staff at the local, state and federal levels better understand the importance and complexity of the essential data and the processes by which various stakeholders access it. Greater understanding can help them make informed decisions to promote improvements. Technology or data limitations are rarely the primary obstacles to achieving a robust information-sharing ecosystem that enables and supports success in VBP. Rather, the greatest roadblocks arise when organizations prioritize business interests over the needs of patients, primary care physicians and care teams and make decisions without fully considering their impact on the information-sharing environment.

A BLUEPRINT FOR TRANSFORMING DATA INTO ACTIONABLE INFORMATION

Enabling Value-based Care Success

QUINTUPLE AIM

■ Increased health of populations ■ Improved clinician experience ■ Increased patient experience ■ Greater health equity ■ Lower care costs (per capita)

Actions to Enable High-Quality Primary Care	Essential Data	Data Holders
• Proactive patient outreach to facilitate transition to ambulatory care	• Admission, discharge and transfer notifications	Hospitals
• Care coordination • Patient diagnosis	• Referral feedback and closure	Other physicians and clinicians
• Diagnosis and condition management	• Lab and imaging results	Labs and imaging centers
• Care management	• Medication fill notifications	Pharmacies and pharmacy benefit managers
• Clear accountability for value-based payment contracts • Proactive identification of patient needs and outreach as needed • Informs quality improvement opportunities • Supports high-value (i.e., high-quality/low-cost) referrals	• Accurate and timely patient lists • Comprehensive patient demographic information and health status (risk level or score) • Timely and frequent contractual performance feedback • Cost and quality information on network referral options	Health plans

Patient-centered data aggregators (e.g., HIE/HDU) create comprehensive patient record

Practice's system of records (e.g., EHR or population health platform) facilitates practice workflows

Taking care of patients using actionable information (without information burdens).

Activity	Purpose of Information
Population management	Understand the health status and associated risks within patient populations and identify patients needing proactive outreach and preventive efforts
Patient care	Optimize all patient interactions (i.e., scheduled, unscheduled and proactive) and care delivery processes (e.g., workflows) to support all visit modes, proactive patient outreach efforts and inbox management
Performance management	Understand overall payer-agnostic performance and current performance on payer-specific value-based payment contracts to inform ongoing improvement efforts

RELEVANT MARKET AND REGULATORY FORCES

Market and regulatory forces are pushing in the right direction. When considered together, these accelerating forces can produce much-needed change. Unfortunately, countervailing forces that threaten the AAFP's vision for an information-sharing environment are strong.

Accelerating Forces

- **VBP adoption.** As VBP increases across all lines of business,[5] the need for a robust information-sharing ecosystem also grows. Accountable care organizations and ACO enablers frequently serve this function because they are incentivized to bring together the data sources necessary to provide the comprehensive, holistic care that VBP requires. However, even the efforts of the savviest high-tech organizations can benefit from the payer- and physician-agnostic data aggregation function offered by HIEs or HDUs.
- **Health data utilities.** HDUs are akin to HIEs, but they are equipped with more advanced and broader data-sharing capabilities, including the exchange of nonclinical data and multidirectional exchange. In addition, they have explicit goals for advancing VBP models.[6]
- **Artificial intelligence.** AI will have a multifactorial impact on health care in terms of information sharing and support for success in value-based care. AI can facilitate efficient clinical documentation capture, improve the timeliness/availability of data, mine through vast quantities of data, and identify care gaps and opportunities to better manage patient populations.
- **Increasingly capable EHR systems geared toward care delivery.** As the industry recognizes the need for systems that prioritize the workflow of physicians and their care teams, more vendors are focused on improvement of health care delivery rather than just the business of getting paid in health care.

Limiting Forces

- **National interoperability networks have improved substantially in recent years but still fall short in meeting complex VBP information needs.** First, they focus on clinical data exchange for point-of-care needs missing crucial elements such as payer generated attribution lists or quality/performance measurement reporting. Second, the payer landscape varies significantly across markets, making regional information exchange more effective in addressing essential payer generated data elements.
- **Emerging health information sources that are poorly connected to existing health infrastructure or lack standardization.** As direct-to-consumer health care companies proliferate, more patient health data are being isolated from the existing information-sharing environment. Additionally, more patient data are being generated by consumer-facing applications and medical devices that are inadequately equipped to engage in information sharing. Health-related social needs data are increasingly being used, but widely accepted standards for how this information is represented within the EHR are just emerging and not widely adopted.
- **Increasing amount of data.** The amount of health care data generated each year continues to grow,[4] making it more difficult for physicians to readily access the information they need at the point of care.
- **Desire to protect market share.** Even as information blocking regulations take effect, some health IT vendors may still attempt to "lock in" customers by encouraging the use of closed systems that make information sharing or vendor switching more difficult.

CONCLUSIONS AND NEXT STEPS

The input from the AAFP's advisory group and other key stakeholders is clear. We must support HIEs and HDUs as community-based, person-centered, bidirectional data and information-sharing infrastructure assets. A nonproprietary (i.e., organizationally agnostic) infrastructure is essential for efficiently and comprehensively connecting all key stakeholders, including payers and provider organizations. Payers, health IT vendors, physicians and other health care professionals. must be held accountable for their roles in making this long-held vision become a reality. We cannot allow data collection, ingestion and management to become the job of family physicians and other primary care physicians.

ACKNOWLEDGMENTS

The AAFP would like to express special thanks to our project partners Elation Health and Centene, as well as to our advisory group, including AAFP's medical directors.

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List as of January 2025

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