America's Most Valuable Care: Primary Care

The Opportunity

There are 'bright spots' in the healthcare system—healthcare providers in communities large and small are consistently delivering high-quality care at a lower-than-average total cost. Perhaps most importantly, some of these providers operate on America's "Main Street," where the advantages of large scale or unique medical cultures formed over decades are nowhere to be found.

The fragmented nature of the U.S. health system and its poor incentive structure have impeded the broad adoption of innovative solutions to improve quality and lower costs. The Peterson Center on Healthcare, established by the Peter G. Peterson Foundation, is developing a comprehensive approach to finding existing innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale.

In early 2013, our research team, sponsored by the Peterson Center on Healthcare, set out to find these high-value providers through a systematic analysis of commercial insurance data. Commercial insurance data reflects market prices, rather than prices set by Medicare and Medicaid, and allows analysis of the "all-in" cost of a primary care physician to his/her patients, including payments for patients' drugs, ER visits, lab testing and other services.

The goals of our project are to:

- Identify primary care practices that are 'positive outliers' in the value – higher quality at significantly lower cost – of the care they provide
- Determine common features that make these primary care practices unique

- Create a 'change package' that enables other primary care physicians to incorporate insights from high-value providers into their own practice
- Demonstrate the replicable nature of, and results from, these features and support accelerated adoption on a national scale.

Primary Care Approach

We set out to systematically identify primary care practices that routinely achieve high performance—high-quality care at a lower-than-average cost. Our team first looked at single- and multi-specialty U.S. physician practices with at least two clinicians providing primary care. Then, we narrowed the list to those whose performance landed them in the top 25 percent on quality measures. Quality measures were predominantly sourced from HEDIS (Health Effectiveness Data and Information Set)—a universally recognized set used by more than 90 percent of U.S. health plans for assessing quality. Finally, we eliminated all sites where total annual per capita health spending by commercial health insurers did not also fall into the lowest 25 percent—after adjustments to reflect the severity of illness of their patients. Fewer than five percent of the roughly 15,000 sites assessed by our team ranked in the top quartile on quality and the bottom quartile on costs.

The second step of the approach was to identify the features or characteristics of these physicians that help explain their exceptional performance. Our team conducted a series of in-depth site visits with a sample of high-performance physicians to understand their distinguishing features. For comparison, we also visited other primary care practices whose quality of care and cost scores were closer to the average.

Our analysis found that total annual health spending was 58% lower for patients cared for by these physicians than for comparable patients cared for by their national peers. Nationwide

adoption of the features observed could improve quality and lower annual U.S. health spending by as much as $300 billion, even using a conservative estimate that only a quarter of the implied savings is achievable due to challenges in replicating new service features and the limitations of such analyses.

The Findings

Through this combination of quantitative and qualitative analyses, our team identified 10 features of primary care sites that consistently delivered exceptional value to their patients.

There is considerable diversity among these high-performing practices. These distinctive features were not linked to the sites' ownership, location, or characteristics of their patient population. About a third are independent, primary-care-only practices. Others are independent, multi-specialty practices, while still others are affiliated with a health system. One practice is a workplace clinic, while another is a federally qualified health center, or FQHC. Their patients vary widely in their age, income, insurance status, and race/ethnicity.

Some are urban, while others are suburban or rural. Geographically, they are spread across the nation—from Rochester, N.Y. to Yorba Linda, Calif., and from Springboro, Ohio to Kissimmee, Fla.

Our team observed that these high-performing primary care sites differ in three ways from practices with average cost and quality scores, specifically:

- Their patient relationships were deeper
- Their interactions with the healthcare system were wider
- Their practice organization was team-based

Deeper Patient Relationships

We found that physicians in high-value practices develop deeper relationships with their patients, often without economic reward for doing so. This deeper physician-patient relationship manifests itself in the following characteristics.

1. **Always on.**

   Patients have a sense that their care team is "always available," and that they will be able to reach someone who knows them and can help them quickly whenever necessary.

   Practices offer same-day appointments and accommodate walk-ins, extend evening and weekend hours, typically take their own after-hours calls, and can rapidly access their patients' electronic medical records outside of conventional office hours.

2. **Conscientious conservation.**

   The care team is conscientiously dedicated to ensuring patients get all necessary care, proactively identifying needed tests and treatments and ensuring patients get them. At the same time, they conserve resources by tailoring care to align with the needs and values of their patients.

   Three components illustrate a dedication to conserving resources without compromising the conscientious protection of patients' health.

   - **Fulfilling Quality of Care Guidelines**: The care team ensures that patients receive all evidence-based preventive care and treatment. This often means making guideline-based reminders available to clinicians at the time of the patient's visit,

right on the electronic medical record, for example. Practices that do this most effectively place responsibility with one person—often the office manager—who holds the care teams accountable by regularly running reports to rapidly identify any outstanding care gaps and alerting the care team to take action. This conscientiousness is balanced with a more thoughtful use of tests, treatments and referrals. In the 'grey areas' of medicine, these clinicians stop to take the time to ask whether additional care aligns with their patients' personal preferences and quality of life goals.

- **Individualized Intensity of Care:** Each patient receives care and support that is matched to his or her unique clinical needs. Patients with the greatest needs receive the most support. For example, patients categorized as 'high-risk' are monitored and advised by a care manager, scheduled for longer office visits or receive frequent phone checks by office staff, or in some cases, clinician house calls.
- **Shared Decision-Making and Advanced Care Planning:** When there are multiple diagnostic and treatment options and they substantially differ in their risk of complications and cost, the physician takes the time to walk a patient through likely scenarios and tradeoffs. This includes discussions about the pros and cons of aggressive treatment options near the end of life.

3. **Complaints are gold.**

   Complaints from patients are regarded to be as valuable as compliments, if not more so. High-value primary care sites take every opportunity to encourage patient feedback.

Wider Interaction with the Healthcare System

Three features illustrate how these high-value providers of primary care play a more active role in orchestrating other players in their local healthcare eco-system. That includes medical specialists, hospitalists and emergency physicians, as well as staff at nursing homes, physical rehabilitation centers, and pharmacies.

4. **Responsible in-sourcing.**

   Primary care teams do as much as they can safely do rather than referring patients out.

   These primary care physicians practice within the full scope of their expertise, delivering minor procedures and other treatments that other primary care physicians often refer out—such as skin biopsies, insulin initiation and stabilization, joint injections or suturing—because they take more time than the average patient visit. If they can arrange specialist supervision, they take on additional low complexity services sometimes performed at a higher cost by specialists, such as treadmill testing for cardiac patients.

5. **Staying close.**

   When services outside the scope of the primary care practice are necessary, these physicians rely on a carefully selected list of preferred local specialists who share their philosophy of conscientious conservation.

   Although these primary care physicians cannot always select the hospitalist or emergency department (ED) physician who cares for their patients, they maintain relationships with them regardless, stay connected with the care of their patient, and assure that treatment plans respect their patients' personal preferences and

health goals. They remain in close communication with other physicians and insist on being kept in the loop as their patient's treatment plan evolves.

6. **Closing the loop.**

   The care team ensures that each element of the treatment plan agreed upon by the patient and their physician is fulfilled.

   This includes confirming that a patient went to her specialist appointment, proactively tracking medication adherence, and following up expeditiously when patients are unexpectedly admitted to a hospital.

Team-Based Practice Organization

Four features illustrate how these high-value sites are organized to support the greater depth and breadth of primary care interactions.

7. **Upshifted staff roles.**

   Physicians are supported by a team of nurse practitioners, physician assistants, nurses, and/or medical assistants—all of whom are working at the 'top of their licenses.'

   This enables physicians to spend more time with the patients who need the most direct physician contact, and to take care of more patients. Upshifted staff roles are often facilitated by an empowered practice manager who runs an efficient office and frontline staff team—allowing the clinicians to focus only on activities that require clinical judgment and training.

8. **Hived workstations.**

Care teams work together side-by-side in an open 'bullpen' environment that facilitates continuous communication among both clinical and non-clinical staff.

This approach, in which physicians work in a room with others on the care team, goes hand in hand with upshifted staff roles. It facilitates learning through collaboration without regard to hierarchy. It also prompts physician-to-physician dialogue about complex cases and differences in practice style. In some larger practices, we saw this dialogue facilitate agreement on approaches to uncomplicated common illnesses. This in turn, allowed their teams to standardize workflow and solve patients' problems more quickly.

9. **Balanced compensation.**

Physicians are not paid solely on the basis of their productivity.

Rather than basing physician income solely on service volume—in other words, 'fee for service'—pay typically also reflected performance on at least one of the following components: 1) quality of care, 2) patient experience, 3) resource utilization, and 4) contribution to practice-wide improvement activities.

10. **Investment in people, not space and equipment**

By saving money on space, equipment and technology, these providers didn't need to see more patients or order expensive tests to generate a competitive income.

These physicians rent very modest offices. To save money and eliminate incentives to use expensive equipment, the practices only invest in lab, imaging and other equipment if it allows them to provide care more cost-effectively in-house. Some partner with other practices to jointly operate imaging equipment. This lowers their

cost and charge per imaging study to patients and insurers by spreading the fixed cost of the equipment over more patients.

Building on Wisdom and Debunking Myths

These findings build on the wisdom of two current physician-led initiatives to improve care: the Patient-Centered Medical Home and Choosing Wisely. However, findings relating to wider interactions with the healthcare system and several findings relating to team-based practice organization extend into new territory.

The findings challenge some common beliefs. While there's widespread recognition that pockets of excellent value exist in the US, some believe they hinge on replicating methods used by very large health systems with an efficiency culture cultivated over many years. The exemplary practices that we found, however, showed that primary care practices without these advantages can also deliver exceptional value. Equally surprising, these small-scale, mainstream primary care exemplars enjoy a competitive income and good quality of work life. Lastly, they demonstrate that superior quality can co-exist with low total population-wide health spending.