Peter G. Peterson Foundation

Our America. Our Future.

Finding and Understanding Exceptionally High Value Mainstream US Health Care Providers

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P4P Summit

Stanford Clinical Excellence Research Center

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Nationally, we don't really know who is providing high value care

There are:

- **Regional bright spots (e.g., IHA, WHIO) as well as…**
- **Analyses looking at regional variation in performance (e.g., Dartmouth Atlas, Commonwealth Local Scorecards)**
- **Self-selecting networks committed to value (e.g., High Value Healthcare Collaborative, Health Value Network)**
- **Quantitative comparisons (i.e., US News), but not focused on affordability**

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Nor do we systematically focus on, measure, or reward value…

Examples:

- **Quality and patient satisfaction**: Patient-centered medical homes
- **Workforce innovation**: Learning from Effective Ambulatory Practices (LEAP)
- **Avoiding burnout**: In Search of Joy in Practice
- **Efficiency:** QUEST Collaborative
- **Financial performance**: Shortell's work on High Performing Medical Groups

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Our project is the first of its kind...

To our knowledge, no one has done this before:

- At a national scale
- Quantitatively
- Using commercial claims data
- With total cost of care as the financial measure of performance (rather than profitability)

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Project Overview

- **Objective:** Reduce American healthcare spending by identifying and accelerating adoption of high value features used by mainstream providers
- **Methods:** Use convergence between “big data” and an expert panel of nationally recognized clinical leaders to:
  - Identify and validate mainstream US providers delivering exceptional value in 3 categories
    - Primary care
    - Hospitals
    - Specialty care
  - Characterize the care delivery features likely to explain their performance

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Assessment of Value: Population Management

- **Unit of analysis:** Medical practices with more than one physician providing at least primary care
- **Cost:** Top quartile performance on observed to expected measure of **risk adjusted total per capita payer-allowed spending** for patients attributed to the practice
- **Quality:** Top quartile performance on weighted composite measure based on observed to expected performance on 41 HEDIS-like measures, with higher weighting for measures with more clinical significance

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IMS helped us to identify high performing practices

Identified Providers (figure not to scale)

Step in process	Count after filter	Description of Criteria	Notes
1. Medical offices in IMS HCRS data set	**~185,000**	• IMS Provider Group Map identifies 490,889 individual providers to this number of medical offices • Address-based identification of medical offices	The full IMS HCRS data set includes 500,000 health care facilities ;
2. Attributed Patients	**~54,000**	• Medical offices with patients attributed to a PCP-specialty provider • Attribution based on highest number of claims with tie breakers set as latest date of service, earliest date of service, total allowed amount, and then allocation to an office before an individual	A total of over 15M enrollees were attributed to one of these medical offices
3. Clinical Risk Group (CRG) Minimum Patient Criteria	**~28,000**	• Only CRGs with at least 150 patients • Only medical offices with at least 30 patients with the CRG	Removes CRGs that either have too few total patients across all offices or those offices that have too few patients in that CRG
4. Valid spend and quality scores	**~15,500**	• Retains medical offices with calculable spend scores • Retains medical offices with calculable quality scores • Restricts to groups with at least 1 PCP	Removes medical offices that will not be rankable on spend and quality criteria due to insufficient data
5. Spend measure	**~3,600**	• BEST quartile of Observed/Expected (O/E) allowed cost • O/E significantly better than 1.0 for Allowed Cost	Top performers on spend measure
6. Quality measure	**~800**	• BEST quartile (0-25%) O/E weighted quality composite	Top performers on quality
7. Quality score representativeness and size	**~120**	• At least 1 quality measure to represent each of 1) Medication compliance and 2) Medication prescribing quality • Offices with more than one provider	Eliminates those whose quality score is based too heavily on prevention or process of care

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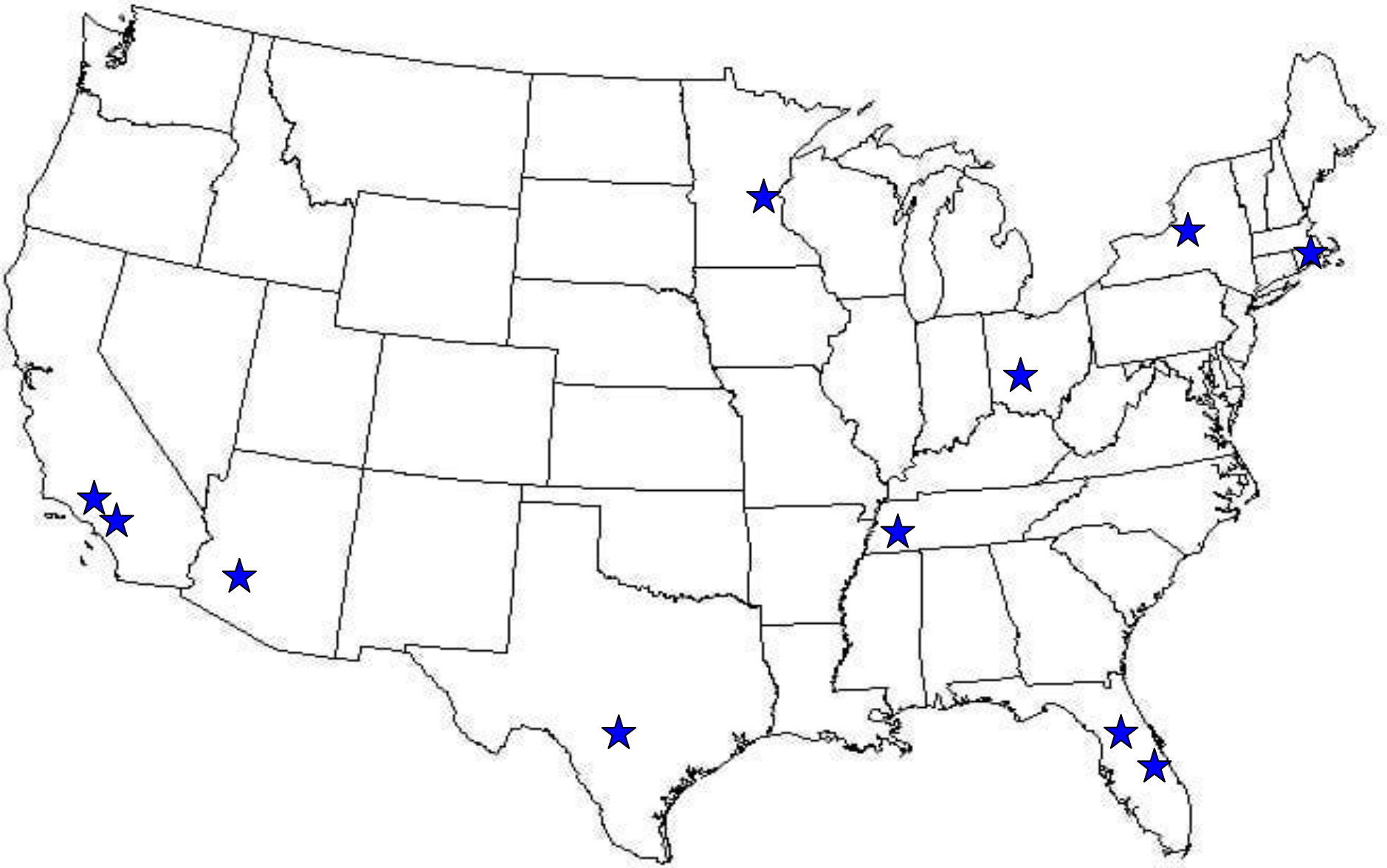
We have visited exemplary sites all over the country

★ : Primary care site visited



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Although the are rarer than you would expect, they operate in multiple contexts

- **In major metropolitan areas and rural outposts**
- **With primarily Fee-for-service reimbursement and with primarily capitated reimbursement**
- **As members of larger systems and independent practices**
- **As 2 physician practices and large multi-specialty groups**
- **As community health centers and workplace clinics**

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V1.0: American Medical Home Runs

Scouted for physician offices for whom at least one of their large payers confirmed that compared to regional peers:

- Average annual per capita combined payer and patient out-of-pocket spending for all covered health care services was at least 15% lower, after adjusting for health spending risk factors such as age and diagnosis; and
- Scores on available publicly released or payer-collected measures of quality and patient experience equaled or exceeded average regional scores.
- All 4 had exclusive or predominant focus on chronic care for older patients

3 Pivotal features:

- An exceptional form of individualized caring tailored to preventing ED use and unplanned hospitalization for chronic illness (A-ICU)
- Efficient service provision – standardization, top of license care teams
- Careful selection of, and coordination with, medical specialists

Personal traits were also important, specifically: persistence, tolerance for risk, instinct for leverage on clinical and financial outcomes, and a strong sense of personal accountability for preventable crises in patient health.

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Stay tuned...

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