# What Makes Michigan's High-Performing Primary Care Practices Work Well?

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Since the advent of the patient-centered medical home and team-based care concepts, health reformers have sought to unearth the specific interventions and techniques in primary care settings that are most likely to improve patient outcomes and value.

For example, the Center for Medicare and Medicaid Services' multipayer primary care demonstration projects, such as Comprehensive Primary Care Plus and Primary Care First, are using value-based payment and care delivery reforms to improve care quality and reduce unnecessary emergency department (ED) and inpatient utilization.

But what precisely makes a difference in primary care? To identify specific interventions or practice characteristics that are associated with high-performing practices, we leveraged the multipayer CPC+ Michigan dashboard made possible by the CPC+ participating payers (CMS, Blue Cross Blue Shield, and Priority Health) to find the practices in the top 20$^{th}$ percentile of performance on both ED and inpatient utilization and conducted in-depth interviews with each. We also collected and collated insights from leading health providers groups such as Ochsner, Geisinger, Stanford, ChenMed, and Village MD.

We identified the following six themes:

1. **Physician engagement drives patient and practice team engagement and promotes a practice culture that embraces adapting innovations to improve care**. Physician engagement in care delivery reforms drove innovation among all of the high performers studied, regardless of setting (large or small practice; part of a health system or independent). Bay Area Family Physicians, for example, characterized "primary care physician attitude and team championing" as the pivotal factor behind their success. Similarly, at Stanford, the cofounder of the Stanford Coordinated Care model noted that staff empowerment was integral to high performance.

2. **Co-located, engaged teams with care management at the core are key. The size of team does not matter.** Co-located (rather than centrally housed) care management in a common space greatly improved practices' ability to share information and coordinate team-based care. This was even more evident with full physical integration of the team in a single office space. The only exception was for transition of care outreach, defined as the contact that primary care practices make proactively to recently hospitalized patients and those who have visited emergency departments. In some of the practices and systems visited, care management and clinical teams literally bumped into each other during the course of a day given the close quarters, prompting opportunities for inter-team dialogue.

   At SMG Okemos, the care manager's office space is near the checkout window by design, to maximize interaction with patients. Some practices were very successful at using instant messaging for team-based care delivery, a practice that might be useful in times of required social distancing, such as during the COVID-19 pandemic. In addition, in high-performing practices, longitudinal and episodic care management was always conducted by the practice team (instead of centrally). All high performers used daily huddles, whether scheduled or impromptu. At Alimenti Family Practice, not only are there physician/team huddles at 5:30 pm each day to prepare for the next day's patients, but also there are twice-a-week clinical huddles with the full clinical team, and monthly all-team meetings where success is celebrated and any crises are reviewed.

3. **Offloading routine tasks (e.g., medication refills, gap closures) from the primary care physician workstream frees them to focus on patient needs and championing team-based care.** When practice teams "ready" the physician for a productive visit with a patient, physician satisfaction increases and so do outcomes. In high-performing practices, patient care gaps were closed prior to or during the visit by care team members. Examples of gap closure included ordering labs such as cancer screening, social determinants of health screenings, depression screenings, and medication refills. At Geisinger Health System, an "Anticipatory Management Program" is performed in advance of the visit. At Village MD, certified coders review patient charts before a visit, adding prompts in the electronic medical record to enhance accurate and complete coding.
4. **Availability and responsiveness to patient needs *as well as patient awareness of the availability* mattered more than extended hours.** Though hours outside traditional 8 am to 5 pm practice operations can be very helpful for certain patients, they are not useful if they are not consistently filled or are unable to accommodate an urgent need. More important is the patient's ability to have quick clinical responses to their questions. At Dr. David Byrens' practice, patient calls about clinical matters were returned by a clinician the same day, and when possible, within an hour. When patients know that they can get responses in a timely way, they can "count on the provider and practice having their back." In all of the Michigan high-performing practices, teams went out of their way to "never turn away patients" with same-day needs.

5. **Integrating performance reporting into regular team huddles or communication drives accountability for performance. Sharing provider-level performance regularly also motivated improvement among individual providers.** Several practices interviewed noted that “no one wants to be at the bottom of the ranking.” At Ochsner Health, systematic and sophisticated reporting is shared regularly with teams to provide line-of-sight understanding of current metric performance. And, at our on-site practice visits, without exception, performance reporting charts could be seen in areas where team members congregated, such as the lunchroom or charting area.
6. **High-performing practices had a method for identifying patients who would benefit from interventions (e.g., care management, self-management programs; remote patient monitoring; etc.) All high performers studied readily recited their “triggers” for intervention and care management.** At SMG Okemos, a care manager is a part of patient visits for those with uncontrolled diabetes, chronic obstructive pulmonary disease, and congestive heart failure (CHF) patients to help identify a need for additional interventions. Alimenti Family Practice uses a complexity scoring system that considers factors such as whether the patient is age 85 or older, has uncontrolled diabetes, CHF, depression, cognitive issues, or an unmet need.

   Hospital discharges were also a common trigger for extra patient support. At one impressive high-performing practice, Kozmic Family Practice, a “bridging clinic” coordinated post-discharge experiences for recently hospitalized patients. In the practices and systems studied, admission, discharge, and transfer outreach calls and gap closure calls were the only two functions that, though often performed within practices, were sometimes performed centrally without compromising outcomes. Both models worked as long as they were used systematically and connected the patient to the primary care practice quickly for follow-up.

Better understanding how high-performing practices achieve success offers an opportunity to share best practices and learnings. In Michigan we are using this work to develop our capacity to achieve team-based care and provide improved experiences and outcomes for patients. We believe that these lessons can be applied around the country.