PETERSON CENTER ON HEALTHCARE

GEORGE WASHINGTON UNIVERSITY
JACK MORTON AUDITORIUM
DECEMBER 4, 2014
WASHINGTON, D.C.

8:00 AM — REGISTRATION AND CONTINENTAL BREAKFAST

9:00 AM

WELCOME AND OPENING REMARKS

MICHAEL A. PETERSON PRESIDENT & CHIEF OPERATING OFFICER, PETER G. PETERSON FOUNDATION

VIDEO PRESENTATION: ONE PRACTICE, ONE PATIENT AND THE POTENTIAL TO SCALE

HOST & MODERATOR: **JON LAPOOK, MD** CHIEF MEDICAL CORRESPONDENT, *CBS EVENING NEWS WITH SCOTT PELLEY*; PROFESSOR OF MEDICINE, NYU LANGONE MEDICAL CENTER

IDENTIFYING EXCELLENCE: AMERICA'S MOST VALUABLE CARE

GARY S. KAPLAN, MD CHAIRMAN & CEO, VIRGINIA MASON HEALTH SYSTEM

ARNOLD MILSTEIN, MD, MPH PROFESSOR OF MEDICINE, DIRECTOR OF CLINICAL EXCELLENCE RESEARCH CENTER, STANFORD UNIVERSITY

NAYANA VYAS, MD FOUNDER & PRESIDENT OF CLINICAL AFFAIRS, FAMILY PHYSICIANS GROUP

There are examples of excellence in the U.S. healthcare system, where higher-quality care is delivered at a significantly lower cost. In its first major initiative, the Peterson Center on Healthcare partnered with Stanford University's Clinical Excellence Research Center (CERC) to find these high-performance providers, understand what is working, and validate their results. In the day's first session, Arnold Milstein from Stanford CERC will discuss this unprecedented study of 15,000 U.S. primary care practices, which identified 11 exemplary practices and the common features that enable them to deliver healthcare that is substantially higher in quality and lower in cost than nearly all of their peers. The session also will feature insights from Gary Kaplan, MD, on the potential to replicate and scale what is working, in addition to personal testimony from a doctor on the impact such care can have on quality of life.

10:00 AM — 15 MINUTE BREAK

10:15 AM

PERSPECTIVES ON U.S. HEALTHCARE: THE URGENT CHALLENGE AND THE GREAT OPPORTUNITY

MARY LANGOWSKI, MPA, JD EXECUTIVE VICE PRESIDENT FOR STRATEGY, POLICY & MARKET DEVELOPMENT, CVS HEALTH

DEBRA NESS, MS PRESIDENT, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

GLENN D. STEELE, JR., MD, PhD PRESIDENT & CEO, GEISINGER HEALTH SYSTEM

An underperforming healthcare system hurts patients, employers and providers alike. These groups have overlapping, complementary interests as we look to improve performance, efficiency and results. Each part of the system has an essential role to play, and a critical opportunity to benefit from improving quality and lowering costs. In this session, leaders representing consumers, a large private-sector employer, and a major health system will share their insights on the shared challenges and opportunities they face in building momentum towards focused, comprehensive system reform.

11:00 AM

THE PETERSON CENTER ON HEALTHCARE: TRANSFORMING U.S. HEALTHCARE INTO A HIGH-PERFORMANCE SYSTEM

DREW ALTMAN, PhD PRESIDENT & CEO, HENRY J. KAISER FAMILY FOUNDATION

MICHAEL A. PETERSON PRESIDENT & CHIEF OPERATING OFFICER, PETER G. PETERSON FOUNDATION

JEFFREY D. SELBERG EXECUTIVE DIRECTOR, PETERSON CENTER ON HEALTHCARE

The Peterson Center on Healthcare will work to transform U.S. healthcare by finding innovative solutions that improve quality and lower costs. In this session, we will hear about the Center's plans to identify, promote, replicate, enhance and systematically scale successful healthcare practices nationwide. First and foremost, securing higher-quality care at less cost from our healthcare system will improve the lives of millions of Americans. Improving performance will also allow greater investment in additional priorities that are key to the nation's long-term economic growth and prosperity. As part of this session, Drew Altman, CEO of the Henry J. Kaiser Family Foundation will discuss a new and unique partnership between the Center and Kaiser to track performance in the healthcare system.

11:45 AM

CLOSING REMARKS

PETER G. PETERSON FOUNDER & CHAIRMAN, PETER G. PETERSON FOUNDATION

11:50 AM

PROGRAM CONCLUDES

Throughout the morning, we will see videos featuring some of the country's most respected leaders who will share their thoughts on healthcare, innovation, and philanthropy.

BILL GATES CO-CHAIR, BILL & MELINDA GATES FOUNDATION

ATUL GAWANDE, MD, MPH SURGEON, BRIGHAM & WOMEN'S HOSPITAL; PROFESSOR, HARVARD MEDICAL SCHOOL

HARVEY V. FINEBERG, MD, PhD CHAIRMAN OF THE ADVISORY BOARD, PETERSON CENTER ON HEALTHCARE

FOR IMMEDIATE RELEASE
December 4, 2014

Contact: Jorge Alday, 646-768-4013
jalday@petersonhealthcare.org

NEW PETERSON CENTER ON HEALTHCARE ANNOUNCES MAJOR INITIATIVES TO IMPROVE PERFORMANCE OF U.S. HEALTHCARE

Launched with $200 Million Commitment, Peterson Center on Healthcare Working to Identify, Validate and Scale Innovations that Improve Health Outcomes and Lower Costs

Releases Early Findings from Groundbreaking Study by Stanford Research Team Finding Features Common to High-Performance Primary Care Providers

New Partnerships Announced with Henry J. Kaiser Family Foundation and National Quality Forum

Washington, DC — Today, the Peterson Center on Healthcare, a new organization established by the Peter G. Peterson Foundation, announced three major initiatives to advance the Center's mission to transform U.S. healthcare into a high-performance system that delivers high-quality care at a lower cost. The Center's first initiatives include collaborations with Stanford University's Clinical Excellence Research Center, the Henry J. Kaiser Family Foundation and the National Quality Forum.

The Foundation has launched the Peterson Center on Healthcare with an initial commitment of $200 million. The Center finds and validates innovative healthcare solutions that improve quality of care and lower costs, and then works to accelerate their adoption on a national scale. The Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. Additional partners, initiatives and grants will be announced in the coming months.

"Improving healthcare performance must be one of the nation's most important priorities," said Peterson Foundation President and COO Michael A. Peterson. "Today, Americans are forced to endure a healthcare system that delivers health outcomes that are worse than many other nations, yet it is the most expensive in the world. This leaves our citizens in poorer health, reduces incomes, and threatens our future prosperity. We have established this new Center to help drive the adoption of innovations that will improve the quality of care and also lower costs. The research that we announced today proves that high-performance healthcare is not only possible, it already exists in parts of the U.S."

"There is an urgent need in healthcare to identify solutions to improve quality and lower costs, validate them, and accelerate their adoption nationally," said Jeffrey Selberg, Executive Director of the Peterson Center on Healthcare. "There are clinicians who already deliver consistently high-quality healthcare at lower costs. America would have one of the world's highest-performing healthcare systems if we replicated these innovations on a national scale – that's the mission of our Center."

The three initiatives announced by the Center today are in the following areas:

Identifying High-Performing Primary Care Practices

The Peterson Center on Healthcare provided a grant to **Stanford University's Clinical Excellence Research Center (CERC)** to find and validate exceptionally high-performing primary care practices in the United States. The study of 15,000 U.S. primary care sites examined 11 exemplary primary care practices and uncovered 10 features of these sites that deliver higher-quality care at a substantially lower total annual healthcare cost. Stanford's research team estimates that spreading and scaling the 10 features could significantly improve the quality of care and lower health spending in the U.S. by as much as $300 billion annually.

This first-of-its-kind study was conducted using 41 widely used quality measures, along with data on total healthcare spending, to gauge performance at more than 15,000 practices with at least two clinicians providing primary care. Analyses showed that fewer than 5 percent of these practices ranked both in the top quartile for quality of care and in the lowest quartile for total healthcare spending (after adjustments to account for the severity of illness among their patients). Independent physicians selected by the research team then visited a sample of these practices, as well as of comparators, to identify features likely to account for the high performance. The study used physicians with performance management experience to conduct the on-site assessments.

The following 10 features can serve as a blueprint for other practices to achieve higher-quality care at lower cost:

1. **The practices are 'always on.'**
   Patients have a sense that the practice is "always on call" and they can reach the care team quickly, whether the practice is open or closed.

2. **Physicians adhere to quality guidelines and choose tests and treatments wisely.**
   Care teams have systems to ensure patients receive evidence-based care and physicians are mindful of benefits, risks and patient preferences when ordering tests and treatments.

3. **They treat patient complaints as gold.**
   Practices actively solicit patient feedback, good and bad, to improve the patient experience.

4. **They in-source, rather than out-source, some needed tests and procedures.**
   Care teams do as many tests and procedures – as can be done safely – in-house, often with guidance from specialists.

5. **They stay close to their patients, even when referring them to specialists.**
   Physicians refer to a select group of specialists they trust to act in their patients' interests, and stay in close communication as care decisions are made.

6. **They close the loop with patients.**
   Practices actively follow up to ensure that patients are seen rapidly after hospitalizations, adhere to medications, and see specialists when needed.

7. **They maximize the abilities of staff members.**
   Support is provided to physicians by a range of staff who are encouraged to perform at the "top of their license."

8. **They work in 'hived' workstations.**
   Open, 'bullpen-style' environments facilitate physician supervision and communication across clinical teams.

9. **They balance compensation.**
   Physicians are not paid solely on volume of services or revenue they individually produce.

10. **They invest in people.**
    Investment in staff is prioritized over space, equipment and technology.

More on the study and its findings can be found here.

"Our findings challenge the belief that excellent primary care can only be provided by large healthcare organizations that are household names," said Arnold Milstein, MD, Director of Stanford's Clinical Excellence Research Center. "We found un-sung physicians who are achieving something extraordinary – much better quality at lower cost. What's most encouraging is that their distinguishing features are tangible, and transferable on a national scale."

Analyzing the Performance of the U.S. Healthcare System

The Peterson Center on Healthcare also unveiled a partnership with the **Henry J. Kaiser Family Foundation** to provide a new digital platform dedicated to analyzing the performance of the U.S. healthcare system. The *Peterson-Kaiser Health System Tracker* went live today and provides comprehensive data on how the U.S. healthcare system is performing on critical quality and cost measures. It provides clear, up-to-date information on trends, drivers and issues that impact the system. The Tracker will also illustrate how the U.S. is performing relative to other countries, and how different parts of the system are performing relative to one another.

Improving Data Transparency and Usability

Patients and providers often are not able to make informed decisions about their care because quality and cost information is not accessible or not reliable. The Peterson Center on Healthcare is collaborating with the **National Quality Forum** to convene leaders from both the public and private sectors to identify specific actions that can be taken to make data and analytics more available to support systems improvement in healthcare. The results from these sessions will inform strategies to improve data transparency and usability and disseminate best practices on health data.

Advisory Board

The Peterson Center on Healthcare's Advisory Board provides key advice and guidance on the Center's mission, strategies and initiatives. The Advisory Board members have vast experience in U.S. healthcare, offer a diversity of perspectives and viewpoints, and represent a range of key healthcare stakeholder groups, including consumers, providers, payers, academia, government, business and philanthropy:

- **Harvey V. Fineberg, MD, PhD**, Chairman of the Advisory Board, Peterson Center on Healthcare
- **Drew Altman, PhD**, President and CEO, Henry J. Kaiser Family Foundation
- **Bill Frist, MD**, Senior Fellow, Bipartisan Policy Center
- **Bill Gates**, Co-Chair, Bill and Melinda Gates Foundation
- **Jim Guest, JD**, Former President and CEO, Consumers Union

- **Joseph Antos, PhD**, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute
- **Stuart Butler, PhD**, Senior Fellow, Economic Studies, Brookings Institution
- **Philip Bredesen, Jr.**, Former Governor of Tennessee
- **Delos M. Cosgrove, PhD**, President and CEO, The Cleveland Clinic
- **Dan Crippen, PhD**, Executive Director, National Governors Association
- **Helen Darling, MA**, Strategic Advisor, Former President and CEO, National Business Group on Health
- **Ezekiel Emanuel, MD**, Vice Provost for Global Initiatives, Chair of Medical Ethics and Health Policy, Diane v. S. Levy and Robert M. Levy University Professor, University of Pennsylvania
- **Mark McClellan, MD, PhD**, Director, Engelberg Center for Health Care Reform, Brookings Institution
- **Arnold Milstein, MD, PhD**, Director, Clinical Excellence Research Center, Stanford University
- **Meredith B. Rosenthal, PhD**, Professor of Health Economics and Policy, Harvard School of Public Health
- **Glenn D. Steele, Jr., MD, PhD**, President and CEO, Geisinger Health System
- **Gail Wilensky, PhD**, Senior Fellow, Project Hope
- **Ronald A. Williams**, Former Chairman and CEO, Aetna; Chairman and CEO, RW2 Enterprises, LLC
- **Olympia J. Snowe**, Former U.S. Senator to Maine

Bill Gates has served as a member of the Center's Advisory Board since its inception in 2012. In addition to the time and effort he has committed, Mr. Gates has also made an initial personal contribution of $1 million to the Center, as a symbol of his support for and strategic partnership with the Center and its mission.

A complete media kit for the launch of the Peterson Center on Healthcare is available here.
For more information about the Peterson Center on Healthcare visit www.petersonhealthcare.org.

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About the Peterson Center on Healthcare
The Peterson Center on Healthcare is a non-profit organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. The organization works to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the organization collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships and research.

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The Peterson Center on Healthcare is a non-profit organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. The organization is working to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale.

Established by the Peter G. Peterson Foundation in 2014 with a $200 million commitment, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. Our approach is data-driven, collaborative, and action-oriented.

OUR APPROACH

FIND AND VALIDATE INNOVATIVE SOLUTIONS

Rather than serving as an inventor of new approaches to care, we seek what already works. We engage with the private and public sectors, practitioners, academics, researchers, and consumer advocacy groups to find the most effective and efficient models of care throughout the country. We currently focus on three key areas:

Healthcare Providers Through scouting and analytical research of providers across the country, we systematically assess and validate high-value healthcare delivery approaches by considering factors such as organizational attribute, type of patient or clinical condition.

Employers and Insurers We engage with employers and health insurance plans to find innovative approaches in health benefits design and management-labor partnerships that effectively improve value for both the employer and employee, and support more informed care decisions for patients.

State-Level Systems As large purchasers and regulators of healthcare, states are well-positioned to improve quality and lower costs. We work with key stakeholders in state and local governments to develop public-private partnerships and initiatives that improve performance.

ACCELERATE ADOPTION AND SCALE

As a result of the fragmented nature of the U.S. healthcare system and its poor incentive structure, barriers have impeded the broad adoption of solutions that have been proven to improve quality and lower costs. The Peterson Center on Healthcare is developing a comprehensive approach to spreading and scaling high-performance healthcare solutions. We are creating a network of organizations that have established relationships across the healthcare system, and collaborate with these organizations to develop change packages, implementation toolkits, and dissemination strategies to spark adoption on a national scale.

FOSTER THE CONDITIONS FOR CHANGE AND IMPROVEMENT

More broadly, the Peterson Center on Healthcare will work on systemic initiatives to encourage and facilitate stakeholder actions to improve quality and lower costs. In addition to building awareness of the need for improvement, this will include work in the following key areas:

- Data Transparency and Information
- Driving Innovation to Improve Quality While Lowering Cost
- Moving to Value-Based Payment
- Engaging Consumers
- State and Federal Policies

OUR WORK

STANFORD UNIVERSITY'S CLINICAL EXCELLENCE RESEARCH CENTER: MOST VALUABLE CARE

We know there is excellence in the U.S. healthcare system, as some physicians and hospitals are delivering higher-quality care at a lower cost. We have partnered with **Stanford University's Clinical Excellence Research Center** (CERC) to find these high-performance providers, understand what is working, and validate their results.

CERC reviewed national quality and cost data on 15,000 sites, and identified eleven primary care practices that are delivering exceptional value – higher quality at significantly less cost – to their patients. These providers of Most Valuable Care have defined a path toward better, more affordable healthcare. They have key features in common, which can serve as a blueprint for others to achieve high performance.

In addition to primary care, CERC is now seeking out similar insights about high-performing specialists and hospitals that improve quality and reduce costs. We will be working in partnership with Stanford and a network of other stakeholders to disseminate these features and accelerate their adoption on a national scale.

PETERSON-KAISER HEALTH SYSTEM TRACKER: MONITORING PERFORMANCE OF THE U.S. HEALTHCARE SYSTEM

We cannot improve what we do not measure. Recognizing this, the Peterson Center on Healthcare launched an initiative with the **Henry J. Kaiser Family Foundation** to monitor how well the U.S. healthcare system is performing in terms of quality and cost. The Peterson-Kaiser Health System Tracker provides clear, up-to-date information on trends, drivers and issues that impact the performance of the system. It also illustrates how the U.S. is performing relative to other countries, and how different parts of the system are performing relative to one another.

The Tracker will put a spotlight on performance and facilitate discussion about how the health system can be improved. Visitors to the website, whether they are healthcare providers, employers, payers, consumer advocates or policy makers, will find data analyses that will provide insight as to what is driving the performance of one of the most vital sectors in the U.S. economy.

The Tracker places a strong emphasis on data and evidence, addressing key questions through collections of charts and analyses, as well as a blog to provide context and synthesize the latest research and developments. We also provide regular insight briefs for a more in-depth review of topical questions.

NATIONAL QUALITY FORUM: IMPROVING DATA USABILITY AND TRANSPARENCY

There is significant variation in outcomes, price, and cost throughout the healthcare system for the treatment of common conditions. Unfortunately, patients often are not able to make informed decisions about outcomes and cost because this information is either not readily accessible or not reliable. We develop initiatives that increase the transparency and usability of critical information on healthcare quality and cost.

Through a grant to the **National Quality Forum**, we have begun a collaboration to convene leaders from both the public and private sectors to identify specific actions that should be taken to enhance the availability of data and analytics to support systems improvement in healthcare. The results from these convenings will inform strategies to improve data usability and transparency, and will develop key strategies for the dissemination of best practices on health data.

PETERSON CENTER ON HEALTHCARE LEADERSHIP

Jeffrey D. Selberg
Executive Director
Peterson Center on Healthcare

PETER G. PETERSON FOUNDATION LEADERSHIP

Peter G. Peterson
Founder & Chairman
Peter G. Peterson Foundation

Michael A. Peterson
President & Chief Operating Officer
Peter G. Peterson Foundation

PETERSON CENTER ON HEALTHCARE ADVISORY BOARD

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PETERSON
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HEALTHCARE

What Other Healthcare Leaders Are Saying About the Peterson Center on Healthcare:

"The innovations identified by Stanford University's Clinical Excellence Research Center, with the support of the Peterson Center on Healthcare, can help all primary care physicians achieve higher-quality outcomes at a lower cost. We support their ambitious efforts to move the needle on both quality and cost of healthcare."

- Steven E. Weinberger, MD, Chief Executive Officer of the American College of Physicians

"The Peterson Center on Healthcare's work to find and spread the adoption of real-world solutions to improve healthcare quality and costs is in line with the goals of the IHI Triple Aim. We look forward to working closely with the Center as they uncover proven strategies to reduce costs and improve healthcare quality."

- Maureen Bisognano, president and CEO of the Institute for Healthcare Improvement

"Many primary care practices are making major innovations in care delivery, and we applaud the Peterson Center on Healthcare's efforts to bring these efforts to light. We need to spread the secrets of high-quality, low-cost care to more providers nationwide."

- Margaret E. O'Kane, President, National Committee for Quality Assurance

"Team-based care is essential for delivering high-value care to patients with chronic illnesses. We support efforts to help spread the principles of team-based care to more primary care practices nationwide."

- Mary D. Naylor, PhD, RN, Director, New Courtland Center for Transitions and Health at the University of Pennsylvania School of Nursing

"Primary care practice transformation is foundational for the redesigned US healthcare system. These findings from the Peterson Center on Healthcare clarify the essential components and organizational characteristics that spell success. We see this as a tremendous boost for our practice transformation work and recommend that anyone interested in developing effective primary care organizations should review this study on high value primary care."

- Bruce Bagley, MD, President and CEO of TransforMED, a subsidiary of the American Academy of Family Physicians

PETERSON CENTER ON HEALTHCARE

THE HENRY J. KAISER FAMILY FOUNDATION

Assessing the Performance of the U.S. Health System

Larry Levitt, Gary Claxton, Cynthia Cox, Selena Gonzales, Rabah Kamal
Kaiser Family Foundation

While health spending growth has slowed in recent years, over the long-term healthcare costs have grown significantly, with per capita spending increasing about tenfold since the early 1980s. Health spending growth has consistently outpaced U.S. economic growth and is higher than health spending in other wealthy countries. Despite spending more, the U.S. does not have better outcomes in terms of better health or longer life.

Considerable attention has been given to the high level of medical spending in the U.S. and the challenges it poses to public and private budgets. Less understood are the different components of cost growth (e.g., price vs. utilization), how the components differ across sectors and funding sources, and how the various drivers of health spending have changed over time. Disaggregating health spending and its growth provides information health industry leaders, policymakers, and the media can use to better understand financial challenges, target policy initiatives, and assess the implications of potential system changes for patients, providers, and payers.

Health outcomes, or what we are getting in exchange for this spending, are even less well understood and are extremely difficult to measure. For other sectors of the economy, measurement of output is often a relatively simple matter of tabulating goods sold or productivity: one can count how many TVs or cars are produced and the resources that went into producing them. Healthcare output can also be measured in terms of the goods and services patients receive – the numbers of physician visits, hospital admissions, and prescriptions are examples – but output alone is an unsatisfying measure of what we hope to receive in return for health spending. What we want are better health outcomes: to get healthy when we become sick or injured and, even better, to avoid getting sick in the first place. It is hard to quantify these outcomes and even harder to put a price on any amount of improvement.

Complicating any assessment of health system performance is the problem of distinguishing health system impacts from those that stem from other societal drivers. Many factors outside of the health system – such as poverty, diet, exercise, substance use, environmental factors, and social policies – not only contribute directly to health status, but also affect access to medical care. Even when potentially informative measures can be identified, consistent trend data may not always be available at the health system level for the U.S. and other countries.

Historically, more emphasis has been placed on cost than on health system outcomes. However, industry leaders and policymakers cannot make good judgments about spending without understanding how well the system is working for patients. To put it simply, we need to better understand how much we are spending, what is driving growth, and what we are getting for what we spend. This means tracking how well the health system is performing at keeping people healthy and treating them when they get sick. Are

we getting better health outcomes for our increased spending? If we are successful at reducing growth in spending, is there a sacrifice in terms of health? At the broadest level, we can think of a dual focus on health system spending and outcomes as assessing the efficiency of the health system.

OUR APPROACH

The Peterson Center on Healthcare and the Kaiser Family Foundation are partnering to create the Peterson-Kaiser Health System Tracker. The aim is to provide an objective resource to help policymakers, journalists, industry professionals, and other stakeholders understand trends in U.S. health spending, how well the system as a whole is performing to improve health outcomes, and how efficiently it is doing so. In all of our analyses, we are taking a macro view in assessing the performance of the U.S. health system. As such, the Tracker does not endeavor to compare individual hospitals or insurers, rank states, nor assess particular medical interventions.

There will be a heavy emphasis on data and evidence, addressing key questions through collections of charts, as well as a blog to provide context and synthesize the latest research and developments. We will also provide regular insight briefs that focus in greater depth on topical questions.

One aspect of our analysis will be a comparison of U.S. health system performance measures to those of other countries. In doing so, we identified a group of countries that are economically similar so that we can look at differences across countries with reasonably comparable opportunities and resources to devote to healthcare. We selected member countries from the Organisation for Economic Co-operation and Development (OECD) based on the size of their economy (having a total GDP above the median for OECD countries) and their level of income (with per capita GDP greater than the OECD median) in at least one of the past 10 years. As national health spending correlates strongly with GDP, lower income countries are not generally comparable to the U.S., and smaller countries face different challenges in structuring their delivery systems. Taking a cross-national approach has the advantage of seeing how health systems organized differently from ours produce different outcomes and utilize resources differently. At the same time, cross national differences in spending and outcomes may reflect differences in factors outside of the health system, such as inequality, lifestyle, politics, and culture.

Another approach we will use is to look at trends in the performance of the U.S. health system over time. This avoids the substantial cultural and behavioral differences that exist across countries. However, trends move very slowly – particularly in the case of health outcomes – so changes become apparent only through observation over long periods of time. This slow pace also poses challenges in attributing changing outcomes to particular innovations or interventions in policy, medical science, or the delivery system. Nonetheless, the examination of trends over time can reveal where the health system has made progress and where gaps still exist.

One can also learn a great deal about what is driving changes in spending or outcomes by looking at different payers and market segments (e.g., Medicare, Medicaid, and private insurance). Breaking down trends and cross-national comparisons by different sub-groups (e.g., by income, insurance status, disease, race, gender, and ethnicity) can also reveal how equitable the health system is – an important element of health system performance evaluation that may reveal the greatest opportunities for improving outcomes. Some examination of regional variation in spending and outcome measures can also shed light on underlying drivers of healthcare spending or successful strategies to improve outcomes.

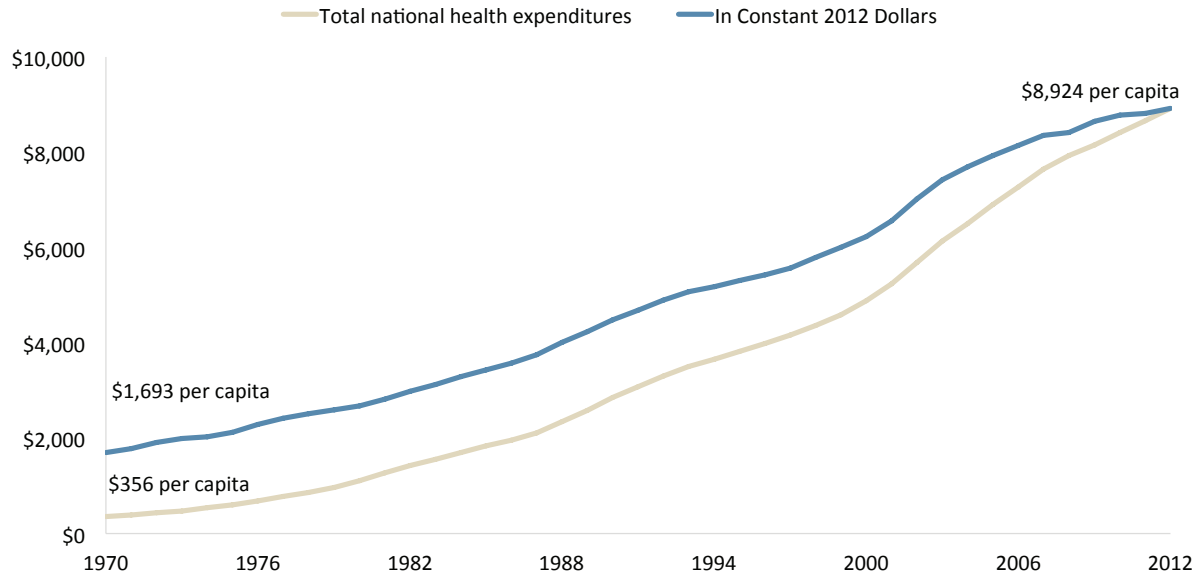
We are initially launching with a set of foundational resources, described below, upon which we will expand over time to explore the historical and current drivers behind health spending trends and the latest research on ways to reduce costs and improve outcomes.

THE COST OF HEALTHCARE IN THE U.S.

The U.S. spent almost $2.8 trillion dollars on healthcare in 2012 (the most recent year with comprehensive data available), or about $8,745 per person (up from $1,693 in inflation-adjusted terms since 1970). Total health spending – which includes spending by both public and private payers on healthcare, administrative expenses, public health, and health research – has grown substantially over time. In nominal dollars, national health spending has increased over 3,600 percent since 1970 (from $74 billion in 1970, to $1.4 trillion in 2000, up to $2.8 trillion in 2012).

On a per capita basis, health spending has grown substantially

Total national health expenditures, US $ per capita, nominal and adjusted for inflation, 1970-2012



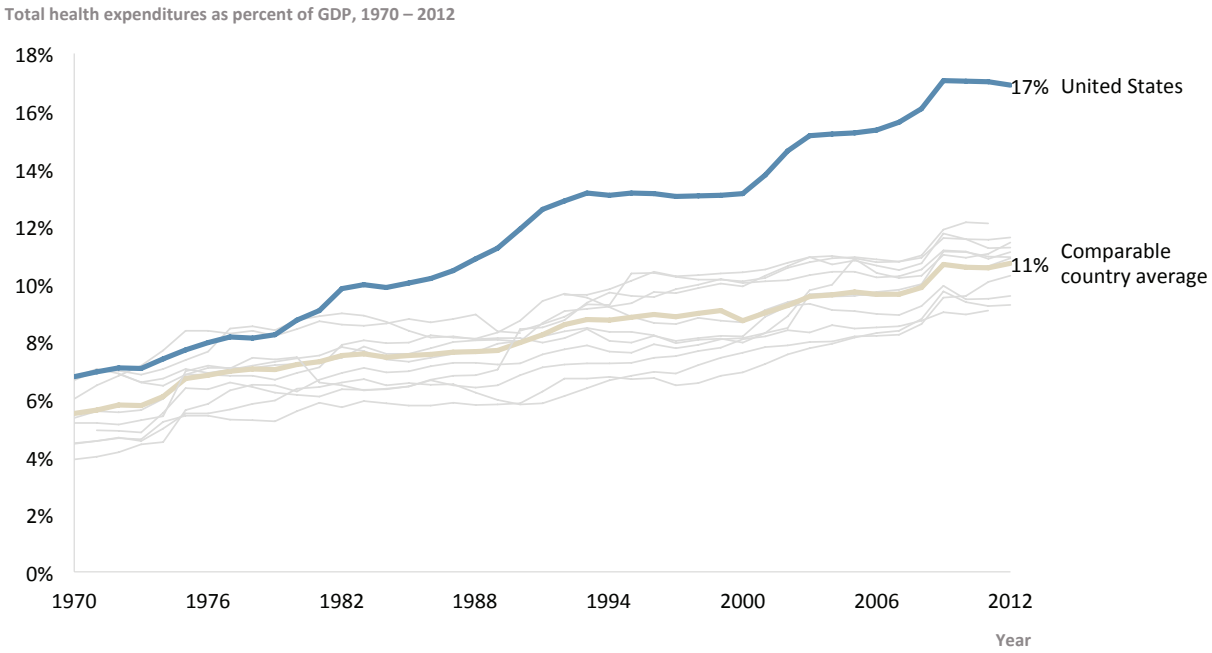
Source: National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2012, file NHE2012.zip).

Peterson-Kaiser Health System Tracker

While other countries have also seen rapid growth in health spending, the U.S. spends far more on health per capita and as a share of the economy. Per capita health spending in the U.S. in 2012 was 42% higher than Norway, the next highest per capita spender. We currently spend 17% of our GDP on health-related expenses (through both public and private funds), compared to an average of 11% of GDP in comparably wealthy countries.

The U.S. has not always been such an outlier. During the 1980s, the gap in health spending as a share of the economy between the U.S. and other wealthy OECD countries widened considerably, with per capita health spending in the U.S. growing faster than any comparable OECD country (10.0% average annual growth compared to an average of 7.1% in comparable countries). The gap largely stabilized in the 1990s but started to grow again during the early 2000s, and once again has stabilized in recent years as health spending growth has slowed in the U.S. and in other countries.

Since 1980, the gap has widened between U.S. health spending and that of other countries



Source: OECD (2013), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). doi: 10.1787/data-00349-en (Accessed on June, 25 2014). **Notes**: Data unavailable for: the Netherlands in 1970, 1971, and 2012; Australia in 1970 and 2012; Germany in 1991; and France from 1971 through 1974, 1976 through 1979; 1981 through 1984, and 1986 through 1989. Break in series in 2003 for Belgium and France and in 2005 for the Netherlands. 2012 data for Canada and Switzerland are estimated values.

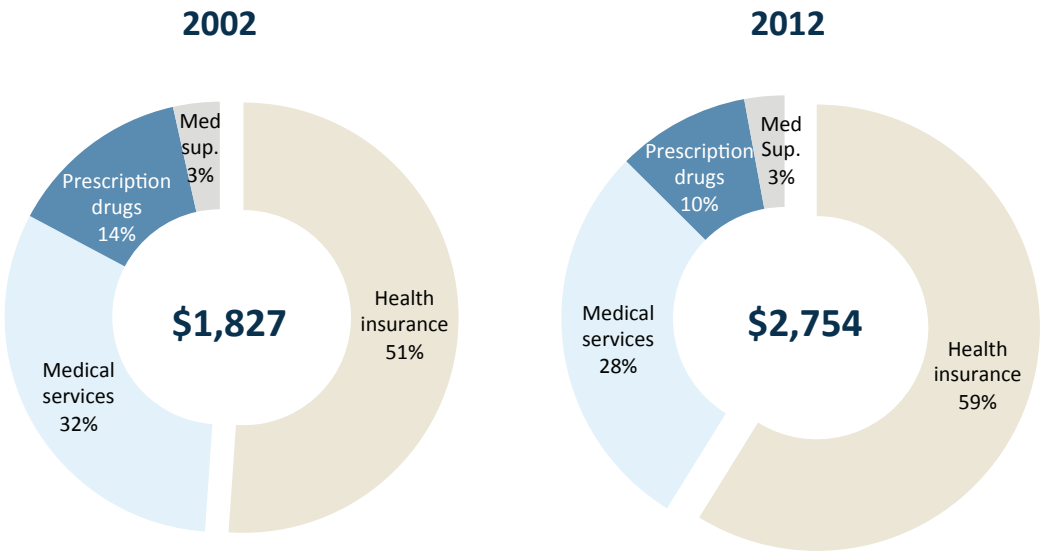
Peterson-Kaiser Health System Tracker

The healthcare marketplace in the U.S. is quite different from comparable OECD countries. In 2012, public sector health spending accounted for about 8% of U.S. GDP and private sector spending accounted for another 9%. In comparable OECD countries, public sector spending accounted for 8% of GDP on average, while private sector spending was less than 3% on average. Over time, public sector spending has grown somewhat faster than private sector spending in the U.S. Since 1970, private sector spending has increased by 5% of GDP (from 4% to 9%) while public sector spending has increased by 6% of GDP (from 2% to 8%). The growth in public sector health spending in the U.S. has been largely due to policy changes (e.g., expanded Medicaid eligibility and the creation of the Child Health Insurance Program) and demographics (e.g., increases in the number of Medicare beneficiaries due to the baby boom) and expansions in Medicaid eligibility. In fact, on a per enrollee basis, Medicare has grown slower than private insurance.

As healthcare spending rises overall, individuals and families are also spending more on healthcare. Over the last ten years, the amount an average American household spent out-of-pocket on healthcare and insurance grew by just over 50% from $1,827 in 2002 to $2,754 in 2012. Adjusting for inflation, the change in out-of-pocket spending over the 2002 – 2012 period was from $2,257 to $2,754 in constant 2012 dollars, or an 18% increase. Health insurance premiums make up a growing share of household health expenditures, while direct expenses for healthcare represent a shrinking portion of overall household spending on health.

A larger portion of household spending on health is on insurance premiums, and smaller portion on OOP costs

Average household expenditures on health (nonelderly families with no Medicare beneficiaries), 2002 and 2012



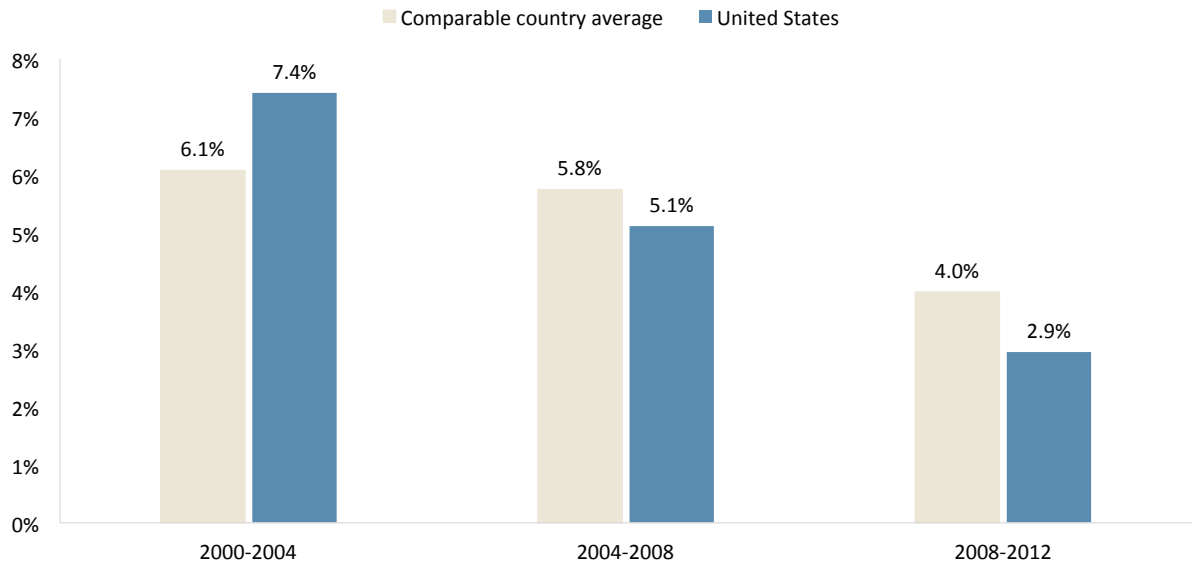
Source: Consumer Expenditure Survey

Peterson-Kaiser Health System Tracker

Overall, health spending growth has slowed recently, both in the U.S. and in comparable OECD countries. Debate continues among experts about how much of the slowdown is tied to the continuing effects of the economic downturn and how much is due to structural changes in the health delivery system. The fact that the slowdown has occurred in other countries as well lends credence to the economic argument, though it could also be explained by fewer new medical technologies. As the economy continues to recover, there will likely be upward pressure on health spending, though growth rates may not return to historical levels if delivery system changes (spurred in part by the Affordable Care Act) continue to take hold and generate efficiencies. Medicare spending has grown particularly slowly in recent years, and there is evidence that Medicare is more immune to changes in the economy than health spending overall.

In recent years, health spending growth has slowed in the U.S. and in comparable countries

Average annual growth rate in total health expenditures per capita, U.S. dollars, PPP adjusted



Source: OECD (2013), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). doi: 10.1787/data-00349-en (Accessed on June, 25 2014). **Notes**: Data unavailable for: Australia and the Netherlands in 2012; France from 1981 through 1984 and 1986 through 1989; and Germany in 1991. OECD reports a break in series for: Belgium in 2003; Canada in 1975 ; France in 2003; and the Netherlands in 2005. Canada and Switzerland data are reported as estimated values for 2012.

Peterson-Kaiser Health System Tracker

HEALTH SYSTEM OUTCOMES

Although the U.S. continues to spend more on health than any other country, it is unclear whether this higher expenditure is yielding better results. System-wide outcomes measurement is fraught with challenges, including confounding social and environmental factors, as well as inconsistent and unavailable data. Still, across a range of measures, a picture begins to develop suggesting that while health outcomes have improved in the U.S. over time, this improvement has generally been at a slower pace than in comparable OECD countries.

THE ABILITY TO IMPROVE HEALTH OUTCOMES

Health outcomes can be measured in a variety of ways, including life expectancy, mortality rates (overall and for certain conditions), the overall health of the population, and the prevalence of various health conditions.

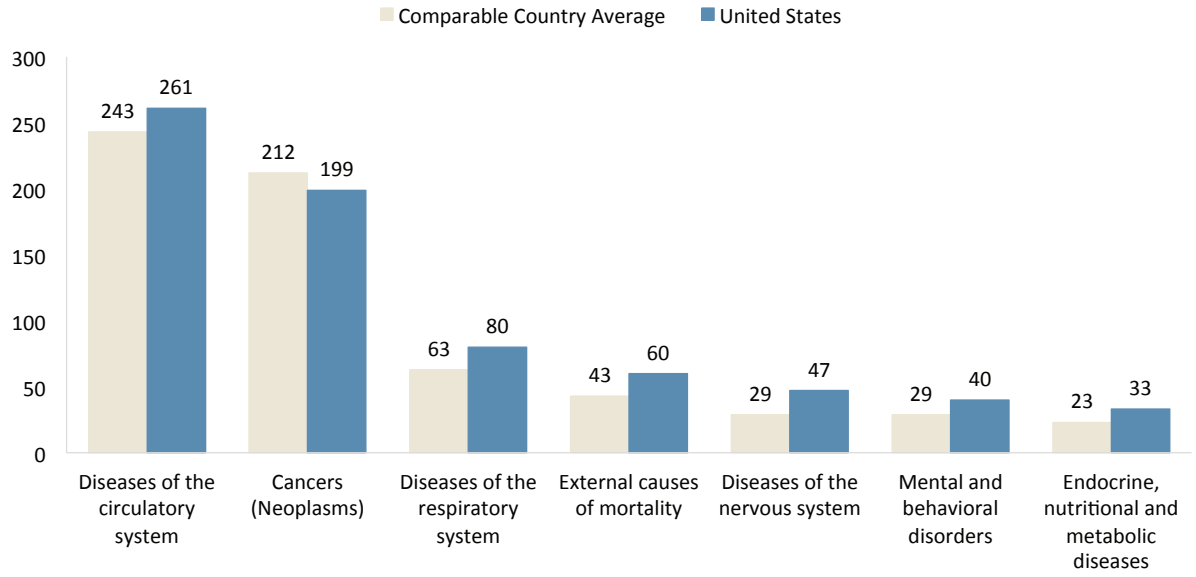
One measure that is often reported is life expectancy at birth. Life expectancy in the U.S. is lower than in other comparably large and wealthy countries, though that has not always been the case. As recently as 1980, the life expectancy at birth in the U.S. was 74 years, approximately on par with comparable OECD countries. Since that time, however, other countries have seen greater gains in life expectancy. Currently, life expectancy in the U.S. is just under 79 years, compared to an average of just under 82 years in comparable countries. While a useful starting point, life expectancy is influenced by many factors inside and outside of the healthcare system. For example, individual behaviors, social and environmental factors, and social values all have impacts on life expectancy.

An Institute of Medicine panel recently noted that high mortality from accidents and violence and lifestyle-related factors such as diet and obesity contribute to the difference in life expectancy.

Consistent with our shorter life expectancy, mortality rates for most leading causes of death are higher in the U.S. than in comparable OECD countries. One notable exception to this trend is in mortality from cancer, an area of performance measurement where the U.S. has seen marked improvement. Lung cancer mortality rates, in particular, have declined rapidly in the U.S. and may be due to lower smoking rates.

For most of the leading causes of death, mortality rates are higher in the U.S. than in comparable countries

Age-adjusted major causes of mortality per 100,000 population, in years, 2010



Source: OECD (2013), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). doi: 10.1787/data-00349-en (Accessed on July 24, 2014).

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In measuring health system performance outcomes, some researchers have examined deaths that conceivably could have been prevented through appropriate medical interventions. In 2006, the most recent year with available data, the U.S. had the highest rate of death amenable to healthcare among the comparable OECD countries included in the study (though the rate has been declining over time in the U.S. and internationally).

HOW EFFECTIVE THE SYSTEM IS AT PROVIDING SERVICES

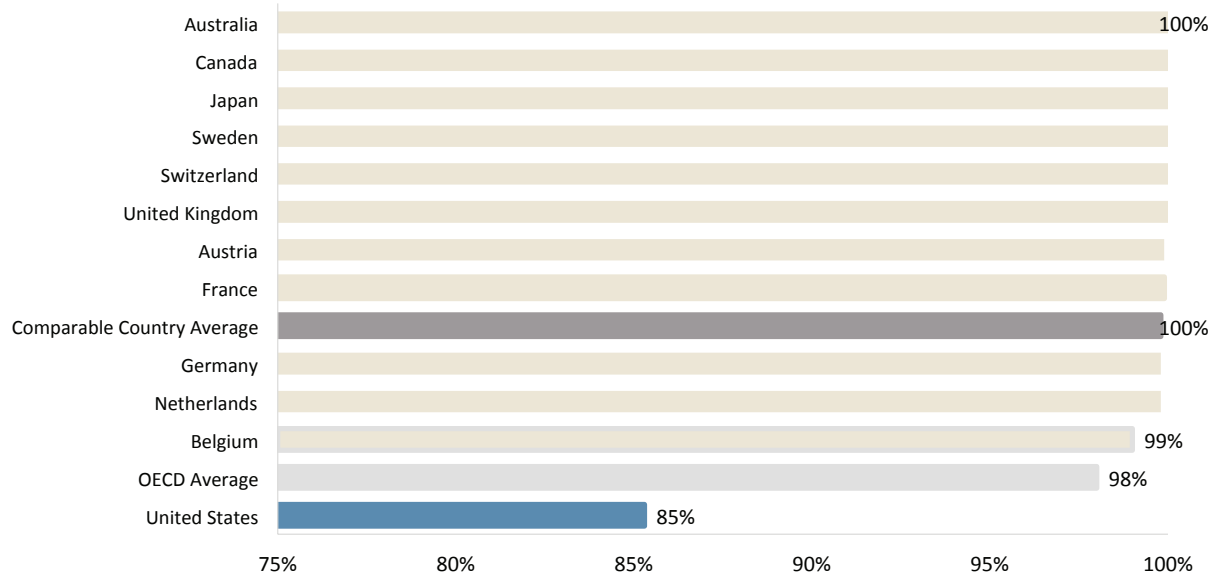
In addition to these health outcomes, which are slow to change and can be affected by many factors beyond the health system, certain intermediate yardsticks can be good indicators of how well the health system is performing. These include measures of system activities and outputs, such as hospital safety, adherence to medical guidelines, and diagnosis rates. Additionally, patient experiences can be assessed by looking at wait times, satisfaction, and surveys of patient engagement and knowledge.

Measuring system activities and outputs, such as adherence to medical guidelines, can be used to highlight the impact of system changes on specific disease outcomes. While there is still much to be done to improve the mortality rate for diseases of the circulatory system, there was great improvement from 2005 (42%) to 2011 (94%) in the percentage of patients with a heart attack given an angioplasty within 90 minutes of arrival at a hospital. Heart attacks account for about half of all deaths attributed to diseases of the circulatory system, and adherence to this medical guideline has contributed to the falling mortality rate for this disease area (268 deaths per 100,000 population in 2005 to 218 in 2010).

The accessibility and affordability of health services is another important measure of the system's performance. With just 85% of the population covered by health insurance in 2012, the U.S. has a lower rate of coverage than any other OECD country. (The OECD average is 98% and comparable countries cover 100% of their populations.) Health insurance shelters people from high medical costs that can result from illness and injury. For example, the Oregon Health Insurance Experiment, which randomly assigned Medicaid to low-income uninsured residents, found that having insurance coverage reduced financial hardships and decreased the probability of a medical bill being sent to collections by 25% compared to a control group of people with similarly low incomes. The Affordable Care Act's coverage expansion provisions, which include the option for states to expand Medicaid and federal tax credits to assist people purchasing their own coverage, are projected to increase the portion of Americans with insurance over time. The extent to which this expansion of coverage translates into more affordable care and better access will be the subject of many evaluations to come.

In 2012, the U.S. had the lowest insured rate of all OECD countries

Percent of total population covered by private and/or public health insurance, 2012



Source: OECD (2013), "OECD Health Data: Health care resources", OECD Health Statistics (database). doi: 10.1787/health-data-en (Accessed on September 10, 2014). **Notes**: In cases where 2011 data were unavailable, data from the countries' last available year are shown.

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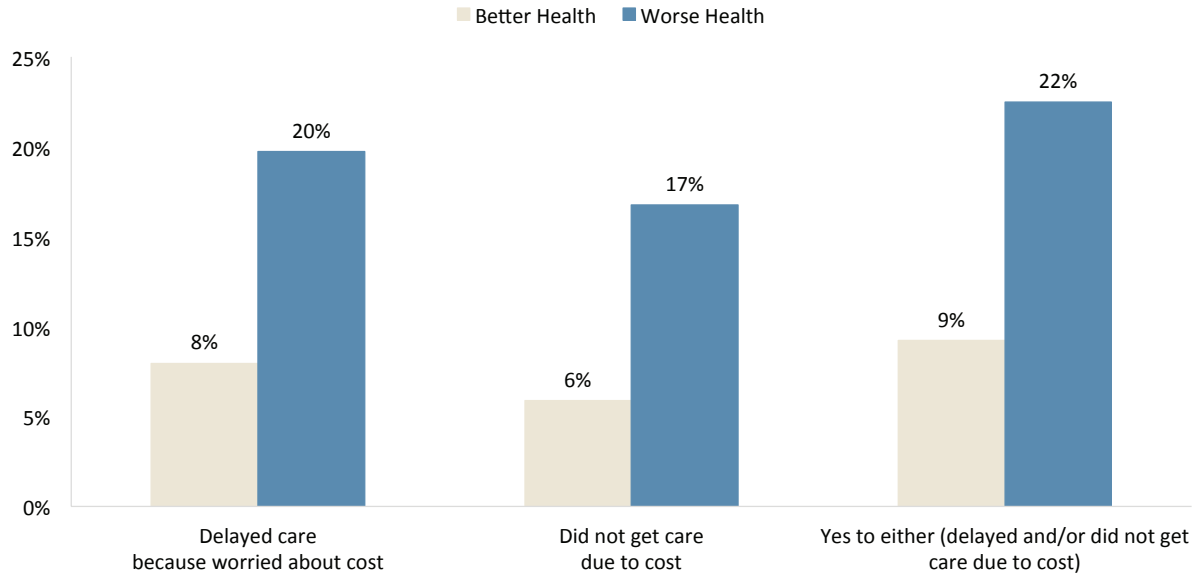
The frequency with which Americans report delaying or forgoing care due to costs is about the same in 2013 as it was in the late 1990s. However, spikes in cost-related access problems during the most recent economic downturn and in the early 2000s were particularly pronounced among adults in worse health and the uninsured. In general, these two groups report significantly more difficulty accessing needed healthcare due to cost than do adults in better health and those with insurance.

Adults who are in worse health have more difficulty accessing care due to cost

Percent of adults who reported delaying or going without care due to cost, 2013



Source: National Health Interview Survey

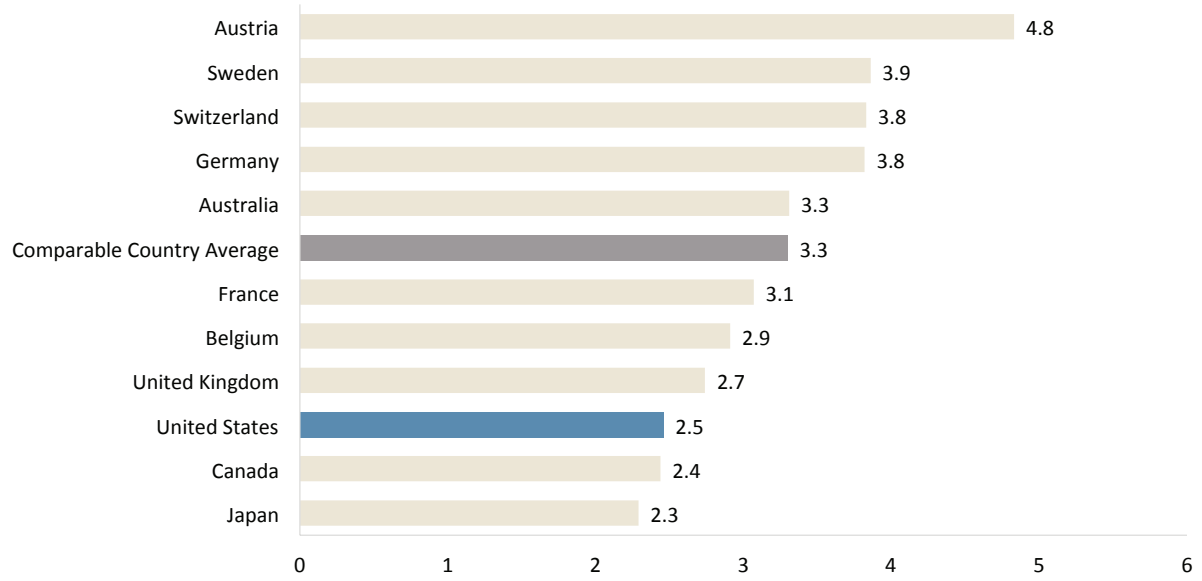
Peterson-Kaiser Health System Tracker

THE CAPACITY OF THE HEALTH SYSTEM TO PROVIDE SERVICES

Health system performance can also be assessed in part by examining the resources devoted to achieving better health in the U.S. Systems with greater capacity – more hospital beds, more physicians, more nurses – are generally better equipped to provide more services to people, all else being equal. The U.S. has similar numbers of nurses per capita as comparable OECD countries, but has fewer hospital beds and physicians.

There are fewer doctors per capita in the U.S. than there are in most comparably wealthy countries

Physicians, density per 1,000 population (2011)



Source: OECD (2013), "OECD Health Data: Health care resources", OECD Health Statistics (database). doi: 10.1787/health-data-en (Accessed on September 10, 2014). **Notes**: In cases where 2011 data were unavailable, data from the countries' last available year are shown.

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In anticipation of more people gaining coverage in the coming years as a result of the Affordable Care Act, concerns have been raised over the system's capacity to meet increased demand for health services, with particular concern regarding a potential shortage of physicians and regional disparities. Of course, a health system that does a better job at providing services that are clinically appropriate and effective may be able to provide comparable or better outcomes with less capacity.

CONCLUSION

In recent years, health spending growth in the U.S. has slowed to historically low levels, likely driven in part by the economic downturn and in part by structural changes in the health system. However, as the economy improves, it will exert upward pressure on health spending and may lead to growing calls for efforts to contain costs. While healthcare costs in the U.S. are substantially higher than in comparable countries, there are also signs that our system under-performs in keeping people healthy and treating them when they are sick.

Our aim with the Peterson-Kaiser Health System Tracker is to provide reliable, up-to-date information on health system performance trends, and to synthesize the latest research in these areas. Initially, the Tracker is launching with a set of basic, foundational collections of data visualizations and blog posts. These include examinations of trends in U.S. health spending by sector and payer; how spending compares to other countries; the recent slowdown in health spending in the U.S. and other countries; how mortality and life expectancy in the U.S. compare to other countries; the capacity of the health system; the health of the population and the accessibility and affordability of healthcare.

Over time, we will regularly add new data to the site, digging deeper into the key drivers of health system performance, such as: how health spending varies by disease, insurance status, age, gender, and race; the concentration of health spending among a small group of patients; how the cost of specific procedures has changed over time; the effects of price vs. utilization in driving spending growth; the role of new drug development and patent expirations; changes in the prevalence of diseases and conditions over time; trends in the quality and safety of the health system; and changes in the efficiency of care delivery.

Ideally, efforts to reduce the growth in health spending will improve the health system's effectiveness as well. The best available evidence should be used to guide those efforts and assess their success.

To learn more, visit www.healthsystemtracker.org

PETERSON CENTER ON HEALTHCARE

Stanford MEDICINE | Clinical Excellence Research Center

Executive Summary

UNCOVERING AMERICA'S MOST VALUABLE CARE

With total spending at almost $3 trillion a year, or 18 percent of the U.S. economy, America's healthcare system is the most expensive in the world. Spending has increased faster than inflation, the economy, or wages—yet when it comes to quality and health outcomes, performance is often no better than in most other developed nations, and in some instances, it is much worse.

The Peterson Center on Healthcare and Stanford University's Clinical Excellence Research Center (CERC) set out to find high-performing primary care providers through a systematic, first-of-its-kind analysis of commercial insurance data reflecting the performance of small front line clinical teams to:

- Identify primary care practices that are 'positive outliers' in performance—delivering higher quality at significantly lower total annual cost
- Determine the features that distinguish these primary care practices
- Create a tools to enable other primary care physicians to incorporate insights from high-value providers into their own practice
- Demonstrate the replicable nature of these features and results, and support adoption on a national scale

This research is innovative in two ways. First, it looked at small clinical teams rather than large medical groups, which reflects how the majority of physicians practice today. Secondly, it used commercial insurance data for the analysis, which reflects market prices, rather than prices set by the government, and allows analysis of the "all-in" cost of healthcare, including payments for patients' drugs, ER visits, lab testing and other services.

11 HIGH-PERFORMING PRIMARY CARE PRACTICES:

The research team identified 11 front line primary care practices in communities large and small that illustrate 'bright spots' in our nation's healthcare system—small clinical teams that deliver high-quality care at much lower-than-average total cost to commercially insured populations. They include: Banner Health Clinic Internal Medicine (Phoenix, AZ); Baptist Medical Group, Memphis Primary Care (Memphis, TN); Family Physicians Group (Kissimmee, FL); Florida Medical Clinic Internal Medicine (Zephyrhills, FL); Northwest Family Physicians (Crystal, MN); Ridgewood Med-Peds (Rochester, NY); St. Jude Heritage Medical Group (Yorba Linda, CA); South Cove Community Health Center (Quincy, MA); SureCare Medical Center (Springboro, OH); TriHealth West Chester Medical Group (West Chester, OH); and USAA Health Services (San Antonio, TX). We believe that there are many more such practices that perform similarly.

10 DISTINGUISHING FEATURES:

Through a combination of quantitative and on-site qualitative analyses, the CERC team identified 10 features that these high performing primary care sites had in common.

1. **Practices are '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 whether the practice is open or closed. Practices offer same-day appointments and accommodate walk-ins, extend evening and weekend hours, and more.
2. **Physicians adhere to quality guidelines and choose tests and treatments wisely**. The care team has systems to ensure patients receive evidence-based 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.
3. **They treat patient complaints as gold.** Complaints from patients are regarded as valuable as compliments, if not more so. High-value primary care sites take every opportunity to encourage patient feedback to improve the patient experience.
4. **They in-source, rather than out-source, some needed tests and procedures.** 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 care 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, such as treadmill testing for cardiac patients.
5. **They stay close to their patients after referring them to specialists.** Physicians refer to carefully chosen specialists whom they trust to act in their accordance with their patients' preferences and needs, and they stay in close communication as care decisions are made by specialists. Although these physicians can not always select the hospitalist or emergency department physician who cares for their patients, they stay connected to assure that treatment plans respect their patients' preferences and needs.
6. **They close the loop with patients.** The care team actively follows-up to ensure that patients are seen rapidly after hospital discharges, are able to continue prescribed medications and see specialists when needed.
7. **They maximize the abilities of staff members.** 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.
8. **They work in '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 goes hand in hand with maximizing the abilities of staff members. It facilitates staff learning through close collaboration with clinicians without regard to hierarchy.
9. **They balance 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 reflects 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. **They invest in people, not space and equipment.** By saving money on space, equipment and technology, these providers don't need to see more patients or order expensive tests to generate a competitive income. They 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 most cost-effectively in-house.

HOW THE HIGH-VALUE PROVIDERS WERE IDENTIFIED

The research team first looked at single- and multi-specialty U.S. physician practices with at least two clinicians providing primary care to a substantial number of patients represented in a national database consisting of private sector health insurance claims for more than 40 million Americans. It further 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. Researchers then 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 the CERC team ranked in the top quartile on quality and the lowest quartile on costs. Of these, the CERC team conducted a series of in-depth site visits to a sample of the highest performing sites and a comparison group from the middle of the distribution on cost and quality. An expert clinical panel, blinded to the cost and quality performance of the sites they visited, validated the performance of the practice and identified features likely to explain high quality or lower total cost of care.

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. But the findings also challenge some common beliefs. While there's widespread recognition that pockets of excellence exist in the U.S., some believe they hinge on replicating methods used by very large health systems with scale advantages and an efficiency culture cultivated over many years. However, the research team found that primary care practices without these two advantages can also deliver exceptional performance.

PETERSON CENTER ON HEALTHCARE

Stanford MEDICINE | Clinical Excellence Research Center

America's Most Valuable Care

THE ISSUE

With total spending at almost $3 trillion a year, or 18 percent of the U.S. economy, America's healthcare system is the most expensive in the world. Spending has increased faster than inflation, the economy, or wages – yet when it comes to quality and health outcomes, performance is often no better than in most other developed nations, and in some instances, it is much worse.

Experts agree that a significant amount of the care being provided is unnecessary or is being delivered inefficiently. Increasing the quality and decreasing the cost of U.S. healthcare is important for many reasons, including improving Americans' quality of life and strengthening the economy.

> *"An expensive healthcare system that delivers poor outcomes threatens our health and undermines our economy. The good news is that there are many opportunities to transform American healthcare into a high-performing system that provides higher quality care at a lower cost."*
>
> Michael Peterson

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 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, the Peterson Center on Healthcare and Stanford University's Clinical Excellence Research Center (CERC) set out to find these high-value providers through a systematic analysis of commercial insurance data. Commercial insurance

What is High-Value Healthcare?

High-value care is what results when care that is high-quality and lower-than-average total cost intersect.

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, emergency room visits, lab testing and other services.

The opportunity presented to the Peterson Center on Healthcare and Stanford CERC teams was 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.

THE APPROACH

Stanford's CERC team systematically identified primary care practices that routinely achieve high performance—high-quality care at a lower-than-average cost.

The team first looked at single- and multi-specialty U.S. physician practices with at least two physicians providing primary care. They 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. Researchers then 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 the CERC team ranked in the top quartile on quality and the bottom quartile on costs.

Engaging Experts

Experts at nationally recognized institutions—including Harvard School of Public Health, RAND Corporation, the University of Michigan, Yale School of Public Health, and others—helped shape the analytic methods of the CERC team.

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

THE FINDINGS

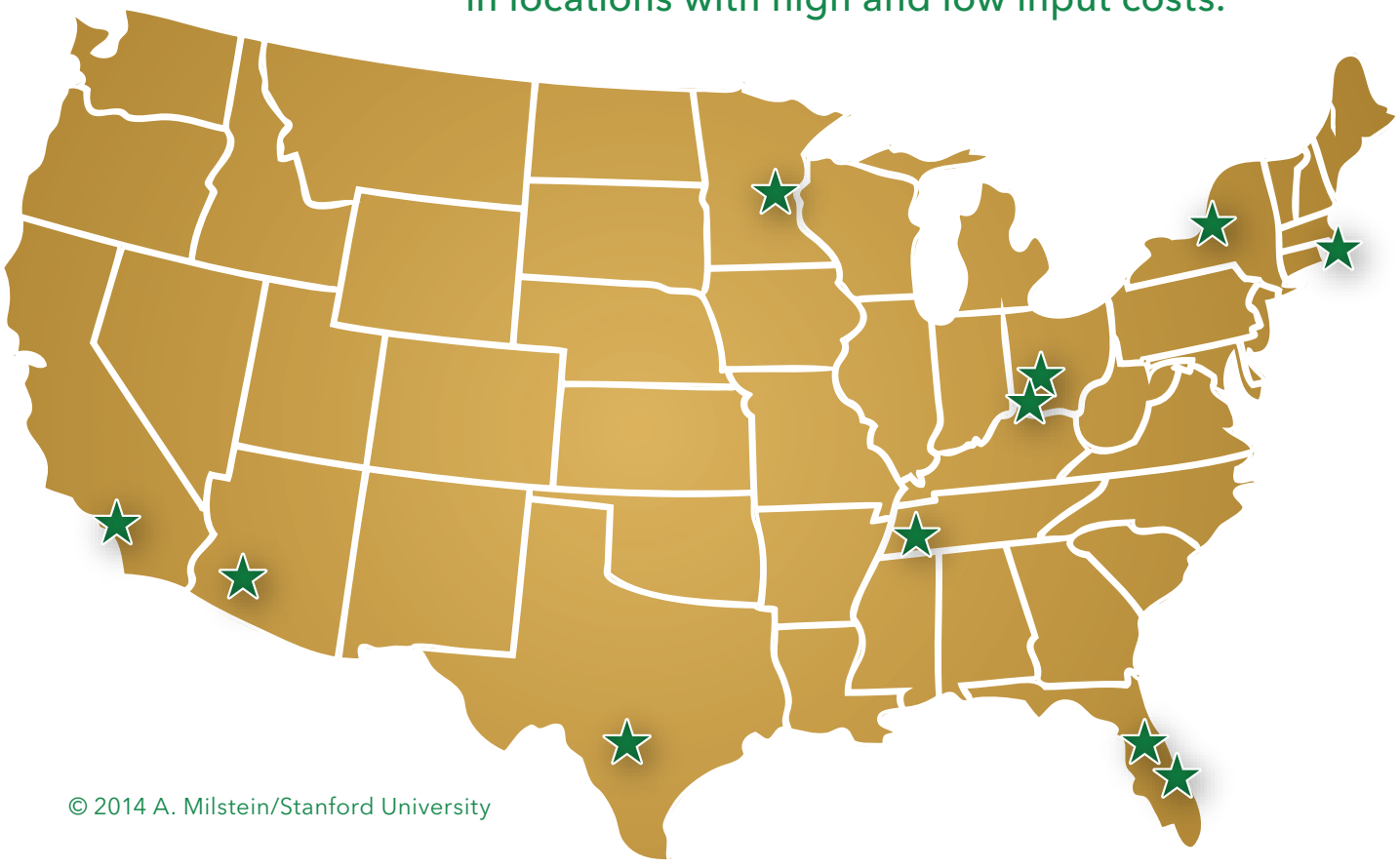
Through this combination of quantitative and qualitative analyses, the CERC team identified 10 features of primary care sites that consistently delivered exceptional value to their patients.

> *"We found that high-quality care is being provided at lower total annual cost at a small number of primary care practices. Many of these providers were largely unaware that they're unique, but they are actually doing something extraordinary, and they have a number of features in common that can be replicated."*
>
> Arnie Milstein

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.

We found most valuable primary care sites in locations with high and low input costs.



THE FEATURES

Stanford's CERC 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

> *"These most valuable care providers are lighting the path toward higher-quality healthcare at lower cost. They show that it can be done without significantly more investment in the practice, or having healthier patients to treat. The features they share are a blueprint for others."*
>
> Jeff Selberg

DEEPER PATIENT RELATIONSHIPS

The CERC team 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 three 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:

A. 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

10 CHARACTERISTICS OF HIGH-VALUE PROVIDERS:

1. Always on
2. Conscientious conservation
3. Complaints are gold
4. Responsible in-sourcing
5. Staying close
6. Closing the loop
7. Upshifted staff roles
8. Hived workstations
9. Balanced compensation
10. Investment in people, not space and equipment

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.

B. 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.

C. 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.

The office manager at Memphis Primary Care Associates speaks with three to five patients daily for immediate, informal feedback on their visit. Not only is the feedback provided in real-time, but it ensures that patients without the interest or resources to fill out an electronic survey are heard.

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.

At Florida Medical Clinic, primary care physicians also act as hospitalists, and go to the emergency department as soon as one of their patients arrives. They use their medical group's personal knowledge of the patient to decide whether the patient needs to be admitted to an inpatient bed or can be safely referred back to the practice for an urgent care visit.

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.

Family Physicians Group in Kissimmee, Fla., obtains health insurance claims data for prescription refills from their health plan's pharmacy to confirm that high-risk patients fill their prescriptions in a timely manner.

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.

Ridgewood Meds-Peds in Rochester, N.Y., calculated that fulfilling all of the administrative and clinical activities associated with an eight-hour day of patient visits requires 18 hours of staff time. Their staffing approaches assure that all activities that don't need to be performed by a physician are assigned to other care team members.

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 U.S., 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.

> *"There's a tendency in healthcare to always look at what the big systems are doing to improve care and lower cost, but this shows that an independent, three-physician practice in a low-income neighborhood can be among the best."*
>
> Woman Employed at one of the High-Value Sites

WHAT'S NEXT?

The Peterson Center on Healthcare and Stanford CERC team are collaborating with a network of organizations with strong, well-established relationships across U.S. healthcare to develop dissemination and implementation strategies designed to spark adoption on a national scale. Stanford CERC estimates that greater adoption of the features observed could improve quality and lower annual U.S. health spending by $300 billion.[1]

To learn more and get involved, visit www.petersonhealthcare.org

About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization works to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the organization collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research.

About Stanford University's Clinical Excellence Research Center (CERC)

The Clinical Excellence Research Center organizes research teams from multiple Stanford Schools to discover, design, and demonstrate nationally new methods of healthcare delivery that substantially reduce annual per-capita health spending and population-wide disability in the near-term. Design and testing is led by teams of post-doctoral research fellows and faculty from multiple Stanford Schools with initial emphasis on Engineering, Social Sciences, and Medicine. The Center has formed two external networks to inform and support its research teams. One network consists of healthcare systems regarded as the most cost-effective in the U.S. and will help researchers to assure that their designs are informed by today's highest-performing care models. The other network consists of health systems willing to allow the Center's researchers to test their new care models and healthcare payers willing to incentivize providers participating in the tests.

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1. This $300 billion estimate would represent savings of approximately 10% of U.S. healthcare spending. The Stanford CERC analysis indicates that the primary care site with the lowest per capita spending among all sites ranking in highest quality achieved 58% lower total per capita health spending compared to national averages. (Please note that prior versions of the Stanford analysis incorrectly indicated that the 58% lower per capita spending was the average savings of the high-performance sites, rather than the savings of the lowest site.) Further analysis by Stanford CERC is underway regarding projections of the potential to reduce the total cost of care through the adoption of these features.

PETERSON CENTER ON HEALTHCARE

Stanford MEDICINE | Clinical Excellence Research Center

America's Most Valuable Care – Primary Care Snapshots

There are 'bright spots' in the healthcare system—healthcare providers in communities large and small who are consistently delivering better value: high-quality care at a lower-than-average total cost. In early 2013, the Peterson Center on Healthcare, established by the Peter G. Peterson Foundation, and Stanford University's Clinical Excellence Research Center (CERC) set out to find these high-value providers through a systematic analysis of commercial insurance data that had never been done before. Through this approach, eleven primary care practices were identified as 'positive outliers' for the value—higher quality at significantly lower cost—of the care they provide.

The CERC team first looked at single- and multi-specialty U.S. physician practices with at least two clinicians providing primary care. They narrowed the list to those whose performance on quality measures landed them in the top 25 percent. These 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. Researchers then 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 the CERC team ranked in both the top quartile on quality and the bottom quartile on costs. Of these, the CERC team conducted a series of in-depth site visits to a sample of the highest performing sites and a sample from sites near the center on cost and quality. An expert clinical panel, blinded to the cost and quality claims data analysis, selected the following sites as providers of Most Valuable Care:

BANNER HEALTH CLINIC INTERNAL MEDICINE – PHOENIX, AZ

Primary care clinic owned by the Banner Health System, staffed by four full- and two part-time internists, nine medical assistants (MAs), seven support staff, and one dedicated nurse case manager.

- Practice follows care pathways developed by clinical consensus; standardization enables greater delegation to MAs.
- Every two physicians are supported by three MAs who work together in a layout that encourages constant communication.
- Physicians prioritize taking the time to help patients to make well-informed care decisions and emphasize access. On occasion, the physicians have opened up the clinic after hours to help a patient rather than send them to the emergency department.

BAPTIST MEDICAL GROUP, MEMPHIS PRIMARY CARE – MEMPHIS, TN

Primary care practice owned by the Baptist Medical Group and run by one family physician and one internist, supported by two medical assistants, two front desk staff, one office manager, and one x-ray technician.

- Practice is noted for seeking and responding to feedback, and using it for improvement in the patient experience.
- Staff systematically ensure patients get recommended care, in or out of the practice, through careful follow-up.
- Physicians have a strong commitment to keep patients out of the hospital. They treat what they safely can in the office, take their own calls two out of three nights and give their cell phone number to patients they think are at risk of a health crisis.

FAMILY PHYSICIANS GROUP – KISSIMMEE, FL

One of 25 locations of an independent, multi-specialty group. This site is led by four primary care physicians, supported by a physician assistant, eleven medical assistants, three case managers, one health coach, and one social worker. The practice sees a high proportion of elderly patients with complex medical and psychosocial needs.

- Practice prides itself on being available to patients 24/7, and has home monitoring in place for its highest risk patients.
- Case managers lead care planning for complex patients and a "concierge" is available to help with things like transportation and translation for their largely Spanish-speaking, socioeconomically disadvantaged patient population.
- Staff members maintain close relationships with a select group of specialists and track the quality and affordability of these specialists' care, in order to ensure value. They work with insurers to make sure these specialists are in-network.

FLORIDA MEDICAL CLINIC – ZEPHYRHILLS, FL

One of 26 locations of an independent, multi-specialty group. It is led by two full-time internists and one part-time family physician, supported by two nurse practitioners (NPs), five medical assistants and two referral coordinators.

- Practice is noted for providing outstanding access and close care management, sometimes seeing a patient as often as three times a week to avoid a crisis. Attention is paid to post-hospitalization follow-up, which reduces readmission.
- Each Medicare patient receives a comprehensive annual physical conducted by the NPs to emphasize preventative care.
- Physicians manage complex conditions themselves, supported by "curbside consults" from specialists in the group.
- Small office space fosters a lively environment of learning and communication between physicians and staff.

NORTHWEST FAMILY PHYSICIANS – CRYSTAL, MN

Independent three-location primary care group led by sixteen family practice physicians, supported by five physician assistants, one nurse practitioner, fourteen nurses, and sixteen medical assistants.

- Physician champions become up-skilled in a specialty and are able to support their colleagues, performing low-complexity procedures and diagnostics for patients that might otherwise be referred to an outside specialist.
- The practice chooses the specialists they refer to carefully, bringing high volume specialists on-site for patient convenience. This includes a half-day a week cardiologist who reads studies, making guideline-based recommendations.
- Physicians work closely with physician assistants, medical assistants, and triage nurses to offer rapid and responsive access and care, supported by standing orders and protocols, all in the context of a four-day work week for physicians.

RIDGEWOOD MED PEDS – ROCHESTER, NY

An independent, physician-owned primary care clinic with five primary care physicians—all certified in both internal medicine and pediatrics—supported by one nurse practitioner, four licensed practical nurses, one registered nurse, two receptionists, three telephone schedulers, and four record-keepers.

- The practice follows evidence-based protocols. Physicians routinely discuss new evidence and sign on to updated care protocols, which keeps them current and enables them to delegate many tasks to other members of their care team.
- Patients with chronic illnesses are prompted for follow-up visits and tests by indexing those visits to prescription refills.
- Physicians refer to a small, informal network of trusted specialists, and carefully manage the referral process, writing a detailed note outlining their expectations to the specialist, which they also take the time to explain to the patient.

ST. JUDE HERITAGE MEDICAL GROUP – YORBA LINDA, CA

A multi-specialty group practice that is part of the St. Joseph Health system. This site is led by twelve family physicians, six pediatricians, and five internists with one nurse practitioner, one physician assistant, and one licensed vocational nurse. On-site specialists include OB/GYNs, dermatologists, allergists, a gastroenterologist and an endocrinologist.

- The practice offers same-day access and, with integrated urgent care, is open seven days a week. Continuity is emphasized.
- Specialists provide education sessions to primary care physicians to help them take on low-complexity specialty care.
- Patients are seen in a special transition clinic post-hospitalization, which reduced readmissions by 67 percent.
- The office space was designed with patient flow in mind. There are no waiting rooms and care teams work together in a shared space, facilitating communication between patient interactions. This improved physician productivity by 21 percent.

SOUTH COVE COMMUNITY HEALTH CENTER – QUINCY, MA

Independent, federally qualified health center, one of four sites, that serves a predominantly Asian population in the Boston area. There are eleven internal medicine physicians and two nurse practitioners who rotate through the four sites. The Quincy site has five registered nurses, a medical assistant per provider, three front desk staff, and three referral coordinators. The center sees a socioeconomically disadvantaged, predominantly Asian population, many of whom do not speak English.

- The center is open seven days a week, accommodates patient walk-ins, and offers a 24-hour nurse advice line.
- Referrals are carefully coordinated, often include a translator, and are stratified based on urgency. The referral coordinators "close the loop" on urgent referrals and proactively bring patients in for preventive care and screening.
- The center acts to make sure patients' social and behavioral needs are met. Mental health is integrated in a culturally appropriate way, and patients receive support to help them maintain health insurance coverage.

SURECARE MEDICAL CENTER – SPRINGBORO, OH

Hospital-owned and operated primary care clinic with eight primary care physicians—one internal medicine, six family physicians, one part-time family physician—supported by one physician assistant, with one medical assistant assigned to each physician, two medical assistants for lab draws, one office manager, four front desk staff, and three billers.

- The practice is open six days a week and late into the evening four days per week, maximizing access and convenience. Staggered schedules and sufficient scale help maintains good work-life balance across the care team.
- Physicians refer patients to each other initially, leveraging expertise developed in dermatology and orthopedics.
- SureCare has cross-trained medical assistants and standardized work to increase office efficiency and patient flow. As a result, physicians report being able to be more hands-on with their patients because they have less administrative work.

TRIHEALTH WEST CHESTER MEDICAL GROUP – WEST CHESTER, OH

Primary care clinic that is part of the TriHealth system in Ohio, led by two internists and two family physicians and supported by one registered nurse, three medical assistants, one registered nurse case manager, and one care coordinator.

- The practice is open six days a week and physicians take their own call five days a week in order to ensure continuity.
- The practice risk-stratifies patients to connect patients with the greatest needs to a dedicated care coordinator, which has improved clinical outcomes and reduced cost of care in patients with chronic illnesses, such as diabetes. In addition, higher complexity patients are seen by an internist-RN team who cares for these patients together.
- The front office staff members are all medical assistants, who follow a symptom-based set of protocols that allows them to rapidly assess and triage a wide variety of ailments, enabling clinically informed scheduling.

USAA HEALTH SERVICES (CHS) – SAN ANTONIO, TX

Primary care clinic located at the headquarters of a large insurance/financial organization and staffed by one part-time physician, three advanced practice providers, eight registered nurses, four medical assistants, and five administrative staff.

- Accommodates both scheduled and walk-in patients with wait times that average less than six minutes.
- Uses a large set of evidence-based protocols embedded in the clinic's electronic health record system to guide care delivery using lower cost providers.
- Utilizes a unique risk-stratification tool that gives all patients a risk index score that combines both direct medical costs and measures of occupational health to highlight patients who might benefit from extra support.
- Patients are offered rapid access to select specialists. During allergy season, they run a nurse-staffed allergy clinic supervised by a local allergist to improve access and compliance with allergen desensitization injection regimens. A cardiologist also offers rapid preferential access.

What the Providers of America's Most Valuable Care Are Saying About How They Provide High-Value Care to Their Patients:

Banner Health Clinic Internal Medicine – Phoenix, AZ
"When addressing health, wellness or a particular condition with our patients, I think it's important for them to understand in plain, clear English what something is, what it means to them, why we need to treat it, and what will happen if we don't. It's important that we spend the necessary time and help our patients feel like they have the resources they need to successfully manage their medical issue. Patients who are better informed about their chronic health condition will experience better outcomes clinically." -- *Lurlyn Pero-Anderson, MD*

Baptist Medical Group, Memphis Primary Care – Memphis, TN
"Our practice is committed to being responsive to patients, not only to their health, but to any concern or question that may arise. We find that, if you take the time to listen to your patients and develop relationships with them, they are more apt to follow your advice, which leads to better health outcomes and less unnecessary testing. We always look at ways to improve our practice to better accommodate the patient's needs." -- *Freddie Everson, MD*

Family Physicians Group – Kissimmee, FL
"Our multi-disciplinary team approach allows the physicians to focus on what they were trained to do—patient care. Having sub-specialists come to the office is a huge help, and the need for specialists who understand and share your vision for patient-centered care is important. Surgery preparation happens in the office, which includes blood work and EKGs, for example. We also prepare patients emotionally and socially for what to expect after surgery and how much time to take off. Our doctors go to the hospital when their patients have been admitted. It's not just surgery and medicine that get patients well. It's everything that goes on around the patient to support him or her. Quality healthcare is about looking at the whole patient—medical, social, emotional and financial." -- *Nayana Vyas, MD*

Florida Medical Clinic Internal Medicine – Zephyrhills, FL
"I always wanted the focus to be on value, not volume. When I first started the practice, I was so busy that I couldn't spend quality time with my patients so I added an extender to increase my capacity. By focusing on the quality of the patient visit, as opposed to volume, we were able to develop a system that focused on comprehensive care of the whole patient. We took pains to know everything about every patient. Our patients appreciated the detailed approach and rewarded us with loyalty. As a rule, we don't take on more patients than we can handle just for the sake of growing our practice. Instead, we take care of the patients we have really well. That is our philosophy." -- *Chandresh Saraiya, MD*

Northwest Family Physicians – Crystal, MN
"Providing high-quality care is the equal responsibility of everyone in our office, from the front desk staff to the business office to the physicians. Our team approach helps us move patients through the office efficiently without compromising quality. Standing orders and protocols help us do this. Our physicians are skilled in performing many procedures that may otherwise get referred out. By making quality care everyone's job, our patients end up healthier and happier." -- *James Welters, MD*

Ridgewood Med-Peds – Rochester, NY
"We do the best we can to give the patient the best care possible, and that holds true even when we're sending them somewhere else for that care. To achieve this, we work with a certain group of specialists, and provide them with complete information on the patient, often through our electronic health

records. We include why he or she is coming to them and what our expectations are. By the time a referral reaches the specialist, we ensure he or she has all of the information they need to accurately and appropriately treat the patient." -- *John Chamberlain, MD*

St. Jude Heritage Medical Group – Yorba Linda, CA
"Physicians and operations managers work together, which increases efficiency in patient care and clinical outcomes. For example, all of the primary care medical assistants were educated on clinical measures that are being looked at today—whether they be pay-for-performance or otherwise—to give context to certain procedures. Not only would they know how to examine a diabetic patient's feet, but they would understand why this is important. This bottom-up approach has empowered staff to come up with their own ways to improve clinical outcomes. When the medical assistants felt more connected to what each clinical measure meant, it gave them greater interest in improving those measures."-- *Khaliq Siddiq, MD*

South Cove Community Health Center – Quincy, MA
"Because we serve a non-English speaking Asian population, we provide our patients with culturally-focused care and help them navigate every aspect of their health care 24 hours a day, 7 days a week. We speak their languages and account for culturally sensitive issues, so we can quickly understand their health needs and assist them in getting the care they need. For example, if they need to go to the ED, we send records ahead of time and provide a translator. Our patients travel many miles for us because of the language, culture and quality of care they receive." -- *Eugene Welch, Executive Director*

SureCare Medical Center – Springboro, OH
"Having cross-trained staff helps us do a lot more for our patients and prevents referrals out. For example, fracture care and many dermatology procedures are done in-house. At least five of our providers are very comfortable with performing a lot of common dermatology procedures, and their staff are too. If a provider wants to do a procedure, he makes sure his medical assistant gets the training needed to do it. It allows us to refer patients to each other before having to refer out." -- *Joe Garland, DO*

TriHealth West Chester Medical Group – West Chester, OH
"Ensuring continuity of care is essential to providing quality care. Our physicians take their own calls five days a week and make closing the gap on hospital visits a priority. When a patient goes to the hospital, our care coordinators contact the hospital to prevent any information gaps. Our coordinators can then facilitate discharge plans, including medications, diagnosis and follow-up. The more we can increase quality through effective communication, the more it will also reduce costs." -- *Kevin Bundy, MD*

USAA Health Services – San Antonio, TX
"Standing orders allow us to effectively treat our patients' symptoms and get them back to work quickly. For example, if a patient comes in to the onsite health center with sinus symptoms, they could have allergies, but the symptoms may also meet the criteria for strep throat. There is a standing order in place to run a rapid strep test. If the test is positive, we can then get them in with a provider almost immediately. If the test is negative, our RNs educate them on how to manage their symptoms and encourage them to come back to the onsite health center if they don't improve." -- *Donna Garcia, NP*

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PETERSON CENTER ON HEALTHCARE

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PARTICIPANT BIOGRAPHIES

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JON LAPOOK, MD

Chief Medical Correspondent, *CBS Evening News with Scott Pelley*;
Professor of Medicine, NYU Langone Medical Center

Jonathan LaPook, MD is the Chief Medical Correspondent for the *CBS Evening News with Scott Pelley*. He is also Professor of Medicine at the NYU School of Medicine and an internist and gastroenterologist at NYU Langone Medical Center. In the area of teaching, Dr. LaPook is particularly interested in weaving media and the arts into the medical training curriculum, with the goal of improving the interaction of health professionals and patients. He has also done extensive work in the field of medical computing, including helping to develop an electronic textbook of medicine and writing a medical practice management software package that he sold in 1999 to a company that was later acquired by Emdeon Corporation, the parent company of WebMD.

Since 2006, he has done more than 600 segments for CBS News, including pieces for *CBS This Morning*, *CBS Sunday Morning*, and *Face The Nation*. He has reported from Haiti on the effects of the 2010 earthquake, interviewed President Obama in the White House about healthcare reform, and covered a wide range of medical news stories. He has won two Emmy awards: for his coverage in 2012 of the national shortage of drugs, and for team coverage in 2013 of the Boston Marathon bombing.

Born in Mineola, New York, Dr. LaPook graduated with honors from Yale University and received his MD from Columbia College of Physicians and Surgeons, where he was elected into AOA, the national medical honor society. He completed his residency in Internal Medicine and fellowships in Gastroenterology and Medical Informatics at Presbyterian Hospital, New York City.

PARTICIPANTS

DREW ALTMAN, PhD

President & CEO of the Henry J. Kaiser Family Foundation

Drew Altman is President and Chief Executive Officer of the Henry J. Kaiser Family Foundation. A leader in health policy, communication, and journalism, the Kaiser Family Foundation is a non-profit organization based in Menlo Park, California, and is not associated with Kaiser Permanente. KFF also operates major facilities in Washington, D.C., including its Barbara Jordan Conference Center and Broadcast Studio.

Dr. Altman founded the current-day Kaiser Family Foundation in the early 1990's, directing a complete overhaul of the Foundation's mission, staff, and operating style. Prior to joining the Foundation, Dr. Altman

was Commissioner of the Department of Human Services for the state of New Jersey under Governor Tom Kean. As Commissioner, he developed nationally recognized initiatives in welfare reform, school-based youth services, programs for the homeless, and Medicaid managed care. Dr. Altman was Director of the Health and Human Services at the Pew Charitable Trusts; Vice President of the Robert Wood Johnson Foundation, where he led the development of the Foundation's programs in HIV/AIDS, health services for the homeless, and healthcare financing; and he served in the Health Care Financing Administration in the Carter administration.

Dr. Altman received his BA from Brandeis University and his Masters in political science from Brown University. He earned his PhD in political science from the Massachusetts Institute of Technology, did his post-doctoral work at the Harvard School of Public Health, and taught public policy at MIT before moving on to public service. He holds an honorary doctorate from the Morehouse School of Medicine. Dr. Altman is a member of the Council on Foreign Relations and the Institute of Medicine. He is an innovator in the world of foundations and a leading expert on national health policy who publishes and speaks widely on health issues.

GARY S. KAPLAN, MD

Chairman & CEO of Virginia Mason Health System

Gary S. Kaplan, MD, FACP, FACMPE, FACPE, has served as Chairman and CEO of Virginia Mason Health System in Seattle since 2000. He is also a practicing, board-certified internal medicine physician at Virginia Mason.

He is Chair of the Institute for Healthcare Improvement Board of Directors and immediate past Chair of the Seattle Metropolitan Chamber of Commerce Board of Directors. He was elected to membership in the Institute of Medicine in 2013.

Dr. Kaplan is also:

- A founding member of Health CEOs for Health Reform
- A member of the National Patient Safety Foundation Board of Directors
- A member of the American Medical Association; American Medical Group Association; American Society of Professionals in Patient Safety; and the Medical Group Management Association
- A member of the Washington Healthcare Forum Board of Directors

Dr. Kaplan received a degree in medicine from the University of Michigan Medical School. He is a Fellow of the American College of Physicians (FACP), the American College of Medical Practice Executives (FACMPE) and the American College of Physician Executives (FACPE).

With Dr. Kaplan's leadership, in 2002 Virginia Mason became the first health system in the United States to adapt the principles of the Toyota Production System as its management methodology for identifying and eliminating waste, improving quality and safety, and controlling cost. Using tools and resources of the Virginia Mason Production System, Virginia Mason has earned international recognition for innovation, quality, safety, and efficiency. In 2010, Virginia Mason was named a Top Hospital of the Decade by The Leapfrog Group, a national non-profit organization representing employers and other large purchasers of healthcare that are driving improvements in quality, safety, and transparency.

Dr. Kaplan has been on *Modern Healthcare* magazine's annual list of the "50 Most Influential Physician Executives and Leaders in Healthcare" for nine consecutive years. He is ranked No. 3 on the 2014 list.

Additionally, Dr. Kaplan is ranked No. 36 on *Modern Healthcare* magazine's 2014 list of the "100 Most Influential People in Healthcare."

MARY LANGOWSKI, MPA, JD

Executive Vice President for Strategy, Policy & Market Development, CVS Health

Mary Langowski is Executive Vice President for Strategy, Policy and Market Development for CVS Health. In this role, Mary directs CVS Health's strategy and market development functions, with a focus on identifying and expanding enterprise opportunities to new markets as the company plays an increasingly prominent role in the evolving healthcare system. Her portfolio also includes leading the company's government affairs and policy development teams at the state and federal level by providing strategic counsel to help navigate the complex and dynamic policies, regulations and market trends that today's healthcare companies face.

Langowski has deep expertise in helping clients analyze and translate public policy into actionable business strategies. Her experience spans the private, non-profit, and public sectors. Langowski previously served as Chair of the Health Care Policy and Regulatory Practice and the Co-Chair of the Food and Beverage Sector at the international law firm of DLA Piper. Prior to her role at DLA Piper, Langowski served in senior positions at Alston & Bird and Sonnenschein Nath & Rosenthal where she provided strategic counsel to clients with a special focus on healthcare.

In addition to her private-sector experience, Langowski served as a senior healthcare policy advisor for Senator Tom Harkin from 2001-2004, and was the chief policy advisor at the Iowa Department of Public Health under Governor Tom Vilsack.

Langowski earned a B.A. and M.P.A from Drake University and a J.D. from the University of Iowa College of Law.

ARNOLD MILSTEIN, MD, MPH

Professor of Medicine, Director of Clinical Excellence Research Center, Stanford University

Dr. Milstein is a Professor of Medicine at Stanford and directs the Stanford Clinical Excellence Research Center. The Center is a collaboration of the Schools of Medicine, Engineering and Business to design and demonstrate in multi-state locations innovative healthcare delivery models that safely lower per capita healthcare spending while improving patients' health and experience of their care.

Before joining Stanford's faculty, his career of applied research spanned private and public sector healthcare delivery and policy. After creating a healthcare performance improvement firm that he expanded globally following its acquisition by Mercer, he co-founded two nationally influential public benefit initiatives, The Leapfrog Group in 1998 and the Consumer-Purchaser Disclosure Project (now the Consumer-Purchaser Alliance) in 2001. He was appointed to a six year term as a Congressional MedPAC Commissioner, originating several subsequently enacted legislative changes. Since its inception, he has served as the Medical Director of the Pacific Business Group on Health (PBGH), the largest employer-led regional healthcare improvement coalition in the U.S.

Citing his national impact on innovation in healthcare policy and delivery methods, he was selected for the highest annual award of both the National Business Group on Health (NBGH) and of the American College of Medical Quality. Elected to the Institute of Medicine (IOM) of the National Academy of Sciences, he

chaired the planning committee of its series on best methods to lower per capita healthcare spending and improve clinical outcomes. He was educated at Harvard (BA–Economics), Tufts (MD) and UC Berkeley (MPH Healthcare Evaluation).

DEBRA NESS, MS

President, National Partnership for Women & Families

Debra Ness is President of the National Partnership for Women & Families. For more than three decades, Ness has been a strong advocate for fairness and social justice. Drawing on an extensive background in health and public policy, Ness possesses a unique understanding of the issues that face women and families at home, in the workplace, and in the healthcare arena. Before assuming her current role as President in 2004, she served as Executive Vice President of the National Partnership for 13 years. Ness has played a leading role in positioning the organization as a powerful and effective advocate for today's women and families.

Ness is a member of the Board of Directors and chairs the Consumer Advisory Council of the National Committee for Quality Assurance (NCQA). She was recently elected to serve as the first public member on the American College of Cardiology (ACC) Board of Trustees and as one of the first public members of the American Board of Internal Medicine (ABIM) Board of Directors. Ness co-chairs the Consumer-Purchaser Alliance, a group of leading consumer, employer, and labor organizations working to improve the quality, accountability and affordability of healthcare. She serves on the Quality Alliance Steering Committee (QASC) and on the Aligning Forces for Quality (AF4Q) National Advisory Committee (NAC). Ness recently completed service on the National Quality Forum (NQF) Board of Directors as well as the Board of Trustees of the American Board of Internal Medicine Foundation (ABIMF).

In addition, Ness serves on the Executive Committee of the Leadership Conference on Civil and Human Rights and co-chairs its Health Care Task Force. She also serves on the Board of Directors of the Economic Policy Institute (EPI) and EMILY's List.

Ness graduated summa cum laude from Drew University with a bachelor's degree in psychology and sociology. After completing graduate work in social welfare and public health policy, she received her Masters of Science from Columbia University School of Social Work. Ness lives in Rockville, MD.

GLENN D. STEELE, JR., MD, PhD

President & CEO, Geisinger Health System

Glenn D. Steele, Jr., MD, PhD, is President and Chief Executive Officer of Geisinger Health System, an integrated health services organization in central and northeastern Pennsylvania nationally recognized for its innovative use of the electronic health record and the development and implementation of innovative care models. Dr. Steele previously served as the Dean of the Biological Sciences Division and the Pritzker School of Medicine and Vice President for Medical Affairs at the University of Chicago, as well as the Richard T. Crane Professor in the Department of Surgery. Prior to that, he was the William V. McDermott Professor of Surgery at Harvard Medical School, President and Chief Executive Officer of Deaconess Professional Practice Group (Boston, Mass), and Chairman of the Department of Surgery at New England Deaconess Hospital (Boston, Mass.). Dr. Steele is past Chairman of the American Board of Surgery. His investigations have focused on the cell biology of gastrointestinal cancer and pre-cancer and most recently on innovations in healthcare delivery and financing. A prolific writer, he is the author or co-author of more than 487 scientific and professional articles.

Dr. Steele received his bachelor's degree in history and literature from Harvard University and his medical degree from New York University School of Medicine. He completed his internship and residency in surgery at the University of Colorado, where he was also a fellow of the American Cancer Society. He earned his PhD in microbiology at Lund University in Sweden.

A member of the Institute of Medicine of the National Academy of Sciences, Dr. Steele serves as a member on the Roundtable on Value and Science-Driven Healthcare, the Committee on the Governance and Financing of Graduate Medical Education and previously served on the Committee on Reviewing Evidence to Identify Highly Effective Clinical Services (HECS). A fellow of the American College of Surgeons, Dr. Steele is a member of the American Surgical Association, the American Society of Clinical Oncology, and past President of the Society of Surgical Oncology.

Dr. Steele also serves on the following boards and national committees: Agency for Integrated Care (AIC) Singapore, Bucknell University Board of Trustees, Cepheid Board of Directors, Congressional Budget Office Panel of Health Advisers, Harvard Medical Faculty Physicians Board at Beth Israel Deaconess Medical Center, Weis Markets Inc., Wellcare Health Plans Inc., xG Health Solutions, Inc. Board of Directors, Healthcare Innovation Program (HIP) External Advisory Board (Emory University), the Peterson Center on Healthcare Advisory Board, Institute for Healthcare Optimization Advisory Board, Third Rock Ventures Business Advisory Board, the State Health Care Cost Containment Commission, and Healthcare Executives Network. Dr. Steele currently serves as Honorary Chair of the Pennsylvania March of Dimes Prematurity Campaign. Dr. Steele formerly served on the following boards: Premier, Inc. Board (Chairman 2011-2013), Temple University School of Medicine Board of Visitors, Commonwealth Fund's Commission on a High Performance Health System, the National Committee for Quality Assurance's (NCQA) Committee on Performance Measurement, American Hospital Association (AHA) Board of Trustees. He also served on the Executive Committee, Systems Governing Council, Long-Range Policy, Committee on Research, and the AHA Physician Leadership Forum Advisory Committee.

Dr. Steele is the recipient of several awards, most recently the 2014 NCHL Gail L. Warden Healthcare Leadership Award; CEO IT Achievement Award (2006); AHA's Grassroots Champion Award (2007); 8th Annual (2010) AHA Health Research & Education Trust Award; and HFMA Board of Directors' Award (2011). He has been named consecutive times to *Modern Healthcare's* "50 Most Powerful Physician Executives in Healthcare," *Modern Healthcare's* "100 Most Powerful People in Healthcare" and *Becker's Hospital Review* "100 Non-Profit Hospital Health System CEOs to-Know" list.

NAYANA VYAS, MD

Founder & President of Clinical Affairs, Family Physicians Group

Nayana Vyas, MD is the Founder and President of Clinical Affairs for Family Physicians Group (FPG). In 27 years, FPG has grown to be one of the largest privately owned medical groups consisting of 26 medical centers, 100 physicians including numerous affiliates, and a hospitalist group serving the healthcare needs of thousands of patients throughout the state of Florida.

This expansion has been possible thanks to Dr. Vyas approach to healthcare. She was one of the first to enter into the managed care environment and implement a "Team Care Approach," which ensures that a patient's care and treatment is planned and coordinated by a team consisting of a primary care physician, hospitalist, case manager, social worker, and above all, the patient and their family.

Dr. Vyas implemented the Disease Management Program, emphasizing on the prevention of complications by utilizing evidence-based practice guidelines. Presently, Family Physicians Group offers National

Committee for Quality Assurance (NCQA) accredited Congestive Heart Failure, Coronary Artery Disease, Diabetes, and Chronic Obstructive Pulmonary Disease disease management programs to their patients.

Family Physicians Group has been awarded by the *Orlando Business Journal* as part of the Golden 100 companies in Central Florida for the last four consecutive years. In 2011, all FPG offices were recognized by the NCQA as Patient-Centered Medical Homes.

PETERSON CENTER ON HEALTHCARE LEADERSHIP

JEFFREY D. SELBERG, MHA

Executive Director, Peterson Center on Healthcare

Jeffrey D. Selberg, MHA, leads healthcare efforts at the Peter G. Peterson Foundation. His key responsibilities include shaping and overseeing a growing program of initiatives and grants aimed at fostering improvements in the U.S. healthcare system. He has more than 35 years of experience in healthcare leadership. Mr. Selberg previously served as the Executive Vice President and Chief Operating Officer for the Institute for Healthcare Improvement (IHI), where he worked closely with the leadership team to continue the focus on patient safety, develop strategic partnerships and innovate and spread new models of care. Prior to IHI, he served as President and CEO of Exempla Healthcare in Colorado, and also served as President and CEO of Southwest Washington Medical Center in Vancouver, Washington, and Executive Vice President for Good Samaritan Hospital and Medical Center in Oregon.

Mr. Selberg currently serves on the board of the National Center for Healthcare Leaders, and previously served on the boards of the Health Research and Educational Trust and the American Hospital Association. Throughout his career, Mr. Selberg has focused on improving patient safety and clinical outcomes in patient care through the combination of effective public policy, system principles, and the development of highly functioning teams.

PETER G. PETERSON FOUNDATION LEADERSHIP

PETER G. PETERSON

Founder & Chairman, Peter G. Peterson Foundation

Pete Peterson is Founder and Chairman of the Peter G. Peterson Foundation, a non-partisan organization dedicated to raising awareness of America's long-term fiscal challenges and promoting solutions to ensure a better economic future. The Foundation works with leading thinkers, policy experts, elected officials, and the public to build support for efforts to put America on a fiscally sustainable path.

Pete's distinguished and far-reaching career spans more than five decades, including contributions and accomplishments in public service, business, and philanthropy.

Pete's public service began in 1971, when President Richard Nixon named him Assistant to the President for International Economic Affairs. One year later, he was named U.S. Secretary of Commerce. At that time, he also assumed the chairmanship of President Nixon's National Commission on Productivity and was appointed U.S. Chairman of the U.S.-Soviet Commercial Commission. He again took on a public service role from 2000 to 2004, when he chaired the Federal Reserve Bank of New York.

In 1985, he co-founded The Blackstone Group, and over the next two decades he helped to grow the firm into a global leader in alternative investments. In the 1970s and '80s, Pete served as Chairman and CEO of

Lehman Brothers and Lehman Brothers, Kuhn, Loeb Inc. Before working in Washington, Pete was Chairman and CEO of audio-visual equipment manufacturer Bell & Howell, and an executive at advertising firm McCann Erickson.

In addition to his current work with the Foundation, Pete is Chairman Emeritus of the Council on Foreign Relations, Founding Chairman of the Peterson Institute for International Economics in Washington, D.C., and Founding President of The Concord Coalition. Along with former U.S. Treasury Secretary John Snow, he co-chaired the Conference Board Commission on Public Trust and Private Enterprise.

He has served as a director of numerous corporations and is the author of six books. His most recent book, *Steering Clear: How to Avoid a Debt Crisis and Secure Our Economic Future*, will be released in February 2015 by Portfolio, a division of Penguin Random House. His other books include the best-selling *Running on Empty: How the Democratic and Republican Parties are Bankrupting Our Future* and *What Americans Can Do About It* (2004) and his memoir, *The Education of an American Dreamer: How a Son of Greek Immigrants Learned His Way from a Nebraska Diner to Washington, Wall Street, and Beyond* (2009).

Pete has five children and nine grandchildren. He lives in New York with his wife, Joan Ganz Cooney, a Director and Co-Founder of the Children's Television Workshop.

MICHAEL A. PETERSON

President & Chief Operating Officer, Peter G. Peterson Foundation

As President and Chief Operating Officer of the Peter G. Peterson Foundation, Michael combines his extensive private sector experience with his dedication to public service. He oversees the strategic direction of the Foundation, guiding policy and shaping strategy for its major initiatives, key partnerships and long-term objectives.

Michael also serves as CEO of Peterson Management, LLC, which manages the Peterson family assets, and is Co-Founder of GPX Enterprises, LP, a private investment firm. In addition to his private sector career in business and finance, Michael has been involved in public policy and economics, serving in policy positions on Capitol Hill and on presidential campaigns, as well as conducting research for the Committee for Economic Development and the Institute for International Economics. In recognition of his significant achievements at a young age, Michael received the "40 Under 40" award from the Philadelphia Business Journal.

Michael is active in civic and philanthropic organizations. He is a founding member and Co-Chair of CGI LEAD, a group of accomplished young leaders selected by President Clinton to form a leadership group within the Clinton Global Initiative. Michael is also a member of the Council on Foreign Relations, serves as a Trustee of WNET, and is a Director of the Peterson Institute for International Economics. In 2014, he received the Corporate Community Achievement Award from the Northside Center for Child Development. He has also established his own foundation, which focuses on a variety of philanthropic areas.

Michael graduated Magna Cum Laude and with Honors from Brown University, where he was awarded the Taubman Prize for his thesis. He received his Master's degree from the London School of Economics. Michael, the son of Pete Peterson, Founder and Chairman of the Foundation, lives in New York with his wife, Tara Peters, and their two children.