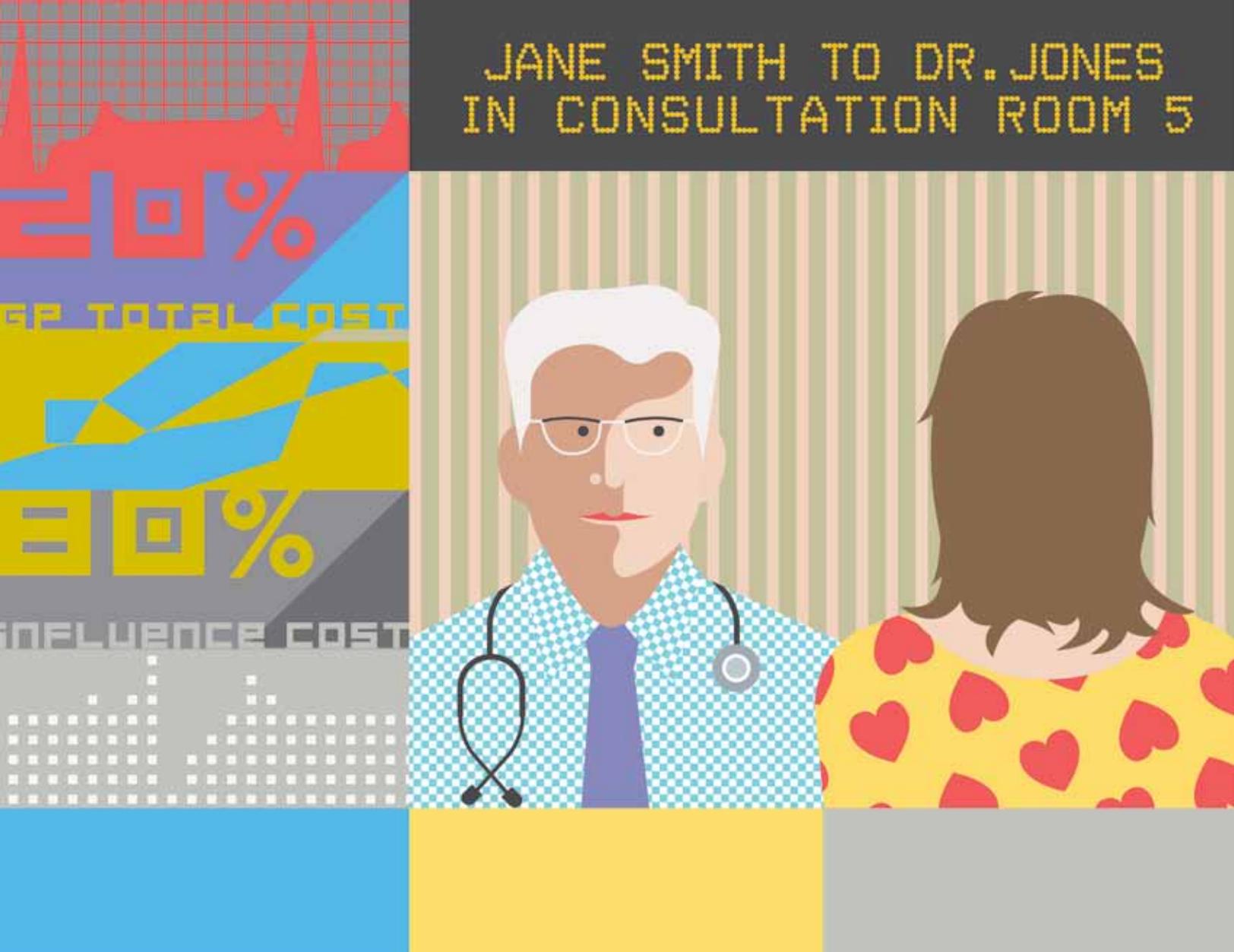


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IN CONSULTATION ROOM 5



How to improve clinical behavior in primary care

Getting GPs to make significant changes to their day-to-day activities can be difficult. But the result can be better patient outcomes and lower healthcare costs.

Tim Fountaine, MD, PhD; Ben Richardson, MPP; and Frances Wilson, MD

Primary care is pivotal to any health system. Primary care physicians are the providers most patients see first when they have a health problem, and the ones they see most often. In the United Kingdom, for example, 70 percent of all interactions patients have with the health system are with general practitioners (GPs).¹ Furthermore, in most health systems, primary care physicians are responsible for coordinating each patient's care (often, this includes not only specialist and hospital care, but also community care, rehabilitative services, and social services).

Primary care can deliver significant value if done well. Effective primary care—defined as comprehensive care for most health needs; first-contact access for each new need; long-term person-focused (not disease-focused) care; and coordination of other health services—has been consistently linked to better outcomes, as well as more appropriate and less costly care.²

Our studies provide an explanation: in most health systems, primary care physicians account directly for only a small fraction of health system costs, but they control or influence about 80 percent of those costs. Primary care physicians also play a crucial role in empowering patients and delivering more responsive, more proactive, and better coordinated care. They can influence both the cost and quality of care by taking a population-health perspective to prioritize where to focus their energies, by working as part of multidisciplinary teams, and by educating patients to take charge of their own health. They can also help control costs by sending patients only to high-value specialists when referrals are necessary, by carefully considering costs when making trade-offs about which tests

and treatments to order, and by closely adhering to standardized evidence-based pathways.

On every continent, therefore, health systems have been viewing primary care as a key part of their efforts to improve care quality and contain costs. Primary care is also a linchpin in their efforts to develop more accountable and coordinated care delivery systems.

Transforming primary care is not easy, though. Existing GP behaviors are often ingrained, and most GPs work independently in small practices. Information systems often have major gaps in what they can tell physicians about the patients in front of them. In many health systems, insufficient resources or misaligned incentives that reward suboptimal behavior hinder primary care from reaching its full potential.

The healthcare environment is shifting, however. Over the past few years, there have been important innovations in information sharing, and many health systems are altering their reimbursement models to focus on value. And although changing primary care practice is challenging, it is not impossible, as the examples cited in this article will demonstrate.

We will begin the article by briefly examining the forces impeding effective primary care delivery today. We will then review the four components that behavioral science has shown are required for altering people's behavior: fostering understanding and conviction, role modeling, developing talent and skills, and using formal mechanisms to reinforce the changes.³ We will also describe a number of practical, innovative initiatives to illustrate how the components can be used to transform the behavior of primary care physicians and thereby improve care quality and drive value.

¹Hansson E, McKenna S. Five strategies for improving primary care. *Health Int.* 2009;8:68-77.

²Starfield B et al. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83:457-502.

³Lawson E, Price C. The psychology of change management. *McKinsey Q.* June 2003;31-41.

“It is especially important that senior leaders model the desired behaviors; anything a senior leader says or does that does not support the desired changes can have a long-term negative impact.”

Challenges in optimizing primary care

A range of factors are making it difficult to deliver primary care effectively. The most notable of these factors include:

Fragmentation. In most countries, primary care is fragmented, which makes it difficult to transmit improvements through the system quickly. In Australia, for example, the typical general practice has only 3.5 physicians⁴; in the United Kingdom, the average is 4.⁵ Practices typically operate independently, and there are few, if any, formal links among them.

Challenges to coordination and communication. Most health systems expect GPs to liaise with the other providers who deliver care to a given patient, yet few systems have put coordinating mechanisms in place to help them do this. Similarly, many systems have not put mechanisms in place to give GPs reliable, up-to-date, user-friendly information about the care their patients are receiving elsewhere, the cost of the services they order, or the quality of care they deliver. Consequently, many GPs are unable to develop a holistic view of their patients' healthcare needs or to recognize where their own performance most needs improvement. Even health system leaders may have little insight into the overall performance of their primary care providers.

Poor understanding of the sources of healthcare waste. The lack of information also makes it hard for GPs to understand how their practices are contributing to waste in healthcare. As one primary care provider we interviewed noted, “I don't know a single doctor who isn't trying to figure out how to be more efficient ... I'm just not sure exactly what it is I would change about my day-to-day work to do that.” Recent McKinsey research has shown that many physicians are willing to make changes to reduce waste in healthcare—but many of them do not think that the sources of waste are within their control.⁶

Shortage of clinical leaders. Despite accumulating evidence that clinical leadership is critical to effective care delivery and service improvement, healthcare organizations often struggle to get physicians to play an integral role in shaping clinical services and leading improvement efforts.⁷ Our research suggests that three issues inhibit the emergence of clinical leaders. First, many physicians are skeptical about the value of spending time on leadership (in contrast, they believe that the value of patient care is obvious). Second, the incentives to become a leader are often weak or even negative. Leadership is not viewed as a well-defined career path, and in many health systems it may involve a salary cut if it requires physicians to take on formal managerial roles. Third, few health systems attempt to nurture clinical-leadership capabilities.

A comprehensive approach to change

Extensive research in behavioral science suggests that four areas matter most when it comes to altering a person's behavior (Exhibit 1).³ These areas hold as true for physicians as for everyone else. First, people will alter their behavior only if they understand the point of

⁴Carne A et al. *Summary Data Report of the 2010-2011 Annual Survey of Divisions of General Practice*. Primary Health Care Research and Information Service (Australia). 2012.

⁵General practice trends in the UK. NHS Web site. http://www.ic.nhs.uk/webfiles/publications/TSC/General_Practice_Trends_in_the_UK.pdf. Updated March 2011.

⁶McKinsey survey of 1,402 US physicians, 2011.

⁷Mountford J, Webb C. When clinicians lead. *Health Int*. December 2009;9:18-25.

the change and agree with it (at least enough to give it a try). Second, they must see others they respect adopt the new behavior. Third, they must have the skills needed to do what is required. Fourth, the surrounding structures (reward and recognition systems, for example) must reinforce the new behavior.

In our experience, a change program achieves the best results when multiple levers are used to address all four of these areas simultaneously; the absence of any one of them decreases the chances of success. For example, it may be possible to get people to change using incentives and training, but unless they truly understand why the new approach is necessary, the change is likely to be fragile and difficult to sustain. Similarly, without the right talent, skills, or formal mechanisms, people may want to change but not be able to. And role modeling is essential; a single act from a leader that is inconsistent with what is being asked of people

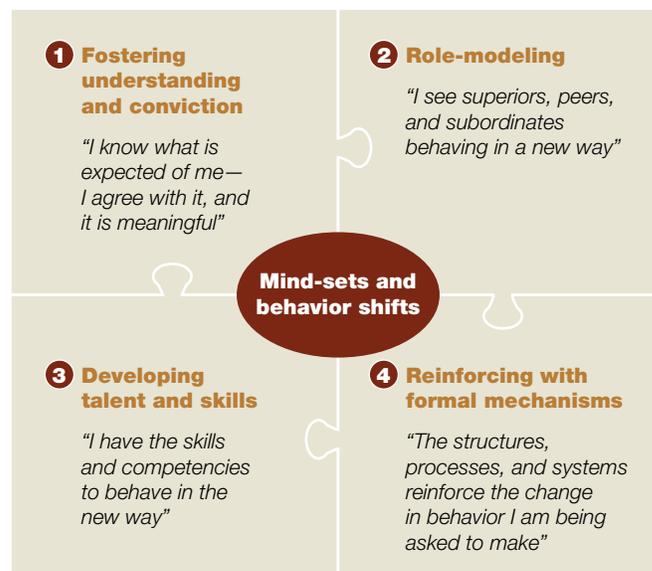
can undermine all other change efforts. When the four levers are used effectively together, the result can be significant changes in physicians' mind-sets and behaviors (Exhibit 2).

Fostering understanding and conviction

Physicians place strong emphasis on their own unique understanding of patients' needs and the evidence base underlying clinical practice, and they are highly unlikely to support any transformation program unless they are convinced of the need for change and play an integral role in developing the transformation program. Convincing physicians of the need for change therefore usually entails three steps: involving some of them in the effort to gather the necessary evidence (especially the data that will prove that the change will help—or at least not harm—patient care), turning that evidence into a compelling narrative, and then using multiple communication channels and simple, repetitive messages to effectively communicate the narrative to other physicians.

Exhibit 1

Four components are needed to change clinical behavior in primary care



Two examples show how programs have sought to create understanding and conviction among primary care physicians:

Australian Diabetes Care Project (DCP). The DCP, which involves 150 primary care practices and about 7,500 people with diabetes, aims to help the practices improve clinical outcomes; maintain reasonably good health status for patients with this chronic, complex condition; and increase access to primary care. Although still in its early stages, the DCP has the potential to guide the way many chronic diseases are managed in Australia.

Because successful implementation requires fundamental modifications in the behavior of GPs (for example, they need to shift their focus from activity-based care for individual patients to population-based management of diabetes), the case for change was developed especially

carefully. Physicians built a change narrative to describe the typically chaotic primary care practice today, highlighting its limited ability to stratify patients by risk, target resources, or empower patients to be part of the care team. In addition, the DCP created an interactive, user-friendly Web site, along with a monthly newsletter for participating practices, to communicate the program's overall progress, provide case studies of successful practices, highlight leading physicians and the latest thinking on diabetes education, and track performance of individual practices against key milestones.

Torbay Care Trust. Torbay, a region in the UK's southwest, has a high percentage of elderly residents, many of whom have multiple chronic conditions. After realizing that poor care coordination was compromising these people's health status and quality of life (and also driving up overall costs), Torbay decided to

Exhibit 2

Mind-set and behavior shifts required to transform primary care

MORE OF	LESS OF
Limiting procedures to ones you perform at reasonably high volume	Making unnecessary referrals
Dedicating more cognitive time to educate patients, reinforce treatment adherence, and manage/refine therapy	Ordering expensive, low-value interventions, diagnostics, and supplies
Accessing economies of scale through consolidation or shared services	Relying on medicines rather than behavior modification as the most powerful treatment for chronic disease
Championing and adhering to standardized, evidence-based clinical pathways	
Accepting responsibility for cost and quality of care that occurs outside the office	
Leading regular practice meetings and working as part of a multidisciplinary team	

integrate all health and social services for them. The impact of this change would be significant for local GPs, who would have to alter many of their care delivery practices.

To rally the GPs and other providers around the need for change, Torbay involved them in developing a narrative about a fictional character. “Mrs. Smith” was an elderly widow who lived alone and was having difficulty coping with her multiple health problems. The story personalized the frustrations elderly people experience in trying to navigate the local health and social care systems (such as the need to repeat information to multiple providers and undergo duplicate assessments) and the problems that arise because of poor communication among providers.

Because most of Torbay’s GPs had many patients like Mrs. Smith, they were able to easily grasp why closer care integration—and changes in the way they provide healthcare—would improve patient outcomes.⁸ They have altered their care delivery practices in numerous ways. For example, they now adhere to a single assessment process for all elderly patients, use care coordinators to more closely integrate service delivery, and work much more collaboratively with a wide range of colleagues.

Role modeling

People who, by their actions, can inspire others to begin to act in the new way are a critical component of any change program. Anyone within an organization—an executive, peer, or subordinate—can serve as a role model. However, it is especially important that senior leaders model the desired behaviors; anything a senior leader says or does that does not support the desired changes can have a long-term negative impact.

Examples of ways to strengthen role modeling include:

Mentorship programs. A large US health insurer that wanted to expand its use of patient-centered medical homes (PCMHs) created a mentorship program to assist new physicians willing to set up medical homes. Within its region, it identified several high-performing, charismatic primary care physicians who were already involved with PCMHs and asked them to provide coaching and mentorship to the new physicians. The mentors receive an additional financial reward based on the new physicians’ performance against targets.

Leadership development programs. In the late 1990s, Kaiser Permanente Colorado was struggling with worsening clinical and financial performance and losing its top physicians to private practice and rival organizations. It therefore made clinical leadership a priority. It revamped its leadership development programs so that the technical skills covered matched the participants’ self-identified needs. (For example, the head of a primary care clinic might be trained in scheduling, multidisciplinary teamwork, and group visits.) It also asked physicians with particular strengths, such as interpersonal effectiveness, to share their expertise by teaching colleagues. Within five years, quality of care in the region had been significantly strengthened, patient satisfaction rates had increased, staff turnover had fallen, and EBIDA margins had markedly improved.⁶

Celebration of clinical leaders. One way to overcome physicians’ reluctance to take on leadership roles is to make “champions” of effective clinical leaders. Systematically gathering stories about the value of great clinical

⁸Lavender A. Creation of a care trust: managing the project. *J Integr Care.* 2006;14:14-22.



leadership, and then having those stories told authentically and compellingly by people who participated in or observed the narrated events, can encourage physicians to become leaders themselves. The stories should highlight how both patients and the teams delivering care benefited from the leader's actions.

By regularly celebrating the accomplishments of all types of clinical champions (both those in formal management and those on the front line), organizations also create a strong bank of role models. In Boston, for example, Partners HealthCare celebrates distinctive clinical leaders not only at annual award ceremonies but also day to day through e-mail, in-house journals, and informal conversations.

Clear expectations. The US Army recruits, trains, and develops leaders in accordance with the explicitly defined leadership model and its threefold “be, know, do” philosophy. Some healthcare organizations with a strong development focus have made their expectations similarly explicit. For example, the Heart of England NHS Foundation Trust in Birmingham and New York-Presbyterian Hospital have worked hard to define their expectations of clinical leaders at different levels. This has enabled them to target their development

programs precisely and create enough leaders to meet their organizational needs.

Developing talent and skills

Improving primary care often requires GPs to work in new ways, something they may not be able to do unless they can develop new capabilities. It often also requires the creation of new roles—roles filled not by GPs but often by people new to healthcare. These people must also learn new skills if they are to succeed. In both cases, a range of methods can be used to help people learn, including forums to exchange best practices across disciplines, boot camp–style programs, ongoing weekly training sessions, e-learning initiatives, and written tool kits.

Examples of effective programs include:

Instituting learning collaboratives. A large US health insurer, concerned about cost increases that did not appear to reflect improvements in care delivery, believed that the best way to tackle both cost and quality would be to strengthen the primary care practices in its region. The goal was to enable the practices to take on a larger role in coordinating patient care and delivering preventive services. As part of a comprehensive primary care transformation program, the insurer established learning collaboratives to encourage all physicians to share ideas and leverage their colleagues' knowledge. The collaboratives, which are standing monthly meetings, use a mix of formats: colleagues may share experiences in improving care, experts may give presentations on topics of interest, or the group may make plans for future improvement efforts. Within the first year, the transformation program significantly lowered the cost of care for high-risk patients, primarily because

emergency room utilization, hospitalization rates, and readmission rates decreased. In addition, the practices' score on quality metrics (for example, for cancer screening and diabetes control) improved. The reaction of most participating physicians has been enthusiastic. Many of them have said that the program has empowered and given them incentives to work more proactively with patients, focus on outcomes, and improve care quality.

Adding health coaches. The AtlantiCare Special Care Center (SCC) in Atlantic City, New Jersey uses health coaches to improve care delivery for chronically ill patients. The SCC provides integrated care to more than 1,000 patients, most of whom are low-income immigrants. Care delivery is overseen by two primary care physicians, supported by eight bilingual health coaches. The coaches lead new patients through welcome visits that include comprehensive intake assessments; they then meet with each patient in person at least once every two weeks.

Because the primary job requirements for the coaches are cultural sensitivity, language skills, and emotional intelligence, not clinical background, they undergo periodic in-house training and attend courses on basic care delivery (glucometer use, for example) at a nearby medical center. In addition, the SCC holds daily 45-minute huddles for all staff, in which they can review and discuss the medical and psychosocial needs of the patients scheduled to be seen that day.

The SCC's innovative approach to patient care, including its use of health coaches, has enabled it to substantially decrease its patients' health-care utilization rates. For example, it has reduced emergency room visits and inpatient admissions by 40 percent, the number of

surgeries performed by 25 percent, hospital length of stay by 8 percent, and the cost per hospital day by 18 percent.^{9,10}

Introducing health and social care coordinators. As part of its efforts to integrate care, Torbay created a new role—health and social care coordinators—so that patients with chronic conditions and complex needs could access services through a single point of contact. The coordinators, who do not have clinical qualifications, liaise with patients, their families, and their care providers. Community-based coordinators know which of their patients are unstable and which have only intermediate care needs; they work proactively with a multidisciplinary team of clinicians and social care workers to arrange and modify care packages as appropriate. They also facilitate effective information sharing among all providers.

Other coordinators based in hospital wards focus on discharge planning. They work with their community-based colleagues to ensure that patients can be sent home as soon as it is medically appropriate and then receive the services that will reduce the risk of readmission. This approach has enabled Torbay to markedly reduce length of stay among elderly patients (its average is now 30 percent below the benchmark for England). In addition, the

⁹Gawande A. The hot spotters: can we lower medical costs by giving the neediest patients better care? *New Yorker*. January 24, 2011;40-51.

¹⁰Blash L et al. The Special Care Center—a joint venture to address chronic disease. Center for the Health Professions at the University of California, San Francisco. Presentation given February 2011.





program has lowered the readmission rate and allowed Torbay to reap significant cost savings.

Using formal reinforcing mechanisms

For a change program to take hold and be sustainable, it is crucial that surrounding structures, including information systems, incentives, and governance arrangements (for example, performance management frameworks), reinforce the alterations in clinical behavior that physicians are being asked to make. Formal mechanisms that have been successfully used to reinforce change include:

Clinical decision-support and performance management. ChenMed, a privately held primary care-led physician group, uses an innovative clinical decision support tool and a robust performance management framework to deliver care to low- and moderate-income elderly patients with multiple chronic conditions. The company operates more than 20 centers in the southeast United States; each center is staffed by five primary care physicians and 10 to 15 specialists (the specialists rotate through on a part-time basis). ChenMed is reimbursed through the US's Medicare program on a risk-adjusted capitation model. The company relies heavily on physician accountability and peer review to deliver high-quality care within the program's payment structure. At each center, physicians meet three times a week to discuss patients with poor outcomes and to review all hospi-

talizations to consider how they might have been prevented.

ChenMed also relies on nimble, highly customized software, developed in-house, to support clinical decision making and performance transparency. Its clinical decision support tool, for example, is embedded in hand-held tablets so that its nurses and primary care physicians have easy access to standardized clinical protocols. However, all data is stored in an online "cloud," and an automated performance dashboard provides a "star system" to track the daily performance of individual physicians and each center as a whole. Among the metrics monitored are hospitalization rates, readmission rates, efficiency, and wait times.

ChenMed's decision support tool and performance management framework have helped the company reduce its patients' hospital admission rate to 18 percent below the national average and their readmission rate to 17 percent below that average.¹¹

Automated provider performance dashboards. Tower Hamlets, a deprived, inner-city borough in London, has long had poor primary care access and poor clinical outcomes for chronic conditions. To address these problems, NHS Tower Hamlets decided to pilot a diabetes program to see whether primary care networks could increase care integration and give providers better peer support. The program's goal

¹¹ Moukheiber Z. Concierge medicine for the poorest. *Forbes Online*. February 23, 2012.

was to ensure that all diabetes patients receive individualized, coordinated care, delivered by a range of clinicians (including GPs, nurses, and others) in multidisciplinary teams.

To create transparency into the program, NHS Tower Hamlets developed automated performance dashboards to monitor the clinical and financial outcomes of individual providers and the new networks. It invested in an integrated IT system to connect the borough's primary, community, and acute care providers and pharmacists. Using the system's data, it then created the dashboards, which track a range of clinical metrics (such as HbA1c and cholesterol levels) and cost indicators (for example, the number of primary care attendances and acute care services).

The program has achieved significant impact. In its first 12 months, it produced an 11 percent increase in the number of patients with good blood pressure control, a 10.4 percent increase in the number with healthy cholesterol levels, a 7.7 percent increase in the number with good glucose control, and a 600 percent increase in the number with diabetes care plans. Financial modeling suggests that these changes should reduce NHS Tower Hamlets' spending on nonelective acute care by 12 to 14 percent.

Shifts in staffing and incentives. Geisinger, a large, physician-led health system in Pennsylvania, wanted to improve care delivery to chronically ill patients and reduce the cost of that care. It developed an advanced PCMH program, ProvenHealth Navigator, to ensure that chronically ill patients get high-quality care. The program embeds nurse case managers (paid for by Geisinger) within primary care practices to drive care coordination. Electronic health records enable Geisinger to stratify patients by risk and send reminders

(to physicians and patients) about preventive and chronic care services.

The program also incorporates a variety of financial incentives to reward the practices for delivering high-quality care. For example, pay-for-performance bonuses are given when quality targets are met. Stipends are awarded to help practices perform certain activities required by the program. The practices are also entitled to share in the cost savings achieved.

Within its first two years, ProvenHealth Navigator lowered the rate of hospital admissions among enrolled patients by 18 percent, the rate of readmissions by 36 percent, and average per-patient costs by 7 percent.¹² More recent studies suggest that the program is continuing to lower the hospitalization rate.



It is neither easy nor straightforward to change clinical behaviors in primary care, but change is essential if today's care quality and cost challenges are to be met. Substantial, sustained change will occur only if primary care physicians play an integral part in shaping the transformation, and they will play such a role only if convinced of the need for change. Furthermore, no transformation can succeed over the long term unless supported by formal reinforcement mechanisms, capability-building programs, and role modeling. The journey can be difficult, but the results—better patient outcomes and less costly care—make the journey worthwhile. ○

Tim Fountaine, MD, PhD, an associate principal in McKinsey's Sydney office, specializes in strategy and health systems work. **Ben Richardson, MPP**, a principal in the London office, heads the Firm's global work on integrated care. **Frances Wilson, MD**, an expert in the San Francisco office, focuses on improving provider performance.

¹² Gilfillan RJ et al. Value and the medical home: effects of transformed primary care. *Am J Manag Care*. 2010;16:607-614.