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Keys to successful health care reform

Insights from successful health care improvement efforts during the last 20 years

Contents

Abstract

This paper identifies and reviews several models of health care reform from the last 20 years with positive documented outcomes of both cost reduction and improved quality care. A review of these models reveals commonalities that are the basis for their success and are also the keys to successful U.S. health care reform going forward. The commonalities lie in two critical, and interrelated, undertakings for each successful model: 1) accurately accumulating cost and quality data to determine areas for waste reduction and to improve the quality of patient outcomes and 2) successfully aligning hospital and physician incentives. Additionally, in the models presented in this paper, physicians initiated and determined the improvement opportunities. This paper demonstrates that physicians can realize significant savings and clinical quality improvement when actuated by accurate data and appropriate hospital-physician alignment incentives.

About the author

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Joane H. Goodroe is credited with helping to change the landscape of the health care industry by developing innovative solutions that allow hospitals to reap long-term rewards. Her goal has always been to empower those who are on the front line of delivering patient care and provide them with the tools to improve clinical quality and reduce costs.

Joane's groundbreaking work led to creating a gainsharing model that is the first and only one approved by the United States Office of Inspector General. Since this landmark decision in 2001, she has since been instrumental in administering more than 70 gainsharing programs in hospitals throughout the United States. Her testimony at a Congressional hearing on gainsharing was helpful to the continued acceptance of gainsharing.

It is because of Joane's innovative approach to solving health challenges that led to Joane's current role in VHA as Senior Vice President of Innovation. In this role Joane continues to influence monumental change efforts for health care, specifically developing innovative decisioning resources for health care executives.

Joane is a sought-after speaker and subject-matter expert and has published and guest-authored numerous articles on topics related to hospital-physician economic alignment programs, clinical patient care and product line development. In 2007, Healthcare Purchasing News named Joane as a supply chain influencer to watch.

Prior to forming Goodroe Healthcare Solutions, Joane was the vice president of Cardiovascular Services and director of The Heart Institute at Saint Joseph's Hospital in Atlanta, Georgia. Before that she worked in several key roles in cardiovascular medicine at Saint Joseph's Hospital and Emory University Hospital. She received a bachelor of science in nursing from the Medical College of Georgia and a master's degree in business administration from Mercer University.

Heading toward health care reform; looking back at advancements in cost and quality

The United States health care system is in need of reform efforts that will reduce costs and maintain, and even, improve the quality of care patients receive. Cost reductions will allow the cost of care to be more widely distributed, expanding care access to patients that previously did not have access to quality health care services.

To employ sweeping changes to improve costs and quality in health care, administrators must review the success of various health care reform efforts in the past, learn from those models and employ the key components required for success. This paper identifies and reviews several models of health care reform from the last 20 years with documented outcomes of cost reduction and improved quality of care.

A review of these models reveals the primary keys to success for future health care reform, pinpoints the hidden cost driver in the current U.S. health payment system, focuses on the leadership role required to make lasting improvements, identifies the existing barriers to success, and reveals the models that have made significant impact on cost reduction and clinical quality improvement. The models presented here could be very important to current health care reform efforts.

Identifying critical success factors for health care reform

A review of past, successful health care reform models reveals commonalities that are the basis for their success and are also the keys to successful U.S. health care reform. The commonalities lie in two critical and interrelated undertakings for each successful model: 1) accurately accumulating data to determine areas for waste reduction and improve the quality of patient outcomes, and 2) successfully aligning hospital and physician incentives. The models reviewed in this paper demonstrate that physicians can realize significant savings and clinical quality improvement when actuated by accurate data and appropriate hospital-physician alignment incentives.

Pinpointing the hidden cost driver in health care

For centuries, medicine has been defined as the science and art of maintaining and restoring human health. And just like artists who have unique styles and interpretations when creating sculptures or paintings, physicians are also unique in their manner of care delivery. In fact, most people do not realize that each physician delivers patient care in a unique manner, even for the same type of patient with the same clinical diagnosis and procedure needs.

To explain further, physicians complete what is known in the medical field as a "preference card" in order to outline how he or she wants to perform an upcoming patient procedure. This is how the physicians indicate the tools and supplies needed for their upcoming patient procedures. Similar to a chef or an artist who chooses his preferred ingredients or materials in order to create the best entrée or work of art, each physician also takes pride in his individual process for patient procedures and selects his preferred products and supplies needed for the best possible outcome. After all, physicians are trained to deliver personal, high-quality care to their patients.

Unfortunately, this is where the hidden costs reside. And these hidden costs add up to significant waste throughout the U.S. health care system. While the personal touch of physicians can be important to patient care, their personal preferences costs the health care system enormously. Most physicians learn hands-on aspects of patient care while interning with more seasoned physicians. Therefore, practice preferences are passed from one physician to another, but are not uniform among physicians, hospitals or even among patient diagnosis or procedure needs. In fact, each individual practice has not been studied to assure that it results in the highest quality patient care with the best allocation of resources required.[1]

Further masking the hidden costs of health care is our current health payment system, which calls for the hospitals to pay for the products and services administered to patients even though the physicians determine what products and services they use for each patient procedure. These products and services equate to the majority of costs for patient procedures. Therefore, physicians control the majority of costs associated with patient care. Unfortunately, in most cases, due to this payment system, physicians have only a limited knowledge or understanding of the total cost of care for their own patient procedures.

Recognizing physicians' critical leadership role

According to the Boston University School of Public Health, "Doctors are the key to cutting costs because their decisions affect 87 percent of personal health spending."[2]

While it's true that physicians control the majority of health care costs through procedure preferences, they also have the medical education and expertise for patient care, many of them specializing in highly technical procedures. And, physicians take personal risks when caring for patients because they assume the ultimate responsibility for patient outcomes. Therefore, health care reform efforts to reduce costs and improve patient care must include physician leadership. Only physicians have the knowledge to decrease costs without compromising quality of care. In the health care reform models presented in this paper, physicians initiated and determined the improvement opportunities.

Summarizing successful models with proven results

This paper identifies and reviews several models of health care reform from the last 20 years with documented outcomes of cost reduction and improved quality of care. The models outlined resulted in better care, increased savings to payers, lower hospital costs, and better payments to physicians. Examining the details in these models can provide valuable insight into needed improvements that should be included in current health care reform discussions.

Keys to success for health care reform

Effective health care reform will be dependent on two essential factors: using data to improve quality and costs, and incorporating hospital-physician alignment incentives.

The first key factor is the ability to accurately measure the diverse ways care is delivered to patients who have the same clinical conditions. By doing so, we can identify variations in physician practice patterns including product and services utilization for like procedures. Then we can facilitate physician leadership of improved care methods and improve the overall quality of care delivered. By accumulating and benchmarking cost and quality data, physicians can determine which delivery methods produce the best patient outcomes at the lowest cost. This monitoring of practice variations must be ongoing, since regular introductions of new clinical technology increases costs as they boost quality of care.

The second key factor is initiating some type of hospital-physician alignment model to create a platform of common goals for both the hospitals and physicians. There are many types of hospital-physician alignment models, one of which is gainsharing, and examples are presented in this paper. Another model presented here is that of global payments for health care procedures. It is proven that hospital-physician alignment models like these create effective partnerships between multi-disciplinary health care provider groups to provide the best possible patient care at highest level of efficiency for all providers involved.

Measuring practice variation to improve cost and quality

For decades, businesses in the manufacturing and service sectors have continuously reengineered their production and delivery processes to remain profitable. The same type of reengineering is critical for the health care industry in order to continue delivering quality patient care and improve access to care without crippling the health system. But this type of reengineering requires comparative data that yields insight into issues and opportunities.

A critical step to extracting meaningful dollars from the health care system involves accumulating and benchmarking comparative data on similar patient procedures including physician practice variations, product and service utilization, clinical quality outcomes, and a breakdown of the costs. Current electronic medical records systems are not equipped to compare similar patient conditions and, therefore, cannot provide the necessary data for cost and quality improvement efforts.

Hospitals also do not capture this data manually. For example, each physician's individual preference card documents how he or she wants to complete a particular procedure. But every hospital captures different data for these procedures, so national comparative information is not available from these.

VHA Inc., a national network of not-for-profit hospitals, maintains the health care industry's most notable advancement in the area of health procedure data capture and comparative analysis. In the late 1990s, VHA's subsidiary, Goodroe Healthcare Solutions, designed and built data capture and analysis systems to identically measure clinically similar cardiac procedures at hospitals throughout the country. We followed that development by creating similar analytical tools to measure orthopedic and spine surgery procedures as well.

Benchmarking national data and analyzing the differences in practice patterns provides the necessary data and insight to determine where resources are being wasted and identify opportunities for improvement. But equally as important, it also provides a great opportunity for physicians to analyze and determine best practices for patient care.

Years into the use of these analytical tools, VHA and Goodroe have compiled a robust data warehouse that compares a wide variety of high-cost clinical procedures. The data results reveal that there are as many ways to successfully perform a cardiac, orthopedic, or spine procedure as there are physicians performing these procedures nationwide. These procedures are some of the health care industry's most expensive medical procedures, due primarily to the high costs of the specialized implants and devices required. Surprisingly, each physician maintains his own practice patterns for clinical cases, and the wide variation in practice patterns creates significantly higher costs and utilization waste in our health system.

An early study using these analytical tools demonstrated this waste and is explained next. Current studies and data analysis continue to identify the same type of waste and cost outliers.

Analyzing the cost of stent procedures using comparative data

Goodroe Healthcare Solutions published a study in 2002 that used data from its national procedure-based data warehouse to analyze the direct costs of 80 hospitals associated with performing a single-vessel coronary stent placement in patients with no acute or remote myocardial infarction.[3] Parameters required that

all hospitals included in the study perform at least 275 of the described cases annually. Doctors performed procedures in the fourth quarter of 2001. At that time, all stents were bare metal stents. Study facilitators used the same method at each hospital to capture and measure procedure costs.

There were five categories of costs measured and all were based on the acquisition costs for supplies multiplied by the supply utilization per case. The five categories were 1) device cost, 2) medical surgical cost, 3) contrast cost, 4) anti-thrombotic cost, and 5) labor cost.

Category	Examples
Device cost	Catheters, stents, guide wires and balloons
Medical surgical cost	Transducers, tubing, inflation kits, arterial needle, manifold, procedure tray
Contrast cost	Type and quantity
Anti-thrombotic cost	Type and quantity
Labor cost	Hourly rate of each staff member participating in case

Results of the study revealed that there was a large variation in total case cost among the 80 facilities studied. For example, the average hospital total cost per procedure ranged from a low of $1,885 to a high of $4,245. That brought the average procedure cost across facilities to $3,091.

When analyzing the costs broken down by the five categories, each category exhibited the same variation in cost, but also revealed variation in utilization. For example, the average cost of anti-thrombotic was $350 at the time of the study. But the hospitals' costs varied from zero dollars to the highest average cost of $1,085 for anti-thrombotic. This is important because it demonstrates that price is not the only driver of cost. Utilization is a key differentiation in the cost of a case.

New clinical technology and its affect on variation and quality

Also important to health care reform is the understanding of the clinical benefits of new procedure technology and its impact on cost and clinical outcomes. With the previous introduction of drug eluting stents and the resulting data on DES procedures, we have an example of analyzing both the variation in practice patterns and the clinical benefits of new technology.

The national Drug Eluting Stent Task Force used Goodroe Healthcare Solutions' Data Warehouse to examine data on stent procedures performed at 100 hospitals. The study revealed that between the first quarter of 2000 and the first quarter of 2003, the mean number of bare metal stents used per case increased from 1.45 to 1.54 stents. The task force also reported that the national level had the potential to increase to more than 2.0 stents per case as more complex lesions were attempted with DES procedures.[4] Prior to the introduction of drug eluting stents, the Goodroe Data Warehouse demonstrated an average cost per case of $2,493 for stent procedures.

By the first quarter of 2005, and after the introduction of drug eluting stents, the average cost per case skyrocketed to $4,432 with 88 percent of the cases using at least one drug eluting stent. The average DES per case was 1.63, compared to the 1.54 average of bare metal stents prior to DES introduction.

Since the introduction of DES, various studies reveal contrasting results about the quality improvement impact of drug eluting stents and experts continue to debate the clinical results of DES in published articles in cardiovascular media.

Another study published in *Clinical Cardiology* in 2006 examined data of 17,102 patient procedures from the Goodroe Data Warehouse who had received bare metal stents.[5] The data was reviewed for evidence of repeat diagnostic or percutaneous coronary intervention anytime within one year from initial stenting. The study reported: "There were 2,070 patients with a repeat PCI and 232 who were referred to coronary artery bypass surgery for in-stent

recurrence. Only 1,207 (7.1%) patients required stent-related PCI after 30 days, the time frame consistent with restenosis."[6] This retrospective patient study demonstrated that the rate of bare metal in-stent restenosis was much lower than in the control arms of some of the DES trials. The study went on to report: "The incremental benefit of widespread conversion from bare metal stents to drug eluting stents may be smaller in some patient populations than is suggested by the results of those trials."[7]

This is a very important example of how the care of patients should be measured and evaluated. Accurate measurement should include comparative patient-to-patient, doctor-to-doctor and hospital-to-hospital data that compares utilization, clinical and cost outcomes. This method will demonstrate whether current practices bring clinical benefit to patients.

Analyzing treatment diversity with comparative data

Another example that demonstrates treatment diversity comes from the Goodroe Data Warehouse. This example used data to look at the practice patterns of one large cardiac hospital program compared to the average practice patterns in the data warehouse.

It's important to note that the number of stents per case is not an accurate clinical comparison. Instead, it is important to evaluate the number of stents utilized by lesion. In addition, since stents come in different lengths, it is important to obtain data that measures the specific length of a stent utilized.

For example, the national average number of stents per lesion in 2007 was 1.21. Examining practice variation revealed one hospital's physicians used an average of 1.61 stents per lesion. Further investigation demonstrated that physicians were using shorter stents than other programs which was contributing to this increased utilization of stents. These extra stents per case cost the cardiac program more than $1 million annually. There was no clinical benefit seen in that patient population compared to the national average of outcomes monitored.

Again, the factual evidence confirms that there is waste in our health care system and that specifically measuring the method of patient care is a key factor in identifying opportunities for improvement.

Aligning hospital and physician incentives

The second area important to health care reform is aligning hospital and physician incentives. Physicians control the majority of health care costs but they don't share the hospital's responsibility for payment. Global payments and gainsharing are two models that provide incentive for hospitals and physicians to work together. Initiating programs like these -- that designate that physicians either share the risk or receive rewards for designing improved processes -- will result in improved quality outcomes and lower health care costs nationwide.

Properly designed, these incentive programs have the power to create fundamental changes to health care processes, create opportunities for skilled medical professionals to work together, and help integrate medical services delivery across multiple providers groups. With these combined results, incentive programs serve to improve quality of care and efficiency of care delivery.

A study in global payments

In May 1991, the Centers of Medicare and Medicaid Services (formerly Health Care Financing Administration) began a four-hospital study to test a fixed-fee, or global payment model for coronary artery bypass surgery.

Under our traditional reimbursement system, patients receive separate invoices from the hospital and from each physician involved in the patient's delivery of care. This process often generates dozens of bills from the various service providers including anesthesiologists, radiologists, pathologists, surgeons, cardiologists, and a number of consultants.

In contrast, this global payment project placed the hospital and the physicians at financial risk for delivering care to the patient and provided an incentive for hospitals and doctors to work together to deliver high-quality patient care while controlling costs.

In the early '90s, with very little managed care in place, physicians had not yet seen decreases in their fee payments and hospital payments were also very good. So the concept of a fixed fee for procedures was quite unusual. On top of that, the project was initially very controversial because the ideas of hospitals and physicians working together and also controlling cost related to patient care was seen as a dangerous proposition.

In fact, the *Wall Street Journal* published a 1992 front-page article highlighting industry critics' concerns. The director of the American College of Surgeons, Paul A. Ebert, stated, "Doctors who participate in bundling experiments risk ceding control over medical decisions to hospital administrators worried more about the bottom line than about individual patient needs. A committee of the American Medical Association is expected to report later this month on bundling's potential for fostering administration abuse."[8]

In contrast, the same *Wall Street Journal* article quoted Douglas Murphy, MD, a surgeon from Saint Joseph's Hospital of Atlanta, a hospital participating in the CMS global payments project. Dr. Murphy's comments indicated his belief that the project would be successful. "You have to take better care of your patients, you have to know them better…if doctors aren't rewarded for cost-effective practice they won't pay attention to costs and the hospital will lose money," Dr. Murphy stated.[9]

From a patient's perspective, the article confirmed their positive reaction to their experience of receiving well coordinated care and no bills.

Global payments results

During my tenure at SJHA, I served as the administrator of the global payment project, and I observed a positive and deliberate effort to align quality and cost incentives between the hospital and physicians in order to ensure long-term success. As part of the project, the physicians were eligible to participate in 25 percent of the savings they generated if quality of patient care was maintained or improved. They were, and in the end, the demonstration reported saving $5.5 million from the SJHA project.[10]

According to the final report published by the CMS contractor, Health Economics Research, the physicians were responsible for a significant amount of the variable cost decreases. At SJHA, the variable cost decreased by 25 percent in DRG 106 which is a coronary artery bypass graft *with* a cardiac catherization. Costs also decreased by 41 percent in DRG 107 which is a coronary artery bypass graft *without* a cardiac catherization.

The largest components of variable cost reductions were seen in operating room and intensive care including staffing, drugs and supplies. Although there were some increases in fixed cost during this time period, the hospital still realized additional profit due to the substantial decreases in variable costs. Before the project, the net income per case for Medicare DRG 106 was $1,482 as compared to a net income of $2,126 three years into the project. DRG 107 showed even more favorable results. SJHA went from an initial net profit of $89l per case to a new profit of $3,513 per case.[11]

The physicians also experienced similar results. The cardiac surgeons' reimbursement increased 28 percent from their original discounted rate which was three percent less than their actual reimbursement

at the time the project started. Both anesthesiologists' and cardiologists' reimbursements increased by more than 20 percent.[12.]

The project's other three participating hospitals were Boston University Hospital (Boston, Mass.), St. Joseph's Hospital (Ann Arbor, Mich.), and Ohio State University (Columbus, Ohio). For the demonstration project, Health Economics Research assumed a 5 percent annual inflation in hospital wages and therefore estimated that all hospitals except Ohio State had seen resource costs drop between 18 and 40 percent.[13]

SJHA achieved the project's highest decrease, due in part to the fact that it was the only hospital to implement a structured hospital-physician alignment program on cost and quality from the start of the project.

Maintaining quality of patient care was also a criteria for the project. Although one participating hospital did not decrease costs, all four hospitals demonstrated a much lower average inpatient mortality rate. Between 1991 and 1993, the four hospitals averaged between 4.1 percent and 4.9 percent mortality as compared with the national average mortality rates of 6.5 percent in 1990 and 5.5 percent in 1993.[14]

Additionally, the demonstration period resulted in a significant positive trend in the rate of complications (at the 10 percent confidence level). This is evidence that the project was controlled for patient risk factors.[15]

Results quantified positive financial and clinical outcomes for global payments in the way of cost reductions, increased reimbursement, improved mortality, and reduced complications, among others. Qualitative results also demonstrated enhanced hospital-physician collaboration on quality of care. Comments from nurses in the final report stated that there was more physician and nurse collaboration on patient care during the project than there had been before the demonstration.

Much progress since then; still work to be done

As a result of the global payments project, SJHA's costs decreased tremendously. But since that time, pressures from managed care and a more conscious use of resources have decreased some of the waste that was prevalent in health care during that project. So, it is fair to say that fifteen years later, a similar project would not yield this level of cost savings.

However, much work during the past ten years continues to demonstrate that there is still waste in our health system and therefore opportunity to increase quality and decrease costs. This project, and results from the following years' work, is also evidence that there is clearly an advantage to aligning hospital and physician incentives to achieve both quality care and cost improvement.

Gainsharing fosters patient care improvements

Global payments are just one of many options in the area of hospital-physician alignment that will be important to health care reform. Gainsharing arrangements can also reveal important lessons on improving cost and quality, and therefore access to care.

In 2001, VHA's subsidiary Goodroe Healthcare Solutions achieved a landmark decision when the United States Office of Inspector General approved the gainsharing model the company developed to monitor and improve patient care cost and quality. This model continues to be the industry's only OIG-approved gainsharing model due in large part to its ability to prove that it safeguards clinical quality while reducing costs.

The gainsharing model allows hospitals to share cost savings with physicians who participate in cost reduction efforts that maintain patient quality of care. Physicians respond to gainsharing because they receive benefit for the work required to improve processes. But physicians are only paid a percentage of the savings when they achieve successful outcomes and cost reduction. Because gainsharing brings hospitals and physicians into a closer working relationship, it allows hospitals to realize cost savings that they otherwise would not obtain.

Reviewing the impact of gainsharing

An independent, peer-reviewed study published by the School of Health and Policy at Arizona State University concluded that gainsharing reduces costs for coronary stent patients while leaving quality and access unharmed. The study examined the effects of 13 gainsharing programs on coronary stent patients. Compared to other hospitals, gainsharing hospitals reduced costs by 7.4 percent per patient, with 91 percent of the savings from lower prices and 9 percent from lower utilization. The available measures of access and quality suggest that neither was reduced, nor was access to drug-eluting stents before 2006.[16]

The study found that the "average in-lab cost per coronary stent patient increased from $3,338 in the fourth quarter of 2001 to $4,644 in the fourth quarter of 2006, and spending on devices and drugs accounted for 98 percent of that increase. The regression results indicate that gainsharing slowed this growth, reducing costs by $315 per patient relative to non-gainsharing hospitals. Nearly all of these savings, 94 percent or $297, were attributable to reductions in spending on devices and drugs.[17] Overall, hospital costs reduced 7.4 percent and hospitals reported that neither access to devices, such as drug eluting stents, or quality, were reduced.

Understanding the current limitations

Although research results from gainsharing during the past eight years are positive, gainsharing hospitals endure long delays to initiate gainsharing because of the wait-time for review from the Office of Inspector General. Undoubtedly, without these significant delays, the momentum to save money would be greater and the percentage of dollars saved would be larger.

In addition, gainsharing programs have been limited to only monitoring the costs and quality in specified procedure areas because medical experts can easily evaluate medical practice changes to meet the expectations that have been required by law and are acceptable to the OIG. As I stated in a previous article published in *The Journal of Cardiac Management*: "In these arrangements, there must be a 'leap of faith' by hospitals and physicians. Hospitals must be willing to relinquish total control. The finance department must step into the world of clinical medicine. The physicians must learn how they impact variable cost."[18]

Existing barriers to success

For decades, businesses in the manufacturing and service sectors have continuously reengineered their production and delivery processes to remain profitable. The same type of reengineering is critical for the health care industry, so we can continue delivering quality patient care and improve access to care, without crippling the health system. But, unfortunately, significant barriers exist in the structure of our current health system and the laws that govern it.[19] These barriers prevent us from transitioning to a focused re-engineering effort that other industries normally employ.

These barriers include two that have already been examined in this paper:

- The traditional evolution of physician training on patient procedures, and
- The lack of quantifiable research measuring the different physician practice patterns, including variation of product and service utilization, and their affect on quality outcomes and costs.

Additional barriers to consider include:

- The structure of U.S. health payment system including Medicare and managed care,
- Current U.S. laws governing hospital-physician alignment,
- Lack of integrated IT systems required to administer and distribute payments in a global payment model,
- Lack of existing national data systems with reliable utilization, quality and cost data, and
- The for-profit drivers of managed care.

Limitations in the U.S. health payment system

The current structure of the U.S. health payment system actually prevents full cooperation between physicians and hospitals. For example, Medicare maintains separate payment systems for physicians and hospitals, and the statutory and regulatory constraints imposed by Medicare make it difficult for physicians and hospitals to work together.

Laws governing hospital-physician alignment

The use of certain operational and financial incentive arrangements, commonly referred to as gainsharing arrangements, can serve to significantly improve the alignment of physician and hospital interests. But the current U.S. laws designed to protect patient care, do not allow hospitals to reward physicians for inventing the next generation of improved processes for better patient care that result in improved overall quality and lower costs.

In testimony before the Health Subcommittee of the House Ways and Means Committee, Lewis Morris, Chief Counsel at the U.S. Department of Health and Human Services' Office of Inspector General, explained the Civil Monetary Penalty law in this way:

"With respect to the CMP, the major concern is the impact of gainsharing on the quality of care provided to Medicare and Medicaid beneficiaries. The CMP, sections 1128A(b)(1) and (b)(2) of the Social Security Act, prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under a physician's direct care.

The CMP is an intentionally broad prohibition, reflecting Congressional concern that under the inpatient prospective payment system hospitals would have an economic incentive to pay physicians to discharge patients too soon—quicker and sicker—or otherwise truncate patient care."[20]

Amazingly, this same law allows *managed care organizations to* work with physicians to reduce or limit services to patients.

Two other laws that interfere with hospital and physician alignment are the Federal anti-kickback statutes and the physician self-referral law, or "Stark" law (not detailed in this paper).

Lack of integrated IT systems required to administer global payments

In the global payment model, administering or distributing these payments to the hospital and the physicians requires integrated information technology systems and creates new administrative costs for hospitals and physicians. In current health care reform, the money to fund this effort should flow from the many intermediary agencies that should have a smaller role in a global environment.

Lack of existing national data systems with reliable utilization, quality and cost data

The other issue is developing data systems that can produce reliable utilization, clinical and cost information. This is a matter of vendors, hospitals, and physicians realizing that most existing systems need to be re-tooled to meet these needs one service line at a time.

For-profit driver of managed care

One final note concerns the role of managed care entities. At one time, it was expected that health care reform would be driven through their work. My experience indicates that managed care will not be able to return value to the health care system. As public companies, their mission is to return value to their shareholders. Decreased reimbursement and costs by hospitals and physicians have only translated into increased profits for these companies and shifts in cost to Medicare. Premiums do not decrease because the customers of these companies will be required to pay whatever price the market bears for managed care products.

In December 1998, a report was submitted on global payments relating to the managed care market in Atlanta, Georgia.[21] Between 1995 and 1996, for DRG 106, coronary artery bypass surgery, the average reimbursement decreased by more than 15 percent to the hospital and physicians. The patients' acuity also increased during this time. Importantly, these reimbursement decreases failed to produce correspondingly better pricing from the managed care company. This issue needs be addressed in the overall health care reform journey.

Conclusion

Effective health care reform will be dependent on the two essential factors outlined in this paper: using data to improve quality and costs, and incorporating hospital-physician alignment incentives.

Without first being able to accurately measure the diverse ways care is delivered to patients with the same clinical conditions, we will not be able to uncover the hidden costs of health care – costs that could be redistributed more effectively and improve access to health care for millions of Americans. Also, without identifying the variations in physician practice patterns, including product and services utilization, for like procedures, we can't engage physicians in the critical decision making for improvements. It is the physicians that must make the improvements in care delivery. Only they can lead the improved care methods and improve the overall quality of care delivered. By accumulating and benchmarking cost and quality data, physicians can determine which delivery methods produce the best patient outcomes in the most efficient manner.

The second key factor is initiating some type of hospital-physician alignment model to create a platform of common goals for both the hospitals and physicians. No matter what model we choose – and there are many types of hospital-physician alignment models – we have proven through years of work that incenting physicians to share in risk and reward creates better outcomes for patients and improved costs for the health system. This paper outlined two of the most impactful hospital-physician alignment models and presented examples -- global payments and gainsharing. Years of research have demonstrated that hospital-physician alignment models like these create effective partnerships between multi-disciplinary health care providers to provide the best possible patient care at the highest level of efficiency.

This paper presents many positive outcomes from previous health care reform efforts. While, challenges remain with these models, they contain valuable lessons for improvements.

Health care reform should be considered in small steps. Just like patients are diagnosed and treatment plans put in place, health care must not look for one giant answer but instead find incremental steps that bring real value. The global packaging, the key data findings and the hospital-physician alignment models have demonstrated better care to patients, greater savings to payers, lower hospital costs and better payments to physicians. If these models had already been implemented, our health care system would be saving significant sums by decreasing the day-to-day waste that does not affect the quality of care delivered to patients.

There are forms of change that will bring value to the payer, the hospital, the physician, and especially to the patient. Sweeping changes would be dangerous, but the benefit-based changes described in this paper assure that patients will have access to quality care. Initiating important steps, such as, global payments for procedures and assuring that physicians and hospitals share in savings programs, such as gainsharing arrangements, will decrease the cost of health care. How do we know that? Because for the past 20 years, these programs have delivered measureable, meaningful and positive results.

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About VHA VHA Inc., based in Irving, Texas, VHA Inc. is a national network of not-for-profit health care organizations that work together to drive maximum savings in the supply chain arena, set new levels of clinical performance and identify and implement best practices to improve operational efficiency and clinical outcomes. Formed in 1977, through its 17 regional offices, VHA serves more than 1,400 hospitals and more than 24,000 non-acute care providers nationwide.

About Goodroe Healthcare Solutions, LLC Since 1994, Goodroe Healthcare Solutions, a VHA company, has been on the forefront of providing cutting-edge information management technologies and processes to help hospitals reduce costs and improve quality. The company has been nationally recognized for its innovative solutions that enable hospitals to increase margins in high-cost specialty areas. In 2001, Goodroe obtained approval for its gainsharing model from the United States Office of Inspector Genera. Since this landmark decision, Goodroe has secured 14 additional approvals for gainsharing programs in hospitals throughout the United States. To date, Goodroe has the only gainsharing model approved by the OIG. VHA Inc. acquired Goodroe Healthcare Solutions in October 2005 to help its member hospitals improve their clinical and economic performance in high-cost specialty service areas. Although Goodroe is owned by VHA, Goodroe's gainsharing solutions are marketed to both VHA members and non-VHA member hospitals across the United States.

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