

Strategies for Reducing Costs in *The Grand Junction Experience*

WITH THE RIGHT DATA, PRIMARY CARE PHYSICIANS
CAN HELP REDUCE COSTS WHILE IMPROVING QUALITY.

Grand Junction, Colo., a community of about 120,000 people on the western slope of the Rocky Mountains, is a typical American city in many ways, save one: It has produced superior cost and quality outcomes for 35 years that have recently drawn national attention. A Dartmouth Atlas of Health Care study first identified Grand Junction as one of the most efficient medical communities in the nation, rivaling integrated delivery systems like the Mayo Clinic and Geisinger Health System – although most of Grand Junction’s providers are independent. Its average Medicare spending per capita was \$5,900 in 2006, about 30 percent lower than the national average of \$8,300, while its quality ratings were much higher.¹ Subsequent reports by The New America Foundation² and *The New Yorker*³ have highlighted Grand Junction’s achievements and even prompted President Obama to pay a visit to the area last year.

As leaders in the Grand Junction medical community, we are often asked: What is it that makes Grand Junction’s health care community so successful, and can these efforts be duplicated in other parts of the country? Admittedly, our success has been 35 years in the making, and most communities will need time to address cost and quality issues.⁴ Nonetheless, there are steps that individual physicians or groups of physicians can take to begin addressing these issues. The following are examples of how physicians in Grand Junction changed their behavior to produce stellar results.

The first step in controlling costs

It is well known that the United States has the most expensive health care system in the world yet is not on

top in terms of quality.⁵ This highlights the need for greater cost-efficiency, which more and more of your patients are probably realizing as they see their out-of-pocket expenses increase.⁶

The first step you can take as a physician to help reduce unnecessary health care costs in your community is to *understand the actual costs of the services your patients receive*. We recommend that you find out the costs of the following services:

- Recent hospital stays for your patients, whether they were admitted by you or your consultants.
- MRIs, ECGs and other tests that you order, both the technical and professional fees.
- Tests that your consultants order for your patients.
- Tests and endoscopies performed at your hospital, compared with other locations. Hospitals make it very easy to have tests done there, but their charges are sometimes double or triple the charges of outpatient labs or outpatient facilities. Your consultants may even be able to perform some tests in their offices with markedly reduced technical fees for your patients, but don’t expect them to market the savings. You have to ask about it.
- Your consultants’ fees. We looked at our consultants’ cost per hip replacement, hospital days per hip replacement and hospital days per laminectomy, among other measures, and were able to encourage our consultants to adopt more financially responsible practices.

It can be difficult to get financial data. It is not an accident that hospitals do not want you to know how much they charge for their services. We were able to get



Your Medical Community:



the data from a local non-profit health plan. You may have to ask your patients to bring in copies of their bills or their explanation of benefits, which will tell you what the hospital charged and what the payer allowed. In our area, the hospitals bill about 300 percent of Medicare fees.

When visiting speakers recommend their pet procedures and tests to your group, ask what these actually cost (including both the technical and professional components) compared with the alternatives. You may be surprised to find out that they frequently have no idea of the costs of the procedures they recommend. It may help to let them know

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in advance that you expect them to present cost data and that if they don't you will be asking them for it.

Three high-cost areas

As you begin to pay more attention to costs, you'll find that three areas are particularly problematic and require greater attention.

1. Pharmaceutical costs. To manage pharmaceutical costs, learn the costs of the drugs you order and what other options are available. Our health plan and IPA provided our physicians with free personal digital assistants (PDAs) loaded with Epocrates pharmaceutical reference software, which makes it quick and easy to look up cost information and identify generic substitutions.

Also, understand that new drugs are not necessarily better. When any drug becomes generic, the pharmaceutical company will often come up with a "new" version of the same drug (e.g., an extended release version), which essentially gives them another seven years of profit at the higher, brand-name price.⁷

To keep yourself informed of new drugs, find an educational resource that is not a product of the drug industry. Excellent resources are *The Prescriber's Letter*, *The Medical Letter* and Epocrates. We have been lucky to have a knowledgeable family physician and health plan pharmacologist who give regular talks on these issues and publish a local newsletter to keep us informed. As a result, we know when drugs go generic and what "new" drugs the companies plan to introduce to keep us from using those generics. Our IPA pays us to attend these meetings.

Finally, don't see drug reps, don't take samples, and don't accept trinkets. There is good data on how much higher the prescription costs are for doctors who see drug reps compared with those who don't.⁸

2. Hospital costs. To better manage hospital costs, seek out data comparing your performance with that of your peers, and then learn from those who are more cost effective. Our IPA generated reports of our hospital costs – with our names on them – and ranked us. All physicians saw these lists. They were a powerful tool because doc-



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AN AFTERNOON DISCHARGE WILL GENERALLY SAVE \$3,000 OVER A NEXT-MORNING DISCHARGE BECAUSE E/M CODES FOR HOSPITAL INPATIENT AND OBSERVATION SERVICES ARE DEFINED BY DATE.

■ The first step in managing health care costs is to understand how much facilities in your area charge for an ECG, an MRI, a hospital stay, etc.

■ To control pharmaceutical costs, get in the habit of looking up drug prices and identifying generic substitutions.

■ To control hospital costs, seek out data comparing your performance with that of your peers, and then learn from those who are more cost effective.

tors want to be stellar performers. Hospitals have this data as well but are often reluctant to share it, perhaps for fear of offending members of their medical staff who do lots of ordering.

Develop a method to help less cost-effective physicians figure out what they are doing differently from their peers. Are they unnecessarily ordering certain tests on every hospitalized patient with a given condition? Are they keeping patients in the hospital too long? We were fortunate to have a utilization nurse who was very helpful at identifying these issues. In addition, because of our relationship with our health plan, we were able to meet with their claims people and identify cost-cutting strategies. For example, they explained to us that an afternoon discharge will generally save \$3,000 over a next-morning discharge because the evaluation and management codes for hospital inpatient and observation services are defined by the date and midnight marks the beginning of another date of service.

Another way to get doctors to pay attention to hospital costs is to use carrots. Our health plan paid one group \$500 per doctor per meeting to come in early and review the group's hospitalizations for the month. The meetings were led by one of our physicians, and a health plan utilization manager was there to answer questions. This maneuver saved the health plan far more than it spent on the carrots.

We also recommend pressuring hospitals and health plans to help you to be involved in your patients' hospital care. Ask hospitals to record the patient's primary care physician's name upon admission, to notify the primary care physician of the admission and send him or her all lab results, X-ray results, discharge summaries and discharge plans. Having you in the loop is good for both quality and costs.

Lobby health plans to pay you as a primary care physician to see your patients in the hospital even when a specialist has admitted them. Our local health plan pays primary

care physicians to see patients in the hospital, review the care and make a note so the specialists know we are aware of what is going on. If we fail to do this, the health plan lets us know and encourages us to do so. At first, specialists seemed apprehensive about this arrangement, but most of them now realize how much it helps with improved discharge planning and care. They frequently ask us to help with patients' secondary diagnoses. If your consultant resists these ideas, find another consultant.

3. End-of-life care. Patients with advanced illness often spend too much time in the hospital during their last days. This is not only needlessly expensive but also not what the patient and family want in most cases.

To manage end-of-life costs, you must find a reliable hospice program in your area that will communicate and coordinate well with local physicians; educate physicians on the rules governing hospice, ways to use hospice and the importance of timing of hospice enrollment; and educate the hospice staff on the best ways to communicate and work with your practice.

Evaluate the physicians in your group on their effectiveness at end-of-life directive discussions – not how they do it, but whether they do it. Documentation of this discussion is part of our performance reviews. Be certain it is part of your routine medical care.⁹

Finally, get feedback on your behavior with regard to hospice referrals. You need to know such things as the average number of days prior to death that you enrolled your patients and compare this number with that of your peers, and be certain you are enrolling patients at the best time for them to receive optimal hospice care.

The importance of data and incentives

The need for having a reliable information system in the community that allows physicians to actually see their cost and quality data cannot be overstated. In Grand Junction, the

local health plan helped pay for the cost of setting up disease registries in our practices. These systems allow us to track key indicators for conditions such as diabetes and asthma and help us better manage the care of patients with these conditions, which in turn reduces unnecessary hospital admissions. The data also allow our physicians to see how their performance compares with that of their peers, which is a powerful motivator. The IPA has also used an incentive pool of funds provided by the health plan to reward different physician behaviors, depending on clinical priorities. We have never known for sure whether the money or the desire to not be at the bottom of the list is the more effective incentive.

What we do know is that most physicians want to do a good job for their patients and do not want to see health care resources wasted. With supportive consultants and appropriate financial data, primary care physicians can significantly influence cost while improving quality. Grand Junction is proof of this fact. **FPM**

Send comments to fpmedit@aafp.org.

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Identifying a reliable hospice program and establishing end-of-life directives are key to reducing costs related to end-of-life care.

Both bonuses and performance data can be powerful motivators.

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