FEATURE STORY

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lessons learned from implementation of gainsharing

Gainsharing programs administered by two hospital associations illustrate how best to implement such a program to control costs through the payment of incentives to physicians.

AT A GLANCE

- Gainsharing offers a hospital a way to control costs by using incentive payments to engage physicians in efforts to improve cost and quality performance.
- Author John Kotter's eight stages of change management can serve as a framework for understanding how the New Jersey Hospital Association and the Greater New York Hospital Association have guided the successful implementation of gainsharing.
- Successful gainsharing fosters a culture of improvement that capitalizes on the creativity, knowledge, and problem-solving ability of physicians to implement change and create added value.

In an era of accelerating healthcare reform, population health management represents a new mode of operation for the industry. Some organizations are transitioning to the new business model by investing in legal and organizational infrastructure—adding new components, contracting to supply new services, and reorganizing internal responsibilities. However, in addition to enacting structural change, hospitals should be transforming their cultures to succeed in a payment system that is based on value, not volume.

Shared-savings programs (e.g., accountable care organizations [ACOs]) typically reduce payments with the aim of encouraging providers to care for patients in the lowest-cost appropriate setting and to eliminate services that are not medically necessary. Payers then give the providers a share of the savings that are realized.

How can hospitals encourage physicians—the people actually responsible for resource decisions in patient care—to deliver care with the quality and efficiency required by the new healthcare paradigm? A gainsharing program enables hospitals to control costs through the direct payment of incentives to physicians based on cost and quality performance (see the sidebar on page 2).

Beginning in 2006, large-scale gainsharing (i.e., encompassing all costs associated with all inpatient cases) was successfully deployed in hospitals caring for Medicare, Medicaid, and commercially insured populations in several states. Notably, the Agency for Healthcare Research and Quality (AHRQ) reports that a three-year Medicare gainsharing demonstration at 12 New Jersey hospitals, administered by the New Jersey Hospital Association

Holding Down Costs

Gainsharing focuses not on revenue streams, but on care redesign and cost reduction. Examples of short-term cost reduction opportunities driven by gainsharing include reduced length of stay, more efficient supply chain management, and improved adherence to pharmacy protocols. Long-term initiatives focus on patient management. For example, optimizing active bed management in the intensive care unit—i.e., transitioning patients to step-down units or med/surg floors when appropriate—not only lowers marginal costs but also increases the availability of clinical resources to facilitate throughput from the emergency department.

(NJHA), generated $113 million in savings and reduced costs per admission by 8.5 percent.[a] Quality measures either stayed the same or improved. A gainsharing program first implemented at Continuum Health Partners (now Mount Sinai Health System) in 2006 and later administered by the Greater New York Hospital Association (GNYHA) achieved a similar decrease in costs per admission in commercially insured populations at participating hospitals.[b] The Hospital and Health System Association of Pennsylvania and the Maryland Hospital Association began the process of implementing gainsharing approaches with their members in late 2014, as did Oklahoma-based Integris Health.

Gainsharing can transform an organization's cultural foundation by directly aligning hospital and physician incentives. Although financial incentives are the most visible and measurable element, they are only part of the equation. A shared strategic vision, implemented through change-management processes, is essential to sustain new and altered clinical and administrative activities.

a. Agency for Healthcare Research and Quality, "Hospital Gain-Sharing Program Offers Incentives to Physicians Based on Their Efficiency, Producing Significant Cost Savings Without Decline in Quality," AHRQ Innovations Exchange, March 17, 2014.
b. Leitman, I.M., et al., "Quality and Financial Outcomes from Gainsharing for Inpatient Admissions: a Three-Year Experience," *Journal of Hospital Medicine*, November-December 2010.

Driving Success in Gainsharing

The details of a large-scale gainsharing program are beyond the scope of this article. Instead, we focus on the factors that are most important to success. We used the venerable eight-stage process of creating major change introduced by John Kotter in 1995 (*Leading Change*, Boston: Harvard Business Review Press, 2012) as a framework to document key lessons learned from the associations that administered gainsharing programs and the hospitals that implemented them.

Establish a sense of urgency. Beyond the pervasive message that hospitals need to cost less, urgency to innovate in health care comes from specific signals being sent by the government, payers, regulators, and patients. However, we suggest adding a corollary about persistence to Kotter's first point about urgency.

For example, some industry observers saw the need to include a physician component in Medicare's DRG-based inpatient prospective payment system (IPPS) when it was developed in the late 1970s and implemented in the early 1980s.[c] However, the political will had not emerged to embrace a larger system that would include physicians. Over time, the success of the Medicare IPPS showed that providers could deliver care more efficiently without compromising quality. Anticipated payment reductions and other economic factors paved the way for the alignment of incentives between physicians and hospitals.

In 1999, NJHA began talks with the Health Care Financing Administration (the forerunner to the Centers for Medicare & Medicaid Services [CMS]) to implement a large-scale Medicare gainsharing demonstration. NJHA recognized that there would be ongoing pressure from all payers to reduce hospital payments and that providers needed a tool to effectively reduce costs. A waiver was granted in 2004, but several nonparticipating New Jersey hospitals sued CMS for the right to join the

c. Quin, K., "After the Revolution: DRGs at Age 30," *Annals of Internal Medicine*, March 18, 2014.

demonstration, specifically challenging the participation cap of eight hospitals. (It also was determined that additional waivers were needed.) NJHA and CMS worked to persuade Congress to enact legislation that waived certain requirements and allowed more hospitals to participate in the program. Eventually implemented in 2009 with 12 hospitals, the demonstration fostered a dialogue and genuine collaboration between hospitals and physicians, many of whom were initially skeptical. It successfully lowered costs while maintaining and often improving quality, according to the AHRQ report.

Create a guiding coalition. Implementing innovative processes and programs may raise anxiety about the risks inherent in making significant changes. Overcoming this hesitancy requires that a few individuals initially adopt the innovation and then spread the word. Kotter notes the importance of establishing a group with enough authority and credibility to guide efforts.

In the New Jersey gainsharing demonstration, a guiding coalition of 12 hospitals working with NJHA was able to overcome the perception of risk and create momentum for the program. NJHA was able to guide the approach with more deliberation, control, and precision than an individual hospital would have been able to exert, thereby providing credibility and confidence to regulators who had concerns. Based on the NJHA program's initial success, CMS expanded the program as part of Model 1 of the Bundled Payments for Care Improvement (BPCI) initiative.[d]

Develop a strategic vision. The underlying problem of escalating healthcare costs cannot be resolved without first aligning provider interests under a common strategic vision. Such alignment requires effective collaboration between physicians and hospitals.

Although financial incentives are at the core of gainsharing, the idea is not for hospital executives to give physicians money to do what the executives want. Such an approach would not produce sustainable change. Instead, the NJHA-led gainsharing demonstration was seen as a framework to align the overall vision of hospitals and physicians using standardized data, best practices as determined by the hospital and medical staff, and focused internal discussion. It was important to harness the financial incentives—as defined and administered uniformly through a collaborative process involving hospitals, medical staff, and the government—to meet the unique priorities of each institution.

When proposing the program, NJHA spelled out a vision: "To enhance the quality of patient care through commitments to care redesign and quality initiatives; and to reduce the cost of care by eliminating medically unnecessary services." The association organized and invested in a process designed to meet the concerns of regulators, hospitals, and physicians. The resulting program was designed to be objective, credible, auditable, replicable, minimally disruptive, flexible, and attractive to physicians.

NJHA consistently reinforced this vision and strategy through the initial demonstration and subsequently during its participation in Model 1 of the BPCI initiative.

Communicate the vision for change. Gainsharing works best when internal champions communicate the vision and benefits. For this reason, it should be implemented from the inside out by a hospital steering committee charged with identifying, prioritizing, and coordinating hospital-specific gainsharing initiatives to engage medical staff and provide "hands-on" governance. The committee should be composed of administrative leaders, a public representative who has no formal affiliation with the hospital, and physicians, who should constitute at least 50 percent of the membership. The committee should provide a venue for physicians who will champion the initiative, creating a feedback loop that allows for continuous fine-tuning based on practical experience. For example, physicians on the committee can share with other committee

d. "How a N.J. 'Gainsharing' Program Pioneered Bundled Pay," *The Daily Briefing*, The Advisory Board Company, Feb. 21, 2013.

members any ideas and concerns that have been raised by their peers.

Each hospital steering committee in the New Jersey demonstration was directed to identify and prioritize quality-of-care initiatives, support patient safety, and develop care redesign measures customized to meet the specific needs of the institution. A steering committee should establish incentive payments based on these sorts of goals, and may terminate the participation of physicians who fail to comply with program guidelines.

Empower physicians to take broad-based action. Although the primary goal of gainsharing is to bend the cost curve, it also should empower physicians to drive change.[e] Physicians will be motivated by the financial incentives, but gainsharing should appeal to their pride in their clinical accomplishments. Physicians in a gainsharing program should be encouraged to initiate positive change in care processes using a reference point of best-practice norms developed from statewide or regional severity-adjusted data. These best practices reflect the performance of physicians treating the same kinds of cases at lower costs with equal or better outcomes.

In the New Jersey demonstration, all participating hospitals received hospital and physician data. For example, physician reports showed actual versus expected length of stay, actual versus best-practice costs, and the incentive available and attained for each case. The reports revealed areas of operation that required effective hospital-physician collaboration, which was coordinated through the steering committee. Other changes required only that physicians use their day-to-day experience and creativity to develop solutions that could improve the cost efficiency of their practices.

Generate short-term wins. Large-scale gainsharing should use practical implementation approaches that enable hospitals to endow incentive payments to physicians within nine months, and every six months thereafter. The author Charles Duhigg describes short-term wins as contributing to "keystone habits."[f]

Contrast gainsharing with ACOs and bundled payment programs, in which savings may not flow to participating providers until 18 months to two years after implementation and payment methodologies may be complex and uncertain. Gainsharing is more likely than those programs to help leadership create short-term wins, build "keystone habits," and leverage momentum to support longer-term strategies. Moreover, the wins are unambiguous, with incentives based on a well-defined, objective, pre-established methodology that is visible to all medical staff. The incentives tie directly to achieved levels of performance, as well as cost and quality improvement.

The experience of NJHA suggests that maintaining momentum, keeping physicians engaged, and building success can convert internal critics of the program. Facilities typically have found that physician participation in gainsharing reaches 70 to 80 percent of covered admissions. The exhibit on page 5 shows how hospitals participating in the New Jersey gainsharing demonstration accelerated cost savings over time after ramping up the program in the first two periods.

Consolidate gains and produce more change. Although gainsharing focuses on inpatient care, its success can be used as a foundation for hospital strategies that involve more risk—such as participation in ACOs, patient-centered medical homes, or bundled payments. Those initiatives require complex analytics, new legal structures, and a strong level of commitment by medical staff. The experience from a well-implemented, productive gainsharing program can help build credibility, trust, and confidence.

e. Amabile, T.M., "Motivational Synergy: Toward New Conceptualizations of Intrinsic and Extrinsic Motivations in the Workplace," *Human Resource Management Review*, Autumn 1993.

f. Duhigg, C., *The Power of Habit: Why We Do What We Do in Life and Business*. New York City: Random House. 2012.

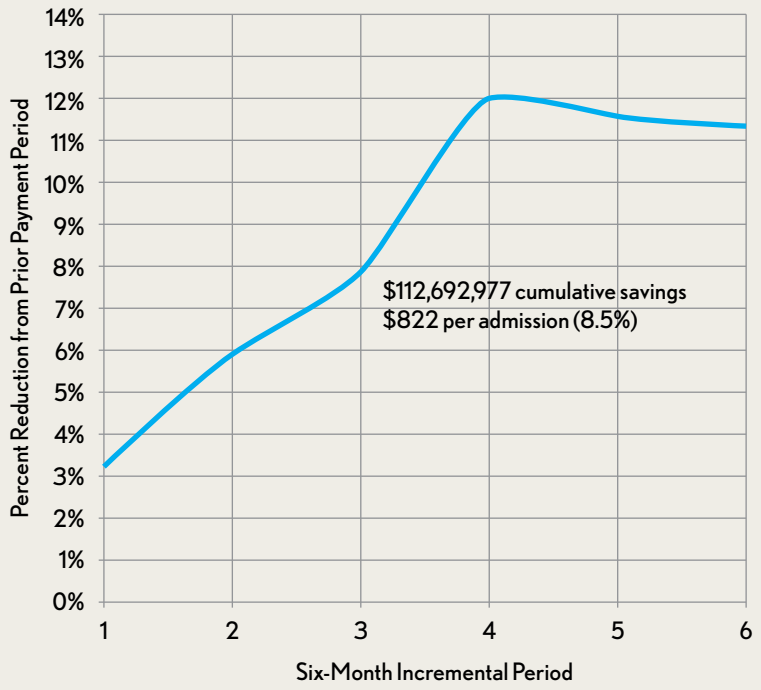
Inspira Health Network in southern New Jersey independently built on the success of its participation in the NJHA gainsharing program to create an employee ACO, which established the bonus pool for distribution to primary care physicians based on savings. Inspira initiated its bonus pool in June 2013, with the first payments made in the fall of 2014. The organization also adopted the federal Program of All-inclusive Care for the Elderly (PACE), a comprehensive managed care program that provides lifetime services to nursing home-eligible frail seniors. Involving interdisciplinary teams of physicians in acute care, long-term care, and chronic care, the PACE program provides comprehensive medical, rehabilitative, social, and support services in an effort to lower costs and meet the needs of families and patients. Inspira leveraged the long-term success of the gainsharing program to invest resources in the employee ACO and in PACE.

Anchor new approaches in the culture. Although hospital strategy increasingly is focused on outpatient care and population health, inpatient acute care continues to shape the hospital culture and forms the foundation of more profound changes.

At NYU Langone Medical Center, the gainsharing program implemented under the GNYHA initiative triggered a significant increase in the response and engagement of the medical staff. During the first six-month period, more than 80 percent of eligible physicians participated, achieving a 4.3 percent reduction in cost per admission along with decreases in readmission and mortality rates.[g] In addition, in those first six months, the hospital:

> Resolved problems related to the large-scale implementation, operation, and administration of gainsharing
> Achieved improvements in efficiency
> Promoted patient safety and quality of care
> Provided support for care redesign

COST REDUCTION OVER TIME FOR HOSPITALS IN THE NEW JERSEY HOSPITAL ASSOCIATION GAINSHARING PROGRAM (2009-12)



Source: Agency for Healthcare Research and Quality, "Policy Innovation Profile," 2014.

Data are from 1,112 physicians and 137,573 admissions, and were adjusted for inflation, case mix, and severity of illness.

Building on those results, NYU Langone formed a clinically integrated network (CIN) to expand on its strong relationships with physicians and capitalize on the redesigned care management infrastructure to reduce costs, improve quality, and provide a better experience for patients throughout the system. The CIN, in turn, became the bedrock of a collaborative accountable care initiative launched with Cigna and the University Physicians Network.[h]

Culturally, physician alignment in inpatient care provided the core for building more sophisticated structures. The gainsharing program was seen to encourage greater alignment between NYU Langone and the medical staff, and placed organizational focus on achieving high-quality outcomes in the most cost-effective way.

g. Seligman, D., and Chorney, G.S., "Aligning Physician and Hospital Goals Through Gainsharing," *AAOS Now*, August 2013.

h. Punke, H., "25 Recently Announced ACOs," *Becker's Hospital Review*, Aug. 8, 2013.

Core Improvements

Gainsharing fosters a culture of improvement that capitalizes on the creativity, knowledge, and problem-solving ability of the physician to implement change and create added value in an era of healthcare reform. The structure of the program also provides for institutional collaboration that amplifies both the process and the results. Kotter's change-management steps provide a useful framework for ensuring that gainsharing continues to encourage improvement and sustain high-quality performance. ■

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DASHBOARD

General Hospital

Prior - January 2010 through June 2010 and Current - July 2010 through December 2010

Non PAR - NPI Accuracy not Verified

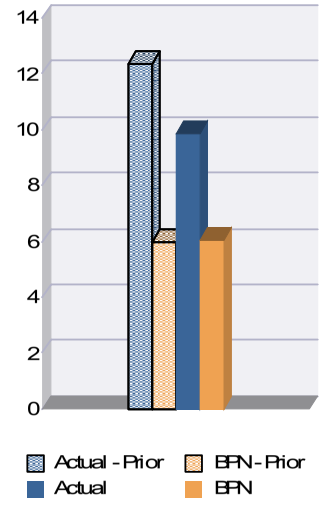
Analytics

Responsible Physician	**0000000001**	**Specialty**	**Surgery/Colo/Rectal Surgery**
Physician's First Name		**Physician's Last Name**	

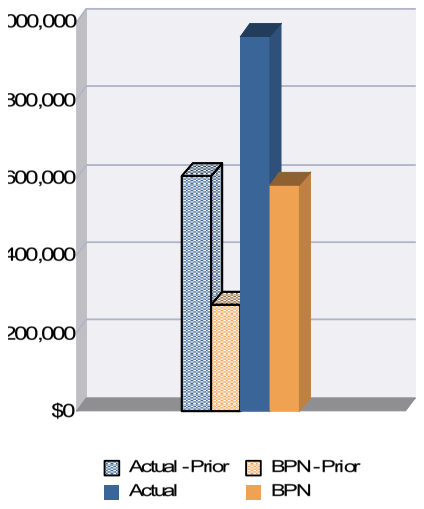
QUICK STATISTICS	Cost		Average LOS		INCENTIVE	Performance		Improvement		Total	
	Prior	Current	Prior	Current		Prior	Current	Prior	Current	Prior	Current
Your Information	$604,092	$962,797	12.35	9.85	**Maximum Incentive**	$4,933	$10,347	$9,750	$20,584	$14,683	$30,931
Best Practice Norm (BPN)	$274,061	$581,886	6.00	6.06	**Your Incentive**	$575	$2,736	$0	$2,534	$575	$5,270
Variance	$330,031	$380,911	6.35	3.79	**Unearned Incentive**	$4,358	$7,611	$9,750	$18,050	$14,108	$25,661

Admissions by Complexity Level (SOI)										
	Current	SOI 1:	12	SOI 2:	14	SOI 3:	15	SOI 4 :	7	Total: 48
	Prior	SOI 1:	4	SOI 2:	8	SOI 3:	7	SOI 4 :	4	Total: 23

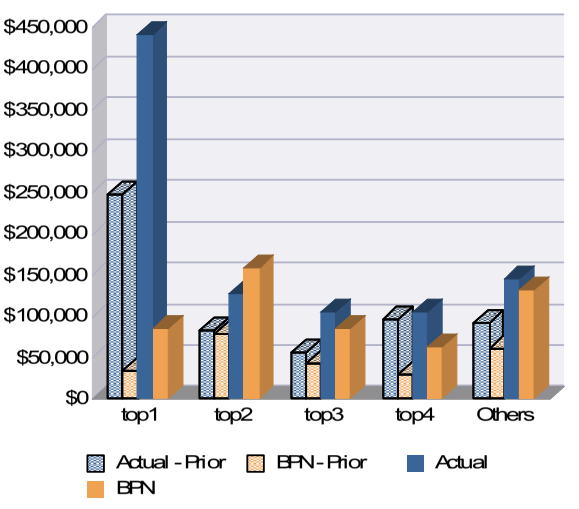
LOS Summary



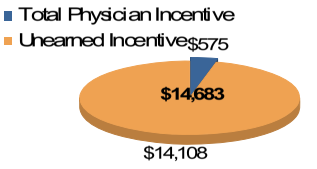
Cost Summary



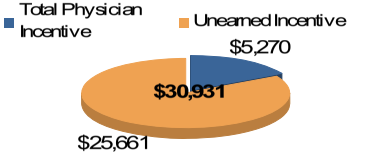
Top Cost Centers



Prior



Current



Cost Center Summary		Your Cost		BPN		Variance	
		Prior	Current	Prior	Current	Prior	Current
Top1	Intensive Care Units Cost	$248,927	$442,456	$34,518	$86,086	$214,409	$356,370
Top2	Adult-Peds Room Board Cost	$83,933	$128,709	$78,295	$159,248	$5,639	$-30,539
Top3	Operating Room Cost	$56,178	$105,458	$43,884	$86,268	$12,294	$19,190
Top4	Med/Surg Supplies Sold Cost	$97,035	$104,980	$30,364	$63,034	$66,671	$41,946
Top5	Laboratory Cost	$22,462	$40,248	$12,964	$27,190	$9,498	$13,058
Top6	Drugs Sold to Patients Cost	$21,254	$38,044	$22,590	$48,273	$-1,336	$-10,230
Top7	Radiology Cost	$18,556	$22,957	$10,218	$22,928	$8,338	$29
Top8	Recovery Room Cost	$13,417	$22,663	$9,877	$19,159	$3,540	$3,504
Top9	Respiratory Therapy Cost	$6,446	$11,747	$4,508	$13,087	$1,937	$-1,339
Top10	Ambulatory Surgery Center Cost	$9,675	$10,063	$740	$1,499	$8,935	$8,564