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Aligning Physician and Hospital Goals through Gainsharing

Program helps improve outcomes, reduce costs

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As health systems and providers adapt to evolving regulations and post-reform challenges, opportunities to develop greater alignment have become a major driver in the healthcare industry—providing better patient outcomes, improving system-wide efficiency, and reducing the cost of care.

Efforts to improve quality and resource efficiency are under way at hospitals across the country, but misalignment between hospitals and physician groups through disparate payment systems may present a barrier in reaching these goals. Physicians are primarily paid on a "fee-for-service" basis while hospitals are reimbursed on a "case rate," or evolving "episode rate" basis. The disconnect arises because physicians are reimbursed based on the number of services provided, while hospitals are increasingly being rewarded for achieving high-quality outcomes in the most cost-effective way.

Hospitals need to engage and reward physicians to prioritize both safe, high-quality, patient-centered care and cost efficiency. Hospitals also need to provide physicians with benchmarking data that indicate how they perform against their colleagues in achieving high-quality and cost-efficient outcomes.

At NYU Langone Medical Center in New York City, physicians have been invited to participate in a gainsharing program that encourages greater alignment of goals. The program promotes a collaborative environment that aligns physician and hospital priorities and helps providers prepare for federal and commercial reimbursement programs focused on value-based purchasing.

Program overview

The NYU Langone Medical Center gainsharing program is based on a partnership with Applied Medical Software (AMS), a healthcare consulting firm that developed the program's framework. AMS has implemented this program in 43 other hospitals in New York and New Jersey, with measurement methodologies that are consistent at each participating hospital.

Due to legal and regulatory considerations, Medicaid and Medicare fee-for-service patients are excluded from the program. All discharged patients from NYU Langone Medical Center insured by a commercial payer (including patients with Medicare and Medicaid HMO coverage) are analyzed for incentive consideration.

To secure physician buy-in, the program is structured with no downside financial risk for physicians. Physicians are not penalized for high-cost outlier cases and, at the end of each period, only cases that met minimum criteria to earn incentive have a financial impact.

Involvement in the program is strictly voluntary; active physicians can end their participation at any time. Participating physicians are provided with reports summarizing their case-level performance every 6 months.

Measurement

The AMS program methodology analyzes case-level data against statewide benchmarks by compiling inpatient records from all hospitals and separating discharges by All Patient Refined Diagnosis-Related Groups (APR DRGs). This system also assigns a severity level to each discharge—1 (minor), 2 (moderate), 3 (major), or 4 (extreme)—depending on the patient's comorbidities and pre- or postoperative complications.

After separating the APR DRG cohorts, a Best Practice Norm (BPN) is derived by identifying the 25th percentile for lowest direct cost and length of stay among New York state hospitals. For example, all discharges statewide that meet the criteria for APR DRG 301, severity 1 are compiled, and the most efficient quartile for direct cost and length of stay are captured as the BPN for that particular classification.

The program then evaluates physician-level activity in two distinct ways—performance and improvement.

The performance evaluation analyzes each eligible discharge against the statewide BPN for the particular APR DRG and severity classification. Physicians can maximize their earned performance incentive by achieving or exceeding the BPN. Physicians can earn a piece of the performance incentive for achieving results near, but not at, the lowest quartile.

The improvement incentive is based on the physician's own performance. Discharge activity during a 6-month program cycle is compared against performance from prior periods. During the initial program cycles at NYU Langone Medical Center, one third of the maximum incentive opportunity was based on performance and two thirds was based on improvement.

This split between performance and improvement provides opportunities to all participating physicians. Physicians who historically focused on cost efficiency were positioned to earn a strong performance incentive from the start of the program. However, because they already had high levels of cost efficiency, these participants would be challenged to collect a significant improvement opportunity. On the other hand, physicians who had historically been high-cost

providers would initially collect very little or no performance incentive but had a significant opportunity to collect improvement incentives as they became more cost-effective providers.

Most importantly, earned incentives can only be collected if the physicians maintain or improve on several quality metrics that would ensure NYU Langone's cultural focus on patient safety and clinical excellence. These quality metrics include the following:

- mortality rate
- 7-day readmission rate
- 30-day readmission rate
- surgical site infection rate
- hospital-acquired venous thromboembolic events
- medication reconciliation
- patient satisfaction-related HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) measures

Program governance
An executive steering committee of clinical and administrative leaders along with select participating physicians provides onsite strategic direction for the program. This group is responsible for determining which quality measures are included and for setting the balance between performance and improvement incentives. Most importantly, the group prioritizes identified cost savings opportunities and engages colleagues.

Each participating hospital must designate a program coordinator as an onsite liaison to AMS. This coordinator is responsible for ongoing program maintenance, physician recruitment and engagement, identification of cost reduction opportunities, and development of intervention implementation strategies.

Identifying opportunities
Through effective collaboration, participating physicians and hospital administrations have identified opportunities to encourage cost-conscious, efficient quality care. Identifying opportunities is an ongoing process based on analyses of variations in clinical quality and cost efficiency.

At NYU Langone Medical Center, the first focus area is length of stay (days and care setting). Ensuring that patients who require a higher level of care in an intensive care unit setting are transitioned to a lower level of care as soon as they are clinically stable enough to be transitioned meets the program goals of maintaining cost efficiency with a focus on clinical quality.

To support participating physicians, involvement from registered nurse case managers and social workers is key. For surgical patients in particular, efforts are made to determine an

expected length of stay prior to a patient's admission. Determining a planned discharge date prior to admission allows the entire care team to communicate consistently with the patient and family. It also allows the team to focus on achieving key milestones, such as meeting particular ambulation targets at different points throughout the admission.

A second focus is on resource utilization. This includes evaluation of appropriate lab orders and marginal but costly diagnostic imaging studies, both in terms of frequency and type of test or modality ordered. Similarly, with perioperative services, developing workflows and procedures to achieve efficiency on room turnover, as well as patient prep and drape time, can decrease overall case time, reduce case cost, and improve physician satisfaction.

The third major category focuses on product selection. Defining evidence-based criteria for use of particular medical and surgical supplies can be a major cost-savings opportunity. For example, the range of expense for a total joint implant is significant. Developing patient criteria for use of high-cost and low-cost implants drives appropriate utilization. Similarly, establishing a drug formulary that prioritizes use of generic medications when clinically appropriate is key.

Each opportunity for improved efficiency or cost effectiveness must take into account potential effects. They must make decisions with the primary focus on achieving the best possible clinical outcome. Physicians need cost information that enables them to consider alternatives when making clinical decisions. When they understand the costs of clinically comparable alternative products, different room and board expenses, and variable labor expenses, they can make sound clinical and cost decisions that will best support their patient care efforts.

Organizational impact

NYU Langone Medical Center began participating in the program in late 2011. During the initial 6-month program cycle, the response and level of engagement from the medical staff were overwhelming. More than 80 percent of the eligible physicians elected to participate. Evaluation of the discharge activity of participating physicians (excluding Medicare and Medicaid fee-for service patients) identified a 4.3 percent reduction in case-mix adjusted cost per admission and a 3.7 percent reduction in length of stay.

During the initial 6-month program cycle, the hospital also experienced improved clinical quality scores, based on an analysis of discharge activity. For example, the 7-day readmissions dropped by 7.2 percent; 30-day readmissions fell by 16.1 percent. Case-adjusted mortality rates fell by 7.9 percent.

Conclusion

Although the initial results are encouraging, continued collaboration between the hospital and the medical staff will determine the degree to which meaningful cost savings can be realized. Based on initial findings, the program encourages greater alignment between the hospital and the medical staff and brings organizational focus on achieving high-quality outcomes in the most cost-effective way.

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