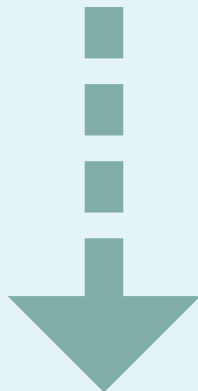


**Transformational change  
in health care:**

*Identifying  
the current state and future state*



*by*

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To say that the U.S. health care system is unsustainable is no longer just rhetoric or theory. Surgeons feel the impact through decreased reimbursements, increased paperwork, and less time available to thoughtfully interact with patients. Furthermore, surgeons see their work environment deteriorating, and it is tempting to believe that they are feeling the brunt of efforts to control spending. In reality, however, all health care stakeholders—patients, businesses, insurers, and other providers—are feeling the impact of this unsustainable system.

Working within the current framework, all stakeholders are recognizing that only partial, short-term, and often frustrating changes are possible. Instead of trying to patch a broken system, transformational change must occur and deliver a new health care framework. This future system must include marked improvement in quality, a payment system that rewards providers for the best care for each patient, and reduction in per-capita spending.

Will the future be defined by slight alterations of the current system or will there be transformational change that leads to a very different health care system? In this article, we will examine the current state and the future state of U.S. health care. We will look at the impact of the current state on all stakeholders and break down the opportunities for change into specific domains. Through this exercise, we hope to gain some clarity about what the optimal future state for surgery (as a component of the larger system) would look like.

### ----> **Current state overview**

Frustrations with the current state of U.S. health care are everywhere. Patients see their health care benefits eroding, becoming increasingly costly, or disappearing altogether. The relationship between patients and providers is deteriorating as patients feel the impact of providers' increasingly busy schedules. Businesses are finding it more difficult to provide health care benefits and many are forced to pass on more of the premium costs to their workers or to consumers by way of the cost of their products. General Motors adds \$1,500 to the cost of every vehicle to cover health care costs for retirees,

employees, and their families.<sup>1</sup> U.S. businesses cannot continue to grow and expand with health care benefits undermining their business models when compared with other global enterprises. Corporate America is losing ground on global competition, and health care is one of the reasons.

Health insurance companies are feeling the impact, too. Businesses look to their health insurance companies to keep health care costs down, which, in turn, leads insurers to impose restrictions and measurement systems on providers. As employers become increasingly unhappy with the results, large businesses are choosing to self-insure or limit agreements with private health insurance companies.<sup>2</sup> This is forcing insurers to implement complex systems to limit expenditures or to become third-party administrators of employer-based insurance. Under the current system, none of the stakeholders are “winning,” and all are becoming increasingly frustrated in fighting a losing battle.

Current and past efforts to rein in spending are not achieving the goal. Government attempts to control growth in Medicare spending, such as the sustainable growth rate (SGR) system, are not improving our health care system but are instead making the system increasingly unsustainable. As the SGR drives down payments per visit and per procedure, providers increase volume and intensity to maintain their income levels or limit their clinical practice to viable business models rather than to necessary clinical care.

Under the current system, payments are distributed with little regard for the appropriateness of the treatment or the quality of care delivered. The inconsistency of payments among procedures leads physicians and hospitals to focus on high-margin areas without understanding the real needs of their patient population. Many have heard the old adage of “no margin, no mission.” Health care capacity, including providers and infrastructure, is increased in these high-profit areas, and research shows that once capacity is in place, it will be used, leading to exponential growth in health care spending.<sup>3-5</sup> Our system is often driven by the supply of services available rather than by the community's need for services. Problems regarding medical malpractice result in excessive testing and overuse

of services to protect providers well beyond the evidence-based needs of the patients.

Providers who try to increase efficiency and communication are actually penalized with lower income. Preventative care with long-term quality of life and cost benefits are not rewarded by our current system, which cares for the sick and not the healthy. In addition, the consistency of evidence-based care delivery is lacking, and there are serious disparities by region, race, and socioeconomic level.<sup>6,7</sup>

The situation sounds dire, but it is only through our understanding of the current state that we can begin to envision the elements of our future state. Each of us likely feels a sense of urgency, but the problems seem beyond our individual reach. Small tweaks to the current system are not going to solve the problem. How do we begin to frame our problems and seek solutions?

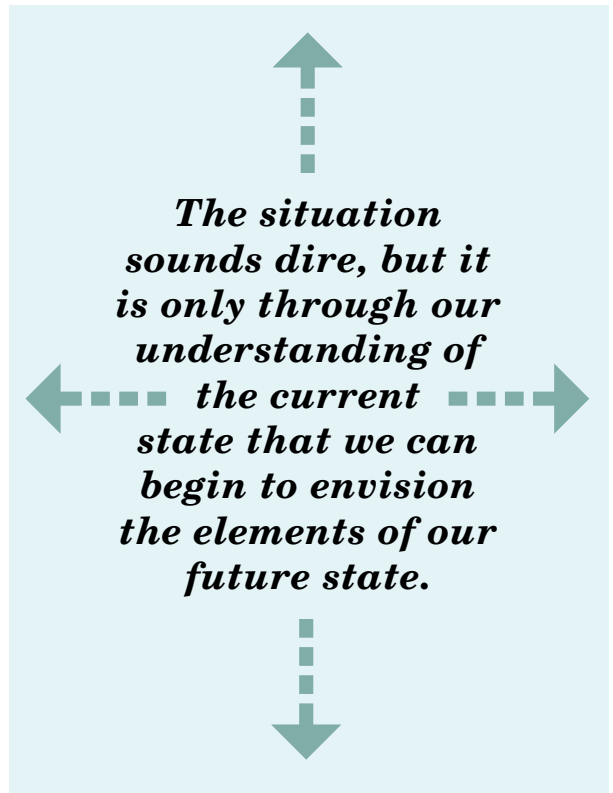
### ---> Domains of change

#### ***Patient-centeredness***

Most surgeons believe that we operate in a patient-centric system. But is this accurate? Have we asked our patients about their surgical experience? Do we know our wait times for appointments?

Patients struggle to navigate the health care system. For some, the experience is filled with stress and anxiety. For most, it is filled with inefficiency and frustration. Seeking care takes time away from work. Once patients arrive at the appointment, they often wait for long periods of time before they are seen by the physician. Once they are seen, surgeons discover that critical information such as laboratory results or imaging information is unavailable. Decisions are delayed, second appointments are scheduled, and patients are left in limbo. The inefficiencies cost patients lost wages and employers lost productivity.

Most office hours are based on the provider's preferred schedule instead of times that are most convenient for patients to have an appointment. When patients need primary care after regular hours, they must visit an emergency room. This outcome is wasteful for the system and inconvenient for the patient.



Patients often do not have ownership of their health and health care. Instead, ownership is deferred to the provider. Suppose the surgeon decides that the patient is a surgical candidate. Our current practice model offers the patient informed consent, but is this truly shared patient decision making? Data suggest patients are not always informed of all their nonsurgical options, and that, if they had been informed, they would have made different choices.<sup>8</sup> Currently, there is little effort toward educating patients beyond the legal requirements in an effort to help them understand the risks and benefits of treatment or, perhaps more importantly, the comparative effectiveness of several options.

The consequence of this lack of patients' empowerment and information about their care is that they then make faulty assumptions, including that more care equates to better care or that more expensive care is higher-quality care. We often excuse our current model with a sense that patients do not wish to understand all the detailed

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decisions. But perhaps we have not presented the choices in a manner that engages them.

Most patients do not have access to their health records. And, as this article will discuss later, if the patients have multiple providers, their treatments and conditions are not being effectively communicated among settings of care. Following discharge from the hospital, patients are often confused about their instructions and unclear about whom to call if problems arise. Better communication with patients following discharge should lead to lower readmissions, which are costly for the system and dangerous for the patient.

At the heart of transformational change in health care is a shift in focus from the providers to the patients. The future state should put the patient at the center of the framework. Appointments could be scheduled directly by patients through online services. Appointment options would be available during evenings and weekends to increase convenience for patients and their employers. To keep costs down and increase access, new models that encourage nonphysician providers to administer basic care should be encouraged.

This shift affects surgeons in a variety of ways, including the rise of new communication models and additional time with patients. Surgeons will be asked to improve their communication and collaboration skills. Care transitions and handoffs will be a strong focus with surgeons expected to relay information quickly and effectively to other providers. Surgeons will also have a new focus on what the individual patient needs and wants. As we will describe in the following paragraphs, the future state will encourage and reward surgeons for performing surgery when optimal and choosing another course of action when surgery is not appropriate. Those decisions will be based on evidence-based guidelines and conversations with patients. The episode of care would be less about 90 days of global care and more about valuing the patient experience, the quality and outcomes of a surgical decision.

### ***Quality and public reporting***

Although no provider likely believes that he or she is providing substandard care, studies show that there is room for improvement. A study by RAND found that roughly 50 percent of evidence-based care is delivered for 30 common conditions.<sup>9</sup>

Can surgeons today reflect on all their cases for the last five years and report on their overall morbidity, readmits, or mortality? Without a repository and standardized collection of data, would it be accurate? When data are collected, patterns of care and problems are easily visible. The data allow us to find gaps and variances in care.

Current efforts to measure the quality of care being delivered are limited. Most programs are being administered by one stakeholder using data from billing systems (such as a health insurance company) and are focused on individual providers, making it difficult to reliably evaluate the quality of care being delivered. Efforts are also limited by the lack of electronic records and meaningful performance measures. Current measures, such as those being used in Medicare's Physician Quality Reporting Initiative, are basic process measures that provide little insight for the physician or patient into how to improve quality.

At the center of the quality improvement transformation is the question of whether surgeons are going to lead efforts to measurably improve surgical care or are they going to have it done to them? Obviously, efforts led by surgeons have the potential to be more meaningful and successful. However, to achieve that success, surgeons must understand that the future state looks very different. Quality improvement must be transparent and available to the public in a format that is easily understandable. Designing these programs will require input from all stakeholders to ensure that multiple perspectives are being addressed. It is only through a concerted effort among stakeholders that providers will benefit from a single measurement system instead of multiple systems for multiple stakeholders.

Many surgeons view the current quality measures as primitive and believe that insurer-based measures are forced upon them with little buy-in that they are meaningful. As the performance measurement field matures, breakthroughs in meaningful measurement will occur. Electronic capture of data will reduce the burden of data collection for performance measurement and give providers the ability to examine their entire patient population.

Quality improvement is done at the local level, and to be successful, surgeons must take ownership of their quality programs. They must work with the hospital and the community to assess the

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current state of surgical care and define measures that will drive improvement.

### ***Efficiency and value***

For many, it is hard to think of efficiency as a necessary component of our health care system, because it is often equated with rationing. However, a focus on quality is not about rationing care. It is about providing appropriate, high-quality care for each patient in the most cost-effective way—and this means working with patients to make informed choices about their medical care. Perhaps it is inappropriate and inefficient to put a \$12,000 hip prosthesis into a nonambulating, 90-year-old woman. Such scenarios should make us question whether we have a true appreciation for the quality and the cost of the services we provide and, more importantly, their effect on the system.

The other side of efficiency is eliminating waste, which can include duplicate testing as well as unnecessary appointments and hospital admissions. Studies show that systems that provide more care actually have slightly worse outcomes than their counterparts.<sup>10,11</sup> Contrary to the concept of rationing, providing the right amount of care actually leads to better outcomes than does over-treating patients.

To improve the efficiency of any system, both providers and patients need to be educated and accountable for their expenditures. Under the current system, the only accountability for putting in that \$12,000 implant is from the insurance company. In the future system, incentives for all stakeholders will be aligned to provide the most appropriate and efficient care for the patient.

In recent years, health care organizations have begun to look at other industries for lessons in waste reduction, process improvement, and quality management. Six Sigma, a management strategy originally created by Motorola, is designed to eliminate errors in a system. Hospital and clinical practices have also learned from the Toyota Production System, including how to foster an environment of constant improvement by examining processes and removing barriers and waste.

### ***Standards and guidelines***

With further expansion of medical science, the use of evidence-based medicine has become widespread over the past two decades. Using the best

evidence available, practice parameters and guidelines have been established. In the future state of care, guidelines are an especially important tool in defining appropriate, quality care. They help providers make good decisions for patients and protect providers against malpractice.

Transforming evidence-based medicine into guidelines, and subsequently performance measures, is a difficult task. To be meaningful, guidelines and their derived measures need to evolve to encompass the “real” patient. Because guidelines are often written with a straightforward patient in mind, not for a patient with multiple comorbidities, the true benefits of translating evidence into guidelines and best practices remains limited.

Guidelines that fit a complex sea of patients are limited, which leads to gray areas in medicine. These blurs cause variations in the system as providers make their own non-evidence-based judgments regarding treatment. Lack of evidence opens the door for disagreements between providers and payors, often resulting in long hours on the phone to seek approval for a procedure. The future state of health care will need to involve large data repositories that hold the essential information to analyze patient care. This system will allow tracking of multiple variables and better alignment of practice outcomes with clinical trials and evidence-based medicine.

### ***Health information technology***

Health care providers are one of the last businesses to enter the electronic age. It is hard to find paper records at the bank, the grocery store, or at the video store. It is safe to say that the information retained by providers is significantly more important to patients than their video rental history. Most health records cannot be viewed while a surgeon is on vacation or when a patient arrives at the hospital with an emergency.

Electronic health records (EHRs) are still a major investment for small practices and are often seen as a hurdle, because they represent a change in workflow with initial decreased efficiency and increased costs. The full value of EHRs has not been recognized because the value comes less from the ability to store information than from the ability to share information across platforms. Many EHRs are not interoperable with other platforms, which greatly decreases

their value to providers and patients.

EHRs will evolve to allow patients to access their records and create personal health records (PHRs), which they can use to track their own health. Patient engagement is a rapidly emerging field with Google and Microsoft developing the next generation of health information technology (HIT). E-prescribing will become the most common form of prescriptions with payor mandates pushing providers into systems with patient safety mechanisms. Providers will also receive e-alerts from the FDA about device warnings and drug alerts. All of these advances will create enhanced efficiencies once their interoperability is complete.

The future has arrived early, with patients gaining access to their laboratory test information, pharmacy reports, drug interactions, and, soon, radiology data through PHRs available online. As more physicians adopt e-prescribing, prescriptions are available more quickly and patients are able to check for medication interactions themselves. The next round of HIT will move providers' clinical decision support closer to the point of care helping providers stay updated on the latest evidence and guidelines. Patients will also have applications available to measure real-time events such as blood pressure, weight, and blood glucose measurements, which will transmit back to the providers and their records in real time.

### **Payment system**

The business model for our nation's health care does not promote a system of integrated care delivery. It is a series of silos within which we purchase episodes of care, a drug, or a diagnostic procedure. As described previously in this article, payments in the current system are completely dependent on volume and intensity with no regard to quality or appropriateness of the care provided. Our payment system provides incentives to hospitals, providers, and ancillary services to offer more care instead of the best care. To improve the care of a population and increase efficiency, all providers must work together as a system of care for their patients.

It is time to think about alternatives to simply paying for an episode of care within a global period of time. Models are evolving to promote systems of care and reward systems that improve quality and reduce per capita costs. In the Bridges



to Excellence model, payments are related to a base rate for the hospital and the surgeon and adjustments are made based on the expected outcomes. The Medical Payment Advisory Commission has considered payment systems involving accountable care organizations. In this model, payments based on the care for a population and the health of the population could align incentives for all providers. In other words, a surgeon would be paid for performing an operation or for not performing an operation, as long as it was the best decision for the patient.

For many of us, it is hard to imagine this type of payment and care model because we are so entrenched in our current payment structure. Providers would be paid as part of a system rather than acting as an individual silo, and a portion of their payment would be based on the provider's ability to meet benchmarks for technical quality, efficiency, and patient experience. If a health system can reduce costs by removing waste and creating efficiencies, the system can reward both the physicians and the hospital. In these models,

providers' incomes are sustained (revenue minus costs), but costs to the system are reduced.

Shared savings programs can help increase the system's focus on efficient care, but to protect patients in these initiatives from overcutting services, shared savings programs should always be contingent on meeting specified quality measures that include patient experience with care. Paying providers as a team based on the health of the population will also reorient the system toward prevention and maintenance. It is much cheaper to keep patients out of the hospital. If all providers received a portion of those savings, everyone would have incentive to maintain a healthier population.

### → Conclusion

Stakeholders within the entire system feel the urgency to transform health care. Few are interested in the additional administrative hassles or more top-down utilization reviews and clinical management systems. Everyone is ready for a system that rewards providers for working smarter, not harder.

We hope that by clearly defining the current and future state, we will open your creative instincts to embrace the changes as true transformations. Individual surgeons who become part of systems of care to work smarter will be valued by insurers, purchaser groups, and patients. The environment that encourages efficient, transparent, and high-quality care will be rewarded.

The future domains described in this article culminate in a practice environment in which surgical practices are simpler and more focused on the patients. By removing the link between volume and payment, pressure to keep increasing work hours should be diminished. More robust guidelines and the removal of fee-for-service payment should eliminate the confrontations with insurance companies. Finally, the ability to truly focus on the health, and not just the sickness, of a population should be a rewarding experience for all providers and an important benefit to the patients they serve. □

### References

1. Connolly C. U.S. firms losing health care battle, GM chairman says. *Washington Post* Online. February 11, 2004. Available at: <http://www.washingtonpost.com/wp-dyn/articles/A15828-2005Feb10.html>. Accessed July 25, 2008.
2. Gabel JR, Jensen GA, Hawkins S. Self-insurance in times of growing and retreating managed care. *Health Aff.* 2003;22(2):202-210.
3. Wennberg JE. On the appropriateness of small-area analysis for cost containment. *Health Aff.* 1996;164-167.
4. Wennberg JE. Outcomes research, cost containment, and the fear of health care rationing. *N Engl J Med.* 1990;323(17):1202-1204.
5. Fries JF, Koop CE, Sokolov J, Beadle CE, Wright D. Beyond health promotion: Reducing need and demand for medical care. *Health Aff.* 1998;17(2):70-84.
6. Wennberg JE, Fisher ES, Goodman DC, Skinner JS. *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008*. Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2008.
7. Fiscella K, Franks P, Gold MR, Clancy CM. Inequality in quality: Addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA.* 2000;283(19):2579-2584.
8. O'Connor AM. Toward the "tipping point": Decision aids and informed patient choice. *Health Aff.* 2007;26(3):716-725.
9. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med.* 2003;348(26):2635-2645.
10. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med.* 2003;138:273-287.
11. Skinner JS, Staiger DO, Fisher ES. Is technological change in medicine always worth it? The case of acute myocardial infarction. *Health Aff.* 2006;25(2):w34-w47.

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