

Redesigning Care Delivery In Response To A High-Performance Network: The Virginia Mason Medical Center

A provider organization attempts to do what purchasers, including Medicare, all exhort: improve care delivery while reducing costs.

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ABSTRACT: We examine how an integrated delivery system responded to threatened exclusion from an insurer's high-performance network by attempting to reduce costs through fundamental redesign of care processes. Some factors facilitating this transformation, such as its structure as a large salaried medical group exclusively affiliated with a hospital, might be specific to the organization and its market. Other essential elements could be replicated. But in a fee-for-service payment system, cost reduction from reducing the number of services or changing their mix can reduce profitability. Making the business case for sustaining desirable provider behavior may require that purchasers and plans make equally fundamental changes in payment policy. [*Health Affairs* 26, no. 4 (2007): w532-w544 (published online 10 July 2007; 10.1377/hlthaff.26.4.w532)]

HEALTH CARE PURCHASERS ARE EXPERIMENTING with market-based strategies to induce providers to improve value. With tightly managed care out of favor, incentive programs such as pay-for-performance (P4P) and tiered networks garner growing attention. These programs profile providers' performance, give feedback, and offer incentives—direct financial rewards or the promise of higher patient volume—for providers who already have higher quality and lower costs or who reengineer care delivery to improve both.

To date, sponsors of incentive programs have been preoccupied with fully engaging providers and with technical design and implementation issues.¹ These programs are regarded as not yet achieving full potential.² It is therefore instructive to consider a case where a provider, willingly engaged, raises questions about

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the extent to which an incentive program's structure can sustainably support total spending reduction.

We report on a case study of the Virginia Mason Medical Center's (VM's) cost reduction and care improvement efforts in response to threatened exclusion from Aetna's Aexcel high-performance network (HPN) product in Seattle, Washington. Aetna's challenge and VM's response have received widespread attention.³ In this paper we analyze their experiences within their market context, to more closely examine the degree to which VM's interventions fundamentally changed its existing care delivery paradigms, the potential for replicating VM's experience, and the implications for broader payment policy.

Study Data And Methods

■ **Interviews.** We selected respondents with different perspectives on the process changes undertaken by VM and their effects on VM and broader dynamics in Seattle. We included VM staff (five operational and clinical executives, specialist physicians directing care improvement for four targeted clinical conditions, and the senior primary care physician on the project); Aetna (medical director for Aexcel, Western Region president); participating executives from three of the four largest employers contracting with Aetna for its HPN; and one executive each at a competitor provider organization and a competitor health plan. Between August and September 2006, two researchers interviewed seventeen respondents using detailed protocols of open-ended questions addressing the topics listed in Exhibit 1.

■ **Other sources of data.** We also drew on longitudinal data from site visits that were part of the Community Tracking Study (CTS), a biennial study tracking health care market changes since 1996 in twelve metropolitan areas, including Seattle. Design details of the CTS have been published elsewhere.⁴ We reviewed information on VM's and Aetna's competitive positions in Seattle; trends in health plan product development; and the history of the organizations and their relationships with one another.⁵

To assess the impact of VM's interventions, we reviewed the progress report that VM submitted to Aetna and the HPN's employer sponsors on cost and service volume reduction one year after the program began, as well as VM's projections of effects on margin based on average discounted commercial reimbursements and costs for specific services. We requested cost and service volume data from competing health plans, for patients treated for the four conditions at VM, and for all patients treated for these conditions in Seattle. The plans declined to participate in such analyses, however, because of concern that data would not be comparable as a result of differing definitions of services and patient populations and differing methodologies in applying grouper software. We therefore only report assessments of impact where interview data and VM's progress report were consistent, and not countered by different respondents.

EXHIBIT 1
Topics Addressed In Interview Protocols, Study Of Virginia Mason (VM) Medical Center, 2006

Structure of Aetna's Aexcel high-performance network (HPN) product
 Methodology for ranking providers
 Weighting of quality versus cost performance
 Consistency with rankings by other plans

Forces motivating Aetna, VM, and employers to collaborate in cost-reduction efforts
 Employers' priorities
 Relationships between the organizations
 Market positions of each organization
 Competitive pressures
 Institutional factors (for example, VM's early reengineering efforts)

VM's response
 Reaction to Aetna's rankings by leadership and clinicians
 Identification of areas to target for spending reduction
 Choice of data and quality standards
 Applications of the Virginia Mason Production System (VMPS) to cost control
 Common versus unique solutions for targeted conditions
 Reactions of staff to process changes
 Other barriers to and facilitators of change

Effects of the process changes on VM's organization and financial performance
 Staffing strategies
 Infrastructure investments
 Changes in service volume and mix, revenues, and costs per episode
 Perceived changes in quality performance

Effects of VM's experience on Seattle market dynamics
 Plan-provider relationships
 Plan-employer relationships

Factors considered essential to sustaining and replicating VM's cost reductions
 Contributions of Aetna, VM, and employers
 Options for payment reform being considered by Aetna and employers

SOURCE: Authors' analysis.

Study Findings

■ **The challenge.** In 2004 Aetna introduced its Aexcel HPN product in several markets including Seattle, tiering providers in selected specialties based on cost performance and allowing employers to choose benefit structures with lower patient cost sharing for using preferred providers. Aetna first screened physicians for quality. Physicians who met quality criteria were then evaluated for cost performance through use of episode grouper software, compared to local benchmarks.⁶ For each specialty in Aexcel, Aetna analyzed cost performance and made decisions regarding network inclusion at the practice level. Aetna identified certain specialties at several group practices as “poor performers” based on their relatively high costs per episode of care. The costs per episode of several medical subspecialty departments at VM far exceeded benchmarks, and Aetna threatened to exclude those departments from Aexcel while including departments in other specialties.

Other health plans in Seattle were also rolling out HPN products at the time. VM's ranking varied across plans, and VM initially attempted to insist on all-or-none inclusion of its specialists in Aexcel. But in an unusual effort to address common goals, Aetna and four of its largest Seattle clients (Costco, Nordstrom, Starbucks, and the King County government) offered to reconsider VM's inclusion if all parties agreed upon a cost-reduction strategy. The employers identified high-priority conditions based on total employee health benefit spending or costs attributable to associated absenteeism and workers' compensation, or both. The four were lower-back pain, cardiac arrhythmias, gastroesophageal reflux disease (GERD), and migraine headaches. Because Aetna wanted to focus on the most expensive providers and was wary of "disrupting" patients' relationships with primary care physicians (PCPs), it targeted only specialists in assigning responsibility for cost performance, a common strategy among HPNs. Teams (including VM staff, Aetna, and the employers) were formed to devise more-efficient care processes for each targeted condition. They did not set specific goals for cost reductions but rather took a "wait and see" approach.

■ **Market context.** Several features of the Seattle health care market made a constructive response from VM seem unlikely. First, Aetna is not as dominant there as Premera Blue Cross and Regence Blue Shield; it has only 10 percent of covered lives. Second, VM is a well-regarded organization with strong patient loyalty; Aetna enrollees might not have tolerated losing access to their physicians. Third, VM had had a disastrous experience with capitation that contributed to a period of financial stress in the late 1990s because, as one VM executive reported, "back then we didn't know how to cut costs."

But countervailing pressures proved more powerful, chief among them VM's structural and managerial evolution over the past decade. VM is an integrated delivery system with a 300-bed hospital in downtown Seattle, ambulatory surgical care centers, and outpatient facilities throughout the region, in total employing 480 physicians.

Gary Kaplan was hired as VM's new chief executive in 2000, assuming leadership during a period of severe financial challenges. One core element of his strategy for reviving the system's fortunes was the adoption of manufacturing processes for process improvement and cost control. VM homed in on the famed Toyota Production System (TPS).⁷ It invested in staff education and reorganization to adapt TPS to the health care setting—sending executives, administrators, and clinicians to learn from managers in Japan and overcoming skepticism from executives and front-line staff. By 2006, VM had committed twenty-one new and reassigned full-time-equivalent (FTE) staff members, along with more than 300 other staff members devoting less time, to design the Virginia Mason Production System (VMPS) and implement TPS principles.

VM conceived of the VMPS as an approach to continuous improvement that could be applied (1) to diverse performance measures of quality and of time and re-

source efficiency; and (2) across different clinical (for example, for different patient populations) and operational (for example, staffing versus inventory strategies) silos. Like the TPS, the VMPS' core elements include customer/patient-centered definitions of problems and solutions; "stop the line" mechanisms that empower staff to alert colleagues and superiors to system failures in real time and make suggestions for improvement; and "thinking lean" through regular reviews of performance and testing of new processes.

An example of patient-centeredness is that problem definition results in analyses of "value streams," such as for back pain, which graphically chart the time and resources consumed as individual patients with back pain navigate the medical center. An example of a "stop the line" mechanism is VM's patient safety alerts, in which staff immediately report instances of medical errors or near-misses.

Initially VM applied the VMPS to target patient safety and workplace improvement (for example, floor layouts to improve workflow). VMPS activity was "internally focused," as one respondent put it, rather than directed at priorities determined by external market forces. Nevertheless, by the time of the Aetna challenge, VM had firmly established infrastructure to support a comprehensive response.

■ **Engagement.** VM leadership viewed Aetna's challenge as an opportunity to refocus VMPS work, and they came to consensus with Aetna and the employers to improve efficiency per episode of care. Respondents believed that front-line clinicians were motivated to improve performance more for quality's sake than to reduce costs. But the employers' persistent presence throughout the experiment bred the perspective among VM's clinicians that they had to reinvent the health care "product" to meet their customers' needs for more affordability.

■ **Making the diagnosis.** To identify areas to target for cost reduction, Aetna shared detailed claims data stratified by individual physicians, practice sites, patients, and cost centers (such as pharmaceuticals). Each team analyzed the "value stream" for its targeted condition. For example, the migraine team mapped out all permutations of care encounters and resource use that a typical migraine patient might experience during an entire episode of care, from the telephone call for their first appointment, to the number of prescribed pills bought and the number of visits to an emergency department (ED) because of failed therapy. Then teams measured time and dollars spent by patients and providers at each step, and they reached consensus about where elapsed time or services were unlikely to improve health or where cost per unit of service could be lowered. Clinicians took the lead in identifying services that were not useful, using published treatment guidelines and detailed review of individual cases.

The teams identified pharmaceuticals, ED visits, diagnostic testing, and, to a lesser extent, physician services as major reducible cost contributors across most conditions. These are cost categories identified in episode grouper software. For example, VM's costs per migraine episode were relatively high, in part because patients went to EDs for severe headaches when they lacked "rescue" medication,

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and VM's imaging costs for migraines were fourfold above Aetna's regional low-cost benchmark; clinicians prescribed excessive numbers of pills for drugs that patients were using on a trial basis (for migraines) or for the most expensive brand-name drug (for GERD), and they ordered diagnostic tests, such as magnetic resonance imaging (MRI), more frequently than recommended by guidelines for back pain care and ordered redundant testing such as echocardiograms and stress tests for cardiac patients.

Teams quickly cast aside Aexcel's focus on specialists. Analysis of value streams revealed that many care decisions made in primary care settings or in EDs at other hospitals contributed to higher costs attributed to VM specialists. Instead of protesting how Aetna assigned care responsibility, the teams broadened their scope of work, to revamp processes across whatever departments touched a particular value stream.

They provided individual physicians with feedback on cost performance. They also improved access to care while reducing spending for physician visits by steering patients to specialty care clinics for most conditions, staffed by nurse practitioners armed with standardized care pathways based on guidelines. This involved establishing formal “service agreements” between the relevant specialty department and primary care departments, delineating criteria for referral and guaranteeing rapid specialty access, previously rare but highly valued by PCPs.

Third, they developed online order entry or preprinted order forms to automate restrictions on the number of pills on initial prescriptions and allow more pills on refills. Fourth, the teams initially tried to change physicians' behavior largely through education (such as dissemination of guidelines), but it became clear that this was not sufficient to prevent all physicians from ordering services judged to be not useful, particularly low-back MRIs and cardiac testing. So teams incorporated decision supports in VM's online order-entry system, to alert physicians when particular tests for individual patients fell into the “not useful” category. If necessary, the next, more heavy-handed approach planned by VM is to restrict options for test ordering. Fifth, employers invited VM clinicians to their companies to educate workers on ways to avoid unnecessary clinic or hospital visits for migraines and back pain.

Finally, the GERD team discovered that (1) the hospital had arrangements with the manufacturer of an expensive brand-name proton-pump inhibitor (PPI) to include the drug's oral form on the formulary in exchange for price discounts on other products; and (2) Aetna did not have a generic version of the drug on its formulary. VM quietly dissolved its contract with the drug manufacturer, and Aetna added a generic PPI to its formulary for all of its customers at the suggestion of one

employer. The same employer also expanded its health benefit plan to offer coverage for an over-the-counter form of the generic drug to all of its employees nationally.

Given Aexcel's focus on specialty care, it was noteworthy that VM turned to PCP leaders early on to implement guideline-based care. Primary care departments had more experience than specialty departments with developing care pathways. VM, Aetna, and employer respondents all asserted that PCPs were eager to exchange time-consuming back-pain patients for faster access to specialist care. Indeed, with the exception of the Physical Medicine department, there was reportedly little resistance from clinicians once they were confronted with data on their individual performance.⁸ Radiologists were reportedly relieved to be rid of inappropriate referrals for imaging, despite the loss of fees. And respondents noted that physicians did not experience declines in volume because demand for services remained high even after interventions reduced the number of inappropriate cases. By reducing resources required per episode, redesigning care delivery increased VM's treatment capacity: for example, from treating fifteen back-pain patients per week to fifteen per day. Thus, one of the advantages of the collaboration was that VM could focus on improving care for the selected conditions across specialties instead of focusing on a single specialty.

■ **Early evidence of savings for purchasers and risk of reduced provider revenues, but limited overall market impact.** There is preliminary evidence that VM's reengineering efforts have resulted in savings for purchasers, but it remains unclear the direction and degree to which VM's margins will ultimately be affected. This is partly because the process changes continuously evolve, and partly because of limited data on both cost impact and other factors that might lower revenues. Some savings, such as those attributable to reductions in pharmacy spending, would not reduce VM's revenues at all—but did not increase margins, either. Others, such as changes in service volume from more-profitable to less-profitable services, would more likely hurt VM's margins. VMPS changes that increased throughput, such as more efficient use of physical space, will increase VM margins without necessarily lowering employer spending. Thus, while VM, Aetna, and employer respondents all believe that VM's risk for substantial losses is real, the net effect on VM's margins is difficult to predict.

In interviews and in the first year's progress report, Aetna, VM, and employer respondents asserted that the process changes resulted in reductions in total spending for each of the four conditions. But because there was no formal program evaluation, the report lacked comprehensive data corresponding to the major cost centers Aetna had initially identified, and it does not allow easy pre- and post-intervention comparisons for Aetna patients only. For example, Aetna claims data revealed that spending on MRIs for back pain declined by 11 percent, resulting in modest savings of \$18,000 for the four employers the first year, but VM had not tracked costs from other back-pain imaging studies or consultations. Similarly, re-

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ductions in MRIs for migraines netted \$97,000 savings for the four employers, and provision of rescue medication resulted in a 26 percent reduction in ED visits for migraine patients at VM, but data on the cost impact of changes in prescribing patterns for migraines were not available.

The impact of VM’s interventions was also difficult to assess because relevant data remain proprietary. For example, the project led one employer to add coverage for over-the-counter PPIs to its benefit structure, with projected savings exceeding \$100,000 per month nationally if half of eligible employees switched to generics, but the actual savings achieved are unknown. And VM’s interventions continuously evolve, making formal assessments difficult. For example, by standardizing care protocols early on, VM reduced redundant cardiac testing, resulting in savings across all VM patients of \$75,000. But VM will not implement changes in online ordering systems to “mistake-proof” ordering of cardiac tests until later in 2007, which respondents claim may result in much more dramatic cost savings and could generate the most resistance from physicians (particularly cardiologists, who, although salaried, still face incentives to generate high service volumes). VM estimates that savings for all payers from reduced use of arrhythmia monitoring may top half a million dollars. Savings potentially achieved through 80–90 percent substitution of echocardiogram stress testing for more expensive nuclear perfusion scans are estimated at nearly \$750,000 annually.

The teams did make one important attempt to confront the trade-off between provider margin loss and purchaser savings. In response to VM’s concerns that reducing MRIs for back pain could hurt an important revenue stream, Aetna and the employers negotiated a new contract for the Physical Medicine department in the second year of the experiment, stipulating that if VM could meet a targeted 50 percent reduction in low-back MRI volume, the employers would share half of the savings through higher reimbursements for physical therapy evaluation and management. But after six months of attempts to change physicians’ behavior through education, physicians at one clinic caused VM to exceed the MRI volume target, prompting VM to institute automated “red flags” in online ordering for radiology.

The teams did not use standardized quality measures (believing that there were few relevant measures).⁹ Respondents argued that by more consistently adhering to guidelines, VM was de facto producing higher-quality care. And respondents were optimistic that interventions would reduce worker absenteeism, although accessing comparative data would require the employers’ workers’ compensation departments to share data with their health benefits departments (which doesn’t routinely occur) or the new use of codes in time-keeping systems for cause of absenteeism.

VM has aggressively disseminated the story of its experiences to stakeholders in Seattle, including its competitors. Despite generally positive reactions, there has been little effect on overall market dynamics. Aetna's negotiations with other providers to engage in similarly intense cost reduction remain nascent. This is partly a result of differences of opinion on whether primary care conditions (such as diabetes) should be included and whether other approaches besides the resource-intensive VMPS can achieve similar results; and partly a result of providers' doubts that VM will be sufficiently compensated for savings accruing to payers. Additional employers have not stepped up to engage providers, reportedly because of the time investment needed. And the shared savings model has not been adopted within other plans' HPNs, in part because of skepticism regarding the magnitude of cost reductions at VM.

■ **Replicability is likely greater in large multispecialty delivery systems.** Although many features of VM's experience may be special, if not unique to the organization and its market context, some essential elements could be replicated at other large provider organizations. Respondents identified as most critical the unusual collaboration among purchasers, health plan, and provider; VM's structure as an integrated delivery system with a salaried physician staff; and access to detailed cost data.

Participants cited the willingness of the parties to avoid temptations to flex their market leverage, and instead to commit to a shared mission of improved affordability, as a primary force behind the project. However, Aetna's four large-employer clients had enough stature in Seattle to command attention from VM's physicians and the resources to actively engage with them. Plans serving mostly small and mid-size firms may find it harder to get employers to assign executives to such collaborations.

Most respondents agreed that while VM's leadership was particularly committed to redesigning care delivery, the more important ingredient was its structure as a large, integrated system with an exclusively affiliated and salaried medical group; a cohesive culture; staff to devote to the VMPS; and information technology to facilitate problem identification and implement change. Most provider organizations are smaller than VM and might not be able to make such sweeping changes. Respondents disagreed on whether the VMPS itself was essential as a change strategy, or if other care improvement strategies could be as successful.

Lack of resistance from clinicians was another important facilitator, and such a program may be less successful where physicians are not salaried. Most physicians who are reliant on revenues from targeted services, or who lack VM's access to new patients to backfill for service volume lost through care redesign, would likely resist such changes in service mix. It remains to be seen how VM's cardiologists will respond to the projected margin losses from less frequent cardiac testing. VM's plans to reduce physician autonomy via "mistake-proofing" the targeted value streams will further jeopardize revenues to specialists and risk physician re-

sistance. Other providers may (as some of VM's competitors have) object more to how episode groupers assign responsibility for costs to particular providers. And many VM physicians were trained in Seattle, with its famously conservative medical care patterns and collaborative culture.¹⁰

Large provider organizations can also better respond to Aexcel's focus on specialists' cost performance. Aexcel's approach is common among HPNs and is unlikely to stimulate similar behavior change among providers not working in a multispecialty group where their patients receive first-contact care. Such specialists would have very limited access to data on, or influence over, how care is delivered by other providers to patients attributed to them.

Finally, Aetna's use of episode groupers, while an important stimulus for VM's activities, has not been instrumental to sustaining those activities. Aetna cannot update VM's cost profiles for at least another year, because reliable performance scores are difficult to generate without large numbers of episodes. In the meantime, VM has relied on proxy performance measures developed in collaboration with Aetna.

Discussion And Implications

■ **What purchasers can do to sustain a credible business case for spending reduction.** Going forward, VM plans to expand VMPS work—by improving existing value streams and creating new ones; extending them “upstream” to prevent acute illness and “downstream” to prevent hospitalizations and improve post-discharge care; and speeding return to work. All parties agreed that the project's sustainability requires solutions for VM's potential revenue losses and its amortized costs of maintaining the VPMS infrastructure, especially if Aetna and the purchasers wish to spread the value streams to VM's competitors.

Several options are available to purchasers seeking to sustain VM's momentum and its replication elsewhere. First, more purchasers might match the creativity and energy that these purchasers displayed in engaging providers. If they wish to avoid active intervention in workers' care, they might instead aggressively steer employees toward efficient providers through differential cost sharing, rather than only offering HPN designations as information for employees, as some of the Aexcel employers did.¹¹ Unless tier differentials are large, employers that redirect patients to VM are unlikely to offset VM's losses from replacing high-margin with lower-margin services. None of the employers have offered to limit their networks to VM if it achieves targeted levels of quality and cost per episode.

Second, purchasers can advocate for Aetna payment changes that more generously reward VM. However, Aetna and four exemplary employers alone cannot make an adequate business case for comprehensive redesign of care delivery. Since more efficient practice patterns apply to all VM patients, savings accrue to all payers in Seattle, including Medicare. Even if Aetna paid much higher rates for re-engineered services, its patients account for only 7 percent of VM's revenues. VM

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cannot expect relief from Medicare, which accounts for more than 30 percent of revenue and under current law cannot share savings with providers outside of demonstrations.¹² Should consumer-directed health plans become prominent, with patients at substantial financial risk and given provider-specific data on costs and quality, this might increase incentives to improve efficiency, but these incentives would be diluted by both the lack of participation of Medicare and the uneven profitability of different services. Moreover, care decisions for very sick and costly patients are not likely to be significantly constrained under consumer-directed health plans, as they quickly acquire protection from out-of-pocket spending limits.

On the other hand, there are reasons for optimism. Reducing costs per unit of service (such as by reducing use of brand-name drugs) does not necessarily reduce providers' margins, and increasing throughput in growing markets such as Seattle can improve providers' margins. Where improving efficiency reduces the volume of services or replaces higher- with lower-margin services, “honest brokers” such as the Puget Sound Health Alliance, a consortium of provider, plan, and purchaser organizations, could bring many parties to the table, ideally to craft a marketwide payment approach that would consistently reward providers for lowering total spending while improving quality. Reengineering that reduces service volume could benefit most physicians in markets such as California, with large medical groups and independent practice associations, common use of capitation, an effective purchaser coalition, and a pay-for-performance (P4P) program that will soon reward lower total spending per enrollee in addition to higher quality.¹³ A Medicare demonstration project that included other major regional payers could capture the majority of covered lives and coordinate payment incentives in any region.

Lastly, the importance of both VM's size and its structure as an integrated delivery system to the breadth of its process changes raises questions about whether even dramatic payment reform, if not accompanied by changes in how providers are organized, would propel major cost reductions among the majority of providers. Purchasers may need to consider explicit incentives for providers to reorganize into entities that can optimally support care redesign. Primary care groups may constitute logical partners for purchasers, since they can focus referrals on efficient specialists without incurring losses from lower spending on high-margin specialty care; to do so, they would need access to accurate data on specialists' cost performance.

■ **A cautionary example.** Aetna, employers, and VM used an ostensible business case to motivate VM to improve efficiency, only to confront the possibility of that business case turning on its head. It is an example of a provider organization at-

tempting to do what purchasers, including the Medicare program, all exhort—improve care delivery while reducing costs—and an illustration of the results that can be achieved through more fundamental care redesign than traditional health industry improvement strategies. It also stands as a cautionary example of how fee-for-service payment and uncoordinated payers present stubborn barriers to sustaining cost control.¹⁴

Purchasers could examine other payment structures to better support spending reduction. Although Aetna and the employers were willing to increase fee-for-service reimbursements for individual services, doing so might inadvertently increase nonuseful instances of the newly favored services. Quality-adjusted forms of capitation, bundled payment or P4P based on gain sharing could, to varying degrees, all encourage responses such as VM's. But if such programs offer rewards large enough to maintain providers' baseline revenues, they cannot lower total spending. There is no escaping the equity issues associated with reducing the 30–40 percent of U.S. health care spending judged to be wasteful.¹⁵ That magnitude of spending reduction implies the loss of many health industry jobs and current income levels. Every dollar used to cushion pain for providers means less spending relief for globally competitive purchasers and increasingly hard-pressed consumers. A blended approach that allows more-efficient providers to retain some savings that would otherwise accrue to payers, while expanding their market share and capacity may represent an intuitive middle ground. However, convincing providers to embrace VM's zeal in demonstrating that “less” can be “more” will require much greater coordination of public and private payers, as well as a difficult, national consensus on the degree of financial cushioning owed to U.S. providers.

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NOTES

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