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Op-Ed Contributors
10 Steps to Better Health Care
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WE have reached a sobering point in our national health-reform debate. Americans have recognized that our health system is bankrupting us and that we have dealt with this by letting the system price more and more people out of health care. So we are trying to decide if we are willing to change — willing to ensure that everyone can have coverage. That means banishing the phrase "pre-existing condition." It also means finding ways to pay for coverage for those who can't afford it without help.

Both of these steps stir heated argument, not to mention lobbyists' hearts. But what creates the deepest unease is considering what we will have to do about the system's exploding costs if pushing more people out is no longer an option. We have really discussed only two options: raising taxes or rationing care. The public is understandably alarmed.

There is a far more desirable alternative: to change how care is delivered so that it is both less expensive and more effective. But there is widespread skepticism about whether that is possible.

Yes, many European health systems have done it, but we are not Europe. And evidence that places like the Mayo Clinic in Minnesota or the Cleveland Clinic are doing it is likewise dismissed because their unique structures (for example, their physicians work on salary rather than being paid for each service) make them seem as far from Middle America as Sweden is.

Yet in studying communities all over America, not just a few unusual corners, we have found evidence that more effective, lower-cost care is possible.

To find models of success, we searched among our country's 306 Hospital Referral Regions, as defined by the Dartmouth Atlas of Health Care, for "positive outliers." Our criteria were simple: find regions with per capita Medicare costs that are low or markedly declining in rank and where federal measures of quality are above average. In the end, 74 regions passed our test.

So we invited physicians, hospital executives and local leaders from 10 of these regions to a meeting in Washington so they could explain how they do what they do. They came from towns big and small, urban and rural, North and South, East and West. Here's the list: Asheville, N.C.; Cedar Rapids, Iowa; Everett, Wash.; La Crosse, Wis.; Portland, Me.; Richmond, Va.; Sacramento; Sayre, Pa.; Temple, Tex.; and Tallahassee, Fla., which, despite not ranking above the 50th percentile in terms of

quality, has made such great recent strides in both costs and quality that we thought it had something to teach us.

If the rest of America could achieve the performances of regions like these, our health care cost crisis would be over. Their quality scores are well above average. Yet they spend more than $1,500 (16 percent) less per Medicare patient than the national average and have a slower real annual growth rate (3 percent versus 3.5 percent nationwide).

Caveat: Because we relied on Medicare data for our selections, it is possible that some of these regions are not so low-cost from the viewpoint of non-Medicare patients. But overall data strongly suggest that most of these regions are providing excellent care for all patients while being far more successful than others at not overusing or misusing health care resources.

So how do they do that? Some have followed the Mayo model, with salaried doctors employed by a unified local system focused on quality of care: these include Temple, where the Scott and White clinic dominates the market, and Sayre, where the Guthrie Clinic does. Other regions, including Richmond and Everett, look more like most American communities, with several medical groups whose physicians are paid on a traditional fee-for-service basis. But they, too, have found ways to protect patients against the damaging incentives of a system that encourages fragmentation of care and the pursuit of revenues over patient needs.

The physicians and hospital leaders from Cedar Rapids told us how they have adopted electronic systems to improve communication among physicians and quality of care. Last year, they decided to investigate the overuse of CAT scans. They examined the data and found that in just one year 52,000 scans were done in a community of 300,000 people. A large portion of them were almost certainly unnecessary, not to mention possibly harmful, as CAT scans have about 1,000 times as much radiation exposure as a chest X-ray.

"I was embarrassed for us," said Jim Levett, a cardiac surgeon and the head of a large physician group. More important, the area's doctors and clinics are turning that embarrassment into change by seeking out solutions to reduce the expense and harm of unnecessary scans.

That number of scans in Cedar Rapids may seem shocking, but there is nothing surprising about it. Nationwide, we do 62 million CAT scans a year for 300 million people. So Cedar Rapids's rate was actually better than average. But all medicine is local. And until a community confronts what goes on in its own population — to the point of actually seeking the data and engaging those who can solve the problem — nothing will change.

The team from Portland told us of a collaboration of doctors, state officials, insurers and community leaders to improve care. For more than four years, physicians have

been tracking some 60 measures of quality, like medication error rates for their patients, and meeting voluntary cost-reduction goals.

Asheville, after gaining state support to avoid antitrust concerns, merged two underutilized hospitals. In Sacramento, a decade of fierce competition among four rival health systems brought about elimination of unneeded beds, adoption of new electronic systems for patient data and a race to raise quality. Sacramento also went from being one of America's high-cost areas for health care to being among the low-cost elite.

In their own ways, each of these successful communities tells the same simple story: better, safer, lower-cost care is within reach. Many high-cost regions are just a few hours' drive from a lower-cost, higher-quality region. And in the more efficient areas, neither the physicians nor the citizens reported feeling that care is "rationed." Indeed, it's rational.

Many in Congress and the Obama administration seem to recognize this. The various reform bills making their way through the process have included provisions to protect successful medical communities by incorporating payment approaches that reward those that slow spending growth while improving patient outcomes. This is the right direction for reform.

There is a lot of troubling rhetoric being thrown around in the health care debate. But we don't need to be trapped between charges that reforms will ration care and doing nothing about costs and coverage. We must instead look at the communities that are already redesigning American health care for the better, and pursue ways for the nation to follow their lead.

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