Grand Junction, Colorado, about half way between Denver and Salt Lake City, is known for its dramatic red-rock country, mountain biking, river rafting, and other outdoor activities.

With about 50,000 people, it’s not a big population center, but it’s become a big dot on the health care map.

That’s because Grand Junction is one of the nation’s lowest-cost areas for Medicare patients, the 6th least expensive among 307 cities. It also does well on quality.

These low-cost, high-quality areas are likely to be getting more attention. The new health care reform law has a bonus program for hospitals in counties that are in the bottom quartile for the lowest adjusted Medicare spending per beneficiary.

Medicare spent $5,873 per year on the average enrollee in Grand Junction in 2006, compared with the national average of $8,304, according to the Dartmouth Atlas of Health Care. The Dartmouth Atlas project, based at Dartmouth University in New Hampshire, has documented glaring regional variations in the use of health care resources across the US for more than 20 years.

The Dartmouth Atlas research has experts asking why Medicare costs vary so much from place to place with no discernable difference in outcomes. In a 2009 report in the New England Journal of Medicine, the researchers documented that Medicare’s average cost per enrollee in hospital referral regions varied widely from a high of $16,351 to a low of $5,310 (map). The rate of cost growth also varied from 5.0% to 2.3% annually. Understanding these big variations could help us understand how to bring down the growth in Medicare costs and affect the program’s long-term financial health, experts say.

What could we learn?

Grand Junction captured notice when it was contrasted with the high-cost city of McAllen, Texas, in a New Yorker article by surgeon and author Atul Gawande, MD. McAllen’s average annual spending is $14,946 per Medicare enrollee.

The Los Angeles Times and Colorado Public News recently wrote about Grand Junction’s focus on primary care, continuity of care for chronic illnesses, clinics for the uninsured, and a strong hospice program for end-of-life care. A nonprofit health plan, Rocky Mountain Health Plans, controls about 40% of the local market.

Skeptics say that Grand Junction’s residents are healthier than in high-cost areas. The Dartmouth researchers say that, while health status does matter, it accounts for less than 20% of the difference between the highest and lowest cost regions. Much of the difference, they say, stems from physi-
How Medicare costs vary

The Dartmouth Atlas Project shows how health care costs for Medicare enrollees vary widely across the US. Reprinted with permission of the Dartmouth Atlas Project.

Impact on surgical services

The CEO of Grand Junction’s Community Hospital, Chris Thomas, says he thinks the decision-making patterns of physicians have a bearing on the community’s health care costs.

“I think the reason we have done so well in the cost studies is that we have a pretty conservative medical community. They are sensitive to unnecessary tests and duplication of services,” Thomas told OR Manager. Community, with 44 staffed beds and 6 ORs in a main OR and ambulatory surgery center, is one of Grand Junction’s 2 acute care hospitals, along with St Mary’s, a regional referral center.

Grand Junction also has an electronic health record data repository in
which the hospitals and most of the physicians participate.

“We share data pretty well across the community,” Thomas says, enabling clinicians to review patients’ histories and avoid duplicating tests.

In addition, most of the city’s health care is not-for-profit, and there is not a lot of physician-hospital competition. Says Thomas, “We don’t have a lot of for-profit services,” such as imaging centers. The city’s 2 surgery centers are joint ventures with the hospitals.

**Shifting payer mix**

Like hospitals across the country, because of the bad economy, Community has seen a shift in the payer mix, meaning the hospital has to look even harder at how to be cost-effective. As more people have lost their jobs, they have turned to Medicaid or self-pay. Grand Junction’s unemployment rate is 9.5%, similar to the 9.7% national average.

The payer mix is 37% Medicare and 37% commercial insurance, with the balance from Medicaid and self-pay.

“We will send out bills for about $125 million this year, and we will collect about $65 million,” Thomas says. “We have to save money all over the place to offset that lost revenue.” There have been layoffs, primarily in support areas. The hospital, which is pursuing Magnet status for nursing excellence, maintains a nurse-to-patient ratio of 1:5 on its med-surg units and 1:2 in the ICU.

**What technology to add?**

For surgery, Thomas says the leaders have to weigh carefully what tech-
nology and services to add. The hospital’s 12-member board includes 5 physicians.

“We sit down with the surgeons and evaluate the cost-benefit of any new service or capital purchase,” he says.

A new subcommittee of the Surgery Section Committee, headed by the chief medical officer, a vascular surgeon, will oversee block time utilization, turnover time, start times, and other operational issues. This group took the place of the previous OR committee, which had surgeons rotating as chairperson, notes Susan Crawford, RN.

Probing into costs

Crawford, previously the OR director, recently made a voluntary decision to assume the role of clinical supply analyst, which she says gives her more time to focus on financial matters.

“I now have time to look at which kinds of surgery are profitable” and to evaluate surgeons’ requests, she says. Plus, the new surgery committee has a more formal process for introducing new procedures, supplies, and equipment.

One major breakthrough came after Crawford scrutinized the spinal implant contract. She discovered the hospital wasn’t getting as much of a discount as it thought it was for components it was actually using.

Thomas says Crawford’s role “has saved us money because we are able to ask better questions. I think we will see major savings this year because of her role.” He sees potential for the role to expand to other areas of the hospital.

The clinical supply analyst role is a good solution for a small hospital that doesn’t have an OR business manager, Crawford notes.

As the OR director, she says she didn’t have time to probe details of contracts and supply spending. With her nursing and management background, she can bring 30 years of experience to bear on supply spending and other cost management projects.

“I think it is a no-brainer,” adds Thomas. “As I see on a weekly and monthly basis the dollars she is able to save us, I’m sure she will pay for herself many times over.”

As for the financial pressures, Thomas says, “I don’t see it ever changing.”

References


