FAT CHANCE: The DHMC cafeterias deep-sized their deep-fat fryers in July 2009 as part of the employee health program. Not only are an estimated 21 million fewer fat calories now consumed per year, but the number of items sold rose by 1.6%

THEN & NOW

A reminder of the pace of change, and of timeless truths, from a 1991 history of Mary Hitchcock Hospital:

"The hospital continued to enjoy . . . the material and financial support of the community. Contributions took many forms, from x-ray machines (the hospital's first, in 1903, was the gift of four Hanover residents . . .) to assorted amenities for patients [such as, in 1906-07]: 'cream, milk, jellies, flowers, string beans, cucumbers, apples, summer squash, grape-fruit, [and] piccalilli.' . . . It became traditional to rely on private donations of fresh produce [and] canned goods . . . to feed patients."

$28.5 million

Contributions (in dollars, rather than in pecks of produce) to DHMC and DMS in 2009-10

Dartmouth is a top performer in federal project

In 2005, the federal Centers for Medicare and Medicaid Services (CMS) devised a five-year pilot project called the Physician Group Practice (PGP) Demonstration, to test the theory that financial incentives could motivate health-care organizations to provide higher-quality care for Medicare beneficiaries.

According to recently published data from the project's fourth year—2008-09—five of the 10 PGPs participating, including the Dartmouth-Hitchcock Clinic, are proving CMS right on the money. The five received bonus payments totaling $31.7 million—a share of the $38.7 million in savings they generated for Medicare.

In year four, Dartmouth met 94% of the project's quality benchmarks.

Bonus-worthy: A participating PGP is deemed bonus-worthy if it spends at least 2% less on Medicare beneficiaries comparable to those of other providers in the area, while performing well on a series of quality benchmarks. Successful PGPs can share in up to 80% of Medicare's savings. In doling out bonuses during the first two years, CMS emphasized cost reduction over quality; since year three, cost and quality have been weighted equally.

Dartmouth-Hitchcock Clinic—a bonus recipient in all but the first year—has so far stockpiled $13 million in monetary rewards, one of the highest amounts awarded any of the 10 PGPs. Much of the focus has been on improving care management strategies, says Dr. Barbara Walters, the Clinic's senior medical director and coordinator of the project. DH has brought in recognized experts to coach physicians and support staff on evidence-based care guidelines. Triage nurses are engaged in more active and motivational outreach; for example, patients get a call a few days before an appointment, plus a follow-up call within 24 hours of a discharge. DH has also integrated more electronic tools into day-to-day practice—for instance, charts that track vital signs and vaccinations; disease registries; and reports to providers showing their individual progress on quality benchmarks. The aim is to zero in on preventive care, reducing readmissions and costly emergency procedures.

The efforts are paying off, especially with respect to meeting the project's 32 quality benchmarks. These were phased in gradually and now cover diabetes, congestive heart failure, coronary artery disease, hypertension, and cancer screening.

Quality: In year four, DH met 94% of the benchmarks, including targets for screening for breast and colorectal cancers. According to Jennifer Snide, a quality measurement analyst at DHMC, CMS stipulated that PGPs should perform mammograms in at least 75%, and colonoscopies in at least 61%, of patients falling within the defined age- and gender-based guidelines. Dartmouth surpassed both those benchmarks and has consistently done well meeting benchmarks for diabetes, too. The biggest improvement was that the percentage of patients having an annual foot exam increased from 21% to 59%.

Model: The project is widely regarded as a model for accountable care organizations (ACOs), a provision of the 2010 health reform law that has received solid bipartisan support. In a recent news release, CMS administrator Donald Berwick hailed the 10 PGPs as "leaders in organizing care delivery" and as a demonstration of what the health-care sector can achieve "if we put the right incentives in place."

JON GILBERT FOX

The rate of annual foot exams for diabetics increased from 21% to 59% under the federal project. Here, Dr. Richard Powell examines the foot of a diabetic who has already lost one toe.

But exactly what the "right incentives" are remains a point of debate. Shared savings may be a great concept, but four of the 10 PGPs have thus far never received a bonus.

"The groups who didn't receive bonuses would tell you that they didn't have a large enough [patient] population," Walters says. "As well, Medicare's 2% savings threshold is perhaps a flawed design."

The lack of financial risk—participating physicians still receive their regular Medicare fee-for-service payments—has also been criticized. As an opinion piece in the October 2010 issue of the *American Journal of Managed Care* put it: "An approach that attempts to upset or dislocate no one" may not prove a strong enough incentive to impel physicians to change their behavior.

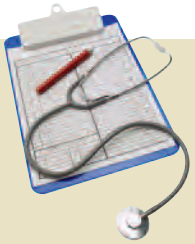
Right: But Walters disagrees. "Doctors want to do the right thing," she says, "and the system should be redesigned to make it easy for them to do so—then their behavior will change."

Meanwhile, DH is launching its own ACO through a joint pilot payment program with Anthem Blue Cross and Blue Shield. However, Walters says, it's "still in the early stages."

CMS is also working to transition all 10 PGPs into a newly-formed ACO program. "We're all eager to continue the good collaboration and improved clinical care begun with [the demo]," says Walters, "and make the terms and conditions better in partnership with Medicare."

Alissa Poh

CLINICAL OBSERVATION



In this section, we highlight the human side of clinical academic medicine, putting a few questions to a physician at DMS-DHMC.

Scott Rodi, M.D.
Assistant Professor of Medicine

Rodi is chief of the Section of Emergency Medicine and medical director of the Emergency Department (ED). He is also the founder and director of DHMC's Center for Rural Emergency Services and Trauma (CREST). He came to DHMC in 2001.

When and why did you decide to become a physician?
There was no one moment. With three generations of physicians in my family, the choice seemed somewhat inevitable but I resisted it during most of my education. At the end of college, though, I realized I was evaluating every alternative in terms of whether it would ultimately make me a better doctor, so I gave up the fight.

What got you interested in emergency medicine?
I came to the specialty indirectly. I started off in orthopaedics but realized that I missed being involved in many other areas of medicine. I also realized that I liked delivering acute care more than elective care. Finally, the societal expectation that emergency physicians will deliver care regardless of the patient's ability to pay is important (albeit at times frustrating) to me.

What is a typical day like for you?
In the ED, by definition, we see everything that comes through the door, so we touch virtually every specialty in medicine. A "typical" day includes everything from traumatic injuries, to cardiac problems, to psychiatric issues, to ingrown toenails and dental pain. From an academic standpoint, this can be a bit of a liability, but from a practice perspective I find it one of the most appealing things about emergency medicine.

What are your favorite nonwork activities?
Skiing, hiking, biking, sailing, and woodworking.

What websites do you use most often?
None. I proudly remain a relative Luddite.

Where would you most like to travel?
At the risk of sounding hedonistic, I'd pick exploring the islands off Southeast Asia on a wooden sailboat.

Finish this sentence: If I had more time I would . . .
In my current life, I would spend more time at home—more time with my family and more time in my workshop.

What is a talent you wish you had?
Other than being able to fly (a recurring childhood dream), I have always wished that I had some musical ability.

What do you admire most in other people?
Honesty.

What was your first paying job?
After miscellaneous jobs—like babysitting, mowing lawns, and sanding boats—my first regular paying job was a newspaper route when I was 12.

What about you would surprise people who know you?
That I spent some time in jail, and then under house arrest, in Ecuador a number of years ago.

What is the greatest frustration in your work? And what is the greatest joy?
Politics is the greatest frustration. At a national and sometimes local level, fights are fought and decisions are made that hinder, rather than enhance, our ability to give care. So we as a system spend an inordinate amount of resources responding to an ever-increasing number of policies and regulations. At an individual level, this ultimately translates to less time with patients. Which, in answer to the second part of the question, is what I still like most about my job.