CREW CUT: DMS's Dr. Kristine Karlson made the cut as the team physician for the U.S. rowing and canoe-kayak teams at the Pan American Games in Brazil in July. A former Olympic rower, she practices family medicine and sports medicine.

IN THE DARK OF NIGHT

Cats, dogs, and deer are among creatures particularly well adapted to see in the dark. Now helicopter pilots on the Dartmouth-Hitchcock Advanced Response Team (DHART) can be added to that list, thanks to their new night-vision goggles—modeled below by DHART pilot Grant Hamilton.

DHART hasn't had a single accident in its 13-year existence. But flying nighttime missions can be quite hazardous, especially in mountainous and rural terrain, says Paul Austin, DHART's lead pilot. At night, the goggles "really allow you to see all of the terrain, the weather, and the clouds."

JON GILBERT FOX

Military pilots have been using night-vision technology for more than 30 years. Over the past five years or so, the technology has become more common among civilian helicopter pilots.

The major reason for the goggles, says Austin, "was to add to our safety. But they will also increase our operational capability"—in other words, making it possible to fly nighttime missions that would not have been feasible in the past. A.P.

AID FROM A FRIEND INDEED

"Always the student advocate, she continually fought to provide students with the money they needed while keeping end-of-school loans to a minimum," reads a plaque that DMS students presented to Nanci Cirone in June, when she retired as the director of DMS's financial aid office.

During her 27 years in the position, Cirone worked tirelessly to help students manage the escalating cost of medical school. She watched as DMS's tuition soared from $9,500 a year in 1980-81 to nearly $38,000 today. And she grew concerned as higher education indebtedness for graduates of private U.S. medical schools rose even faster; it averaged less than $20,000 in 1981 and is now over $150,000.

Fortunately, however, average indebtedness is only $106,000 at DMS, thanks to the fact that though over 87% of DMS students qualify for financial aid, 50% of students receive some scholarships—aid that doesn't need to be repaid.

Cirone has stayed in touch with many of the students she's helped over the years. "Her door was always open," reads the plaque, "as an advisor, counselor, and friend." L.S.C.

Clinic saves feds $2.8 million *and* improves care

In the first year of a three-year trial, the Dartmouth-Hitchcock Clinic saved the federal government $2.8 million, while providing better patient care. That's according to a Centers for Medicare and Medicaid Services (CMS) trial, the Physician Group Practice Demonstration, which began in April 2005. The demonstration is designed to reward providers for reducing costs and improving quality.

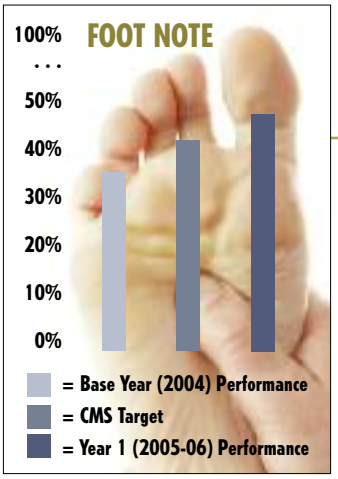
Demo: The Dartmouth-Hitchcock Clinic, one of 10 groups to participate in the demonstration, exceeded 9 of the 10 quality targets CMS set for year one. The other groups did well, too; altogether, the participants saved Medicare $21 million. Yet only two met the financial requirements to share in those savings. Medicare paid those two groups a total of $7.3 million, even though they did not meet all the trial's quality targets. In year one of the demo, reducing costs was more important than achieving the quality targets, at least in terms of divvying up the money saved. Dartmouth-Hitchcock just missed the threshold for sharing in the savings. But that doesn't seem to bother Dr. Barbara Walters, the project coordinator at Dartmouth.

Dartmouth exceeded 9 of the 10 quality targets set for year one.

"This is the kind of clinical care that we should be moving toward and practicing anyway," she says. It's not known how much Dartmouth-Hitchcock has spent on the project, but the only personnel cost was half of a full-time position, Walters points out. She and her team focused on changing providers' responsibilities rather than simply hiring more staff.

Coaches: Among the changes was the integration of health coaches into primary-care departments. The coaches, who are R.N.'s, worked from a registry of about 30,000 patients who had certain diseases or had been recently hospitalized at DHMC for a major condition. By mail and phone, the coaches provided education, counseling, and an occasional nudge to get needed tests. Sometimes the coaches helped with such basic tasks as reading and filling out forms. Then, when the patients came in for appointments, they were better prepared, says Walters, and could "have a much more productive physician encounter." After visits, coaches checked in with patients again. The goal was to help them manage their chronic illnesses better, keeping them healthier and avoiding costly hospitalizations and emergency procedures.

To gauge the performance of the 10 trial participants, CMS set quality benchmarks and looked at the total cost of care for Medicare patients treated by each group. The quality targets for year one of the trial centered on diabetes care and included blood-sugar testing and control, blood-pressure control, lipid testing and LDL cholesterol control, urine-protein testing, eye and



This shows the Clinic's performance in a federal CMS trial on one of 10 quality measures—the percentage of diabetic patients who get regular foot exams.

foot exams, and influenza and pneumonia vaccinations. For example, CMS's target for LDL cholesterol was that about 65% of patients test below 130; nearly 90% of Dartmouth-Hitchcock patients achieved that goal.

The target for reducing costs was more complicated. The cost for patients who get most of their care at Dartmouth-Hitchcock had to rise more slowly than the cost of care for similar Medicare patients in the region who get their care elsewhere. The difference had to be more than 2% in the first year of the demo.

Cost: In year two, saving money will again be given more weight than improving quality. But by year three, cost and quality will be weighted equally. This structure has drawn criticism from the American Medical Association and others, though "it's better than the fee-for-service . . . model that we're all stuck with at this moment," says Walters. (For more on alternative payment models, see page 14.)

"Pay-for-performance," she adds, "at least attempts to bring quality into the equation."

Jennifer Durgin

DHMC puts itself on the pharm-freebie-free team

"The longer I've been taking care of patients and teaching students, the more convinced I am that receiving a gift from a drug company, any kind of gift of any size, biases your prescribing," says Dr. David Nierenberg, a clinical pharmacologist at DMS. "I decided years ago the only good policy with drug companies was 'don't take any gifts.'"

Since January 2007, that's the policy everyone at DHMC is following. The new policy prohibits the acceptance of gifts, meals, and all "freebies" from drug and medical-device companies. DHMC is among a small number of academic medical centers—including UPenn, Stanford, Yale, the University of California at Los Angeles, and the University of Michigan—to have adopted policies that are even stricter than guidelines set by the American Medical Association in 2002. Those guidelines allow gifts "of modest value," if they relate to physicians' work or benefit patients, and meals "of nominal value," if they are provided during educational programs. But that didn't go far enough, felt officials at DHMC.

"Research . . . clearly shows that even small gifts [affect] behavior."

Policy: Doctors don't intentionally allow gifts to influence them. But "there's a body of social science research that clearly shows that even small gifts have an effect on peoples' behavior," says Dr. Carl DeMatteo, chief compliance officer at DHMC and a member of the committee that developed the new policy. "The drug industry spends billions of dollars every year on influencing physician behavior to meet [its] corporate goals . . . profit for their shareholders."

A recent paper in the *New England Journal of Medicine* reported that over 90% of physicians who responded to a national survey had some relationship with the industry, with 83% having received free food and beverages in their workplace. At DHMC, before the new policy went into effect, there was at least one vendor-sponsored meal for staff every day.

"I think what has been the most pleasant surprise" about the new policy, says DeMatteo, "is so many people have said, 'It's about time you did this.'"

Safe: Nierenberg, who was also on the committee that developed the policy, agrees. In fact, he's been advocating for such a policy since 1981, when he began teaching DMS students to prescribe drugs that are safe, effective, and affordable.

Even little gifts—pens, pads, or other items emblazoned with a drug name or logo—bias physicians because, says Nierenberg, they subconsciously want to reciprocate. "The only way you can reciprocate [is] by prescribing their drug," he explains. "And most of the time the drug they want you to prescribe is not the best drug for the patient. It's not the most effective. It's not the safest. And it's not the cheapest."

He hastens to add that he respects drug companies and appreciates the products they develop. "They deserve to make a reasonable profit," he says. "But biasing prescribing by giving presents is the wrong way to go."

Grants: DHMC still allows unrestricted grants from drug and device firms to fund continuing medical education programs and provide modest meals during them, as long as DHMC controls the program content. In addition, 10 to 20 drug and device company representatives and technicians visit DHMC daily. But they are now required to register with the purchasing department and wear name badges.

"Our mission as an organization [is to] deliver high-quality, safe care in a patient-focused, patient-centered way," says DeMatteo. "Taking gifts, whether they're big or small, from a for-profit vendor doesn't really contribute to that."

Laura Stephenson Carter

JON GILBERT FOX

Nierenberg has collected drug company "freebies" like these for years as a lesson to students of what not to accept.