

## Keeping room

By John H. Wasson, M.D.

**T**he diagnosis is not in doubt: Compared to other advanced economies, the U.S. suffers from a chronic disease called low-value health care.

And the prognosis is clear: Given the aging of the U.S. population, the nation's health-care demand will continue to grow. And given the aging of the primary-care workforce and its replacement by higher-priced specialists, the price per unit of demand will also increase. Since the volume of care delivered escalates in proportion to the availability of high-priced medical goods and services, more money will be wasted each year. Thus the outlook for cost control of health care—much less improved health outcomes—looks bleak.

All “treatments” tried so far for chronic low-value care have caused pain and stress for many health professionals. Even modest proposals to adjust medical reimbursements have provoked strong reactions. More successful and concerted efforts to change patterns of use—such as “gatekeeping” by primary-care physicians, or the coordination of patients' care and of referrals to specialists, hospitals, and other services—have resulted in near-death for gatekeepers and dissolution of the effort. When one person's waste is another person's income, it is very difficult to treat the problem of cost in health care.

**Care:** Can anything be done? Short of a clear crisis, pundits contend the answer is no. However, there is a relatively painless and more than palliative treatment option for low-value health care. Unlike gatekeeping, which pitted primary-care physicians and employers against patients, “gain-keeping” is a model that patients love. Gatekeeping bolstered the impact and incomes of distant, anonymous intermediaries, but gain-keeping builds quality and cost controls into the front line of care delivery, where they are more likely to be effective.

For example, Quad/Graphics, a large national printing company based in Wisconsin, provides very high quality health care in an on-site clinic to employees and their dependents at a cost 17% to 20% lower than other similar companies. The money “gained,” or saved, is “kept” and used to benefit the patients/employees, physicians, and employer/payer. Hence the term “gain-keeping.”

Despite the appeal of gain-keeping, few businesses have the ability to establish their own clinical services. Instead, they may contract with intermediaries who have priorities quite divergent from those of a frontline physician and of the patient/employee. Or companies may ask their employees to pick up more of the costs. Either way, the value of health care becomes less competitive.

But a small and growing number of frontline physicians are build-



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ing a national network of gain-keeping practices. They use the commonsense components demonstrated at Quad/Graphics: easy access to providers, adequate patient time with primary-care physicians, incentives based on quality and “team play,” the use and monitoring of “best practices,” the use of selected specialists whose performance is audited, third-party assistance and monitoring, and self-care programs.

Efficient practice design enables gain-keepers not just to improve care but to reduce their overhead costs. Overhead averages 60% of revenue in primary-care practices but only 35% in gain-keeping practices. Low overhead, coupled with computerized systems, results in smooth workflow; integrated scheduling, billing, messaging, and record-keeping; minimal need for handoffs among office staff; and even reduced staffing.

**Time:** These practices can see fewer patients and still cover their costs. Doctors can avoid the devastating consequences of productivity fatigue. Patients and physicians alike appreciate being able to spend more time together. In fact, 60% of patients in gain-keeping practices strongly agree that they receive “exactly the care I want and need exactly when and how I want and need it.” In traditional practices, less than half as many have such a positive assessment of their care.

And gain-keepers make sure that referrals to specialists don't result in excessive visits and revisits. To reduce costs, inefficiency, and fragmentation of care, these practices are beginning to aggressively standardize and monitor referrals and follow-ups.

Quality measurements are built into all patient interactions. The key quality measures emphasize good collaborative care focused both on “what is the matter” with the patient and “what matters to” the patient. Superb access to providers (same-day if needed) by phone or e-mail is one critical attribute of good collaborative care. Another is patient confidence in self-care. In gain-keeper practices, about 60% of patients with chronic illnesses report that they have been helped “a lot” to live with their illness; in traditional practices, only 35% report as much help.

**Teaching:** Primary care and the teaching of it must change in order for it to survive and be relevant far into the 21st century. Yet we seem committed to training future doctors in settings where patients are less likely to be satisfied, where physicians are usually unhappy, and where overhead is high. Feeling under assault by cost-cutters, many primary-care teachers feel they must churn, refer, or burn.

Dartmouth researchers have documented that higher costs are associated with fewer primary-care physicians and that better quality measures are associated with more primary-care physicians. If gain-keepers offer even greater quality, efficiency, and cost reduction than traditional primary care, might not gain-keeping be the best way to treat the intractable disease of chronic low-value care? ■

*The Grand Rounds essay covers a topic of interest to the Dartmouth medical faculty. John Wasson is the director of the Center for Aging and a professor of community and family medicine. He is also a member of the DARTMOUTH MEDICINE Editorial Board. For more on his work in office practice improvement, which was the subject of a front-page article in the February 23 issue of the Wall Street Journal, see [www.IdealMicroPractice.org](http://www.IdealMicroPractice.org).*