aware of the state protections and submit a substantial amount of paperwork to get redress.

Ultimately, surprise out-of-network billing is the result of a market failure: the lack of a competitively set price for physician services. There are various ways such a price could be established. We believe the best solution would be for states to require hospitals to sell a bundled ED care package that includes both facility and professional fees. In practice, that would mean that the hospital would negotiate prices for physician services with insurers and then apply these negotiated rates for certain designated specialties. The hospital would then be the buyer of physician services and the seller of combined physician and facility services. If physicians considered the hospital's payment rates too low, they could choose to work at another hospital.

This solution preserves price competition. Emergency physicians would compete on price and quality to offer services to hospitals. Hospitals would compete on the price and quality of their package of emergency services to be included in insurers' networks. Hospitals would also compete to offer sufficiently high rates to attract physicians. Insurers would compete on premiums and quality to attract employers and enrollees but would increase provider payments to create attractive networks. Most crucially, patients would always be protected.

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Adding Value by Talking More

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The prevailing fee-for-service payment model has led U.S. health care administrators and physician practices to impose severe constraints on the time physicians spend talking, for which they are reimbursed poorly or not at all. New value-based reimbursement models, however, such as bundled payments, accountable care organizations, and shared savings plans, provide powerful incentives for physicians to regain control over the quantity and quality of time they spend talking. As we have helped dozens of organizations to estimate total care-cycle costs, we've identified many situations in which having physicians and other clinical personnel talk more with patients and each other can be the least expensive and most effective approach for delivering better patient care.

One important role of physicians' talking is to motivate patients to make earlier and better decisions about their care. Less than half of patients with chronic kidney disease, for example, currently prepare effectively to start dialysis. Ideally, a vascular surgeon should place a fistula or graft several months before the start of hemodialysis. But nephrologists, under pressure to maximize the number of patients they see per day, often lack sufficient time to persuade patients to start dialysis with a matured fistula or graft — a conversation that we calculate costs less than $200. The consequence is that too many patients begin dialysis with a catheter and subsequently have high rates of infections and other complications that not only harm them but also increase treatment costs during the next 6 months by more than $20,000.[1]

Similarly, many patients with diabetes delay the recommended regimen of insulin injections. Physicians who take the time to understand patients' reasons for delaying can help overcome such resistance and thereby avoid higher-cost complications of untreated disease.

A related role of talking is motivating patients with chronic conditions to adhere to their treatment plans. Several studies have shown that spending more time addressing patients' concerns and discussing their management of their own chronic conditions leads to substantially higher levels of treatment adherence and fewer costly complications. For example, patients' adherence to statin therapy often drops substantially when they receive no encouragement from a clinician. The cost of the incremental physician and clinical staff time for talking with patients about the benefits of self-management is $100 to $200. Increasing the use of phone calls and electronic communications to monitor and encourage patient adherence is also inexpensive, perhaps tens or hundreds of dollars per year. Averting complications and hospital admissions saves tens of thousands of dollars.

Physicians can also productively use talking time to set patients' expectations. Several studies have shown that patients with high expectations for the outcomes of their care have greater improvement than those with low expectations.[2,3] These studies also showed that physicians' expectations can differ dramatically from those of their patients, a finding that suggests that a doctor–patient conversation could have a positive influence on patients' behavior and recovery.

Several orthopedic practices that we studied realized large benefits from educating and setting expectations with patients and their families. The conversations, often conducted by a nurse, required about 30 to 60 minutes of extra time, either one-on-one or as part of a group class. The discussions led to shorter inpatient stays, reductions in complications, and much higher rates of discharge to home rather than to a costly postacute care facility. The presurgical conversation cost less than $200 for the clinician time, and it produced cost savings of more than 10 times that amount, as well as better patient outcomes.

Talking is also required for engaging patients in their care choices, and when patients are actively engaged in decision making, they have better outcomes and less expensive care. One study examined patients' choices of care for six conditions for which more than one choice was reasonable. Patients who received enhanced decision support had total care costs that were 5% lower than those of patients who didn't receive such support, and they had 12% fewer hospital admissions than the comparison group.[4] Studies involving high-risk geriatric patients indicate that conversations among physicians, patients, and family members led to better patient outcomes, including reduced mortality and higher quality of life, and substantially lower treatment expenses.[5]

More talk can increase interdisciplinary interactions with patients in outpatient settings. Kaiser Permanente Colorado, for example, has established Primary Care Plus, a program targeting higher-need Medicare beneficiaries with interdisciplinary team care and proactive nurse outreach. Kaiser Permanente developed a robust system for identifying these patients, who were then assigned to a program in which personal goals and priorities were central to the development of a care plan. The frequency of outreach calls fluctuated with changes in the acuteness of patients' needs, their family or caregiver situations, and their need for social supports.

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Though the program required greater investment in care coordination, behavioral and social supports, and pharmacy and palliative care services, it reduced utilization of inpatient care and overall pharmacy costs. The cost for office visits was 21% higher among program participants than in a matched control group, but that increase was more than offset by inpatient costs that were 74% lower than those for the control group. A holistic focus on patients' goals and priorities, meeting social and behavioral health needs,

interdisciplinary team care planning, and proactive outreach and care coordination helped avert inpatient stays, with their associated financial burdens and effects on quality of life.

Communication among clinicians as they work to reach the correct diagnosis and treatment plan also leads to higher-value care. The M.D. Anderson Head and Neck Cancer Center holds a weekly treatment-planning conference, attended by 50 participants from multiple medical specialties, to discuss all new patients. After a faculty member presents a proposed treatment plan for a patient, the group discusses it until agreement is reached. A discussion for a typical patient takes 1 to 2 minutes; when the patient has complex needs, it takes about 5. Assuming that the average cost of a participating professional's time is about $3 per minute, a 5-minute discussion costs $750. But as the center's vice chair has noted, about 30% of the discussions of patients with complex needs conclude with a different proposed treatment plan, one that will lead to substantially better care and lower total costs. A patient whose case is not subject to such a dialogue and who is incorrectly treated could receive hundreds of thousands of dollars in unnecessary and ineffective care. The extra cost of bringing 50 highly paid professionals together, for a nonreimbursable meeting, to discuss patients' treatment plans is repaid many times over.

Similarly, all the clinicians at Martini-Klinik, a prostate cancer center in Hamburg, Germany, meet weekly to determine the best course of action for patients who have presented during the previous week. They also participate in many other meetings to review cases of patients with complications or unusual conditions, to identify innovations in recent research literature, and to review and improve their absolute and relative performance. These meetings consume sizable amounts of clinician and support personnel time. But the clinic's patients have complication rates that are 75% below the German average, and its earned reputation for superior outcomes has enabled it to become the highest-volume prostate cancer treatment center in the world.

As these examples illustrate, increased physician communication is time very well spent when it leads to better patient outcomes and lower total costs. Clinicians who are reimbursed under new value-based payment plans should seize the initiative to determine how much of their valuable time should be spent in the various types of productive conversations, especially as they become more accountable for their results. Physicians now have the discretion, incentives, and accountability to use their time wisely and productively to reduce the total costs of patient care and improve the outcomes they deliver.

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FOCUS ON RESEARCH

A New Cell-Cycle Target in Cancer — Inhibiting Cyclin D–Dependent Kinases 4 and 6

Charles J. Sherr, M.D., Ph.D.

Orally available drugs that potently and specifically inhibit the activities of the cyclin D–dependent kinases CDK4 and CDK6 represent paradigm-shifting antineoplastic agents.[1] Unlike traditional cytotoxic drugs, which kill dividing cells by interfering with DNA replication (S phase) or mitosis (M phase) during the cell-division cycle, CDK4–CDK6 inhibitors arrest progression through the G1 phase, promoting transient cell-cycle withdrawal into a quiescent state (G0) or, possibly,