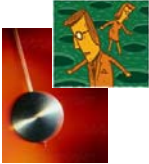


Concierge Medicine

The Pitfalls and the Pendulum

David Albenberg, MD
Access Healthcare
Charleston, SC



Objectives

- Convey our experiences and the experiences of others transitioning to Direct Practices
- Highlight the steps in transitioning to a Direct Practice
- Itemize successes and pitfalls along the way

2

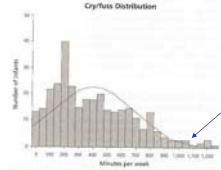
Not Covered

- Current state of traditional primary care
- Ethics
- Step-by-step approach to setting up a practice

3

Ground Rules

No Whining



4

2006 American Family Physicians www.aap.org/afp

Natural History of Your Future

- Resentment
- Burnout
- Early Retirement
 - Dear Dave,
 - Glad to see you're succeeding in the boutique practice business. I'm in solo practice, Carson City, NV. I see pts 5 days/week, 1/2 Sat each month, having about 15 patients I still do house calls on (mainly bed-ridden). However, the financial rewards have really not been there. My practice is about 50-60% Medicare. The overhead, even employing 2 people, is killing me. We grossed \$250k last year, I took home \$44k after taxes. So, I'm really considering calling it quits.
 - Dear Dave,
 - One of my colleagues who had 4000 active charts, went out of business last year, saw at least 25 pts/day, couldn't make ends meet. Another one had to sell his practice to an urgent care set-up to avoid going under. Another closed and went to work in Reno. No one is buying primary-care practices anymore. When practices go under around here, the patients vanish, since all docs are busy. No new PCPs are moving into the area. Most internists don't earn \$120k around here either. Not worth continuing as far as I'm concerned.
- Ethics Question
 - How ethical is it for an overworked, burnt-out provider to spend 7 minutes with a patient in their time of need?

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Your Options

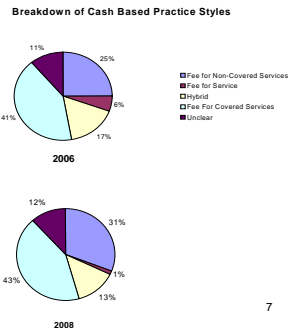
- See more patients?
- Tweak the system?
- Go to work for the insurance companies?
- Retire?
- Academic medicine?
- Laser hair removal?
- Cash-only practice?

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“Cash-only” Practices a Misnomer?

Three models of Direct Practices:

- **Fee-for-Service**
- **Retainer-Based Practice** –
 - **Fee for Non-Covered Services** – aka “Double Dippers”
 - **Fee for Covered Services** – Pure Retainer
- **Hybrids**



Survey of SIMPD Member Websites – SIMPD.org

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Milestones in Direct Practices: The Pendulum Swings

- **1996:** MD² founded by Howard Marion, *NYT* coins movement — “boutique”
- **3/2002:** “Waxman Letter” — questioning “double-dipping” / MDVIP
- **10/2003:** AMA forms “Ethical Guidelines” re transition
- **12/2003:** George Bush furthers “ownership society” — establishment of HSAs promotes consumer directed medicine
- **2/2004:** ASCP founded
- **3/2004:** OIG Alert — “double-dippers” beware
- **2005:** *Inc.* magazine rates MDVIP in fastest growing private companies
- **8/2005:** GAO report on concierge medicine
- **2/2006:** Washington is the first state to rule on retainer practices
- **3/2006:** West Virginia insurance commissioner ruling

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Direct Practices AMA Survey

- **Motivation** — ethics
 - possible decreased in physician charity care
 - risk of patient abandonment
 - exacerbation of existing healthcare inequities based on rationing by ability to pay
- **Methods** — survey of 144 retainer physicians standardized to randomized control physicians
- **Findings**
 - much smaller panels 900 v 2300 pts
 - retainer physicians treat fewer minority and Medicaid patients
 - Retainer physicians are more likely to
 - accompany patients to specialists
 - do house calls
 - have 24 / 7 access
 - do more charity work (non-statistical)

J Gen Intern Med. 2005;20(12):1079-1083.

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Direct Practices AMA Survey

- **Additional stats:**
 - 85% converted from non-retainer practices
 - 94% perform charity care
 - 12% retention of patients through transition
- **Conclusions** — Despite differences between retainer and non-retainer practices, there is also substantial overlap in services provided. These findings, in conjunction with the scope of patient discontinuity when physicians transition to retainer practice, suggest that ethical and legal debates about the standing of these practices will endure.
- **Outcome** — AMA Ethics Position Statement

J Gen Intern Med. 2005;20(12):1079-1083.

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Direct Practices GAO Report

- **Motivation** — The recent emergence of concierge care has prompted federal concern about how the approach might affect beneficiaries of Medicare, the federal health insurance program for the aged and some disabled individuals. Concerns include the potential that membership fees may constitute additional charges for services that Medicare already pays physicians for and that concierge care may affect Medicare beneficiaries’ access to physician services.
- **Identification** — 147 Concierge Physicians — 112 responded to survey, almost all practicing primary care
- **Fees** — ranged from \$60-\$15,000 / year averages \$1,500-\$1,999

8/05 - <http://www.gao.gov/new.items/d05929.pdf>

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Direct Practices GAO Report

- **Features** — same- or next-day appointments for non-urgent care, 24-hour telephone access, and periodic preventive care examinations
- **Insurance** — About three-fourths of respondents reported billing patient health insurance for covered services and, among those, almost all reported billing Medicare for covered services
- **Resolutions**
 - HHS has determined that concierge care arrangements are allowed as long as they do not violate any Medicare requirements
 - The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems
 - GAO’s review of available information on beneficiaries’ overall access to physician services suggests that concierge care does not present a systemic access problem among Medicare beneficiaries at this time

8/05 - <http://www.gao.gov/new.items/d05929.pdf>

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Direct Practices Amenities

- Access — same day visits, 24/7 access, minimal wait times, cell phone access, e-mail, telephone consults, house/office calls
- Amenities — more “pleasant” surroundings, coordination of care
- Attention — longer visits, accompaniment to specialists
- Focus on prevention — annual executive PEs

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Our Story...

Year Zero: 2002 – March 2003

- **May to December 2002** — “12 Steps to Freedom”
- **December 2002** — The Letter
- **December 6, 2002** — No Looking Back
- **December 2002 to March 2003** — The Rebirth
- **March 2003** — Shouting from the Rooftops

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The Transition Letter

November 15, 2002

Dear _____,

After five years at James Island Medical Care, I am **excited** to inform you of plans to establish my new practice at a downtown location. In my time here, I have been grateful for the **relationships** that I have established with my partners, Drs. Costa and Scott, my loyal and hard-working staff, and most of all, my **valued patients**. While I am fortunate to have been given the opportunity to nurture honesty, trust and respect within those relationships, my one regret is that our current high-paced and volume-driven practice environment has not allowed me the time during daily encounters to further those relationships.

Not only will my new model reflect a move towards a retrospective era of traditional family medicine with the patient at its heart, but it will help me launch Charleston's first example of a national model of “Retail Medicine” characterized by reduced time in the waiting room, **increased amount of physician attention, more “access”** to the physician in the way of evening and weekend hours, e-mail contacts, cell-phone after hours access and even house calls for emergencies. I intend to provide the same base of continuity care, mixed with same-day availability for walk-in urgent care, but at a reduced cost to you. In exchange, I will ask that patients make payment at the time of service. For those that have insurance plans, **we will provide you** with the documentation necessary for you to directly receive out-of-network reimbursement from your insurance carrier. A lower daily patient volume will allow me the ability to spend **more time with each patient** to provide the type of **individualized attention** that I believe you are looking for and deserve. Your help in this respect will allow me to turn my focus away from the daily frustrations of practice management, in which I have no formal training, back to the patient where my attention belongs.

After completion of my duties at JIMC over the next few weeks, I will be pursuing the full-time task of setting up the practice in anticipation of a March 1st opening. In the meantime, please read the enclosed article entitled, “Pay as you go”, which highlights the nationwide growing trend towards this type of “patient-focused” practice. If you are interested in making the transition to the new practice, please sign the below transfer of records request and fax it or mail it to us at the above address so that copies of your record will be available to us on your first visit. Those of you who fax records requests will be kept up to date on our progress with future mailings. For those of you who wish to remain with James Island Medical permanently or in transition towards our opening, you will be seen by Dr. Robinson who will be taking my place in the practice. I welcome any questions that you may have in the interim.

Looking forward to simplifying,
David L. Albenberg, MD

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Our Story...

Year One: March 2003 – March 2004

- **March 17, Opening** — saw 20 patients that week, 11 the following week; 04/03 Income: \$7,085 — Expenses \$42,751
- **Branding** — “The doctors that don’t accept insurance”
- **Hybrid Model** — “contra-insurance” model tested
- **Personal Financial Status** — savings dwindling
- **July** — first paycheck!
- **Identity Crisis** — struggling to find our niche/branding
 - Confusion
 - Healthcare “Spa”
 - Concierge/Boutique
 - Consumer-Directed “friendly”
 - Doctor in the House

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Our Story...

Year Two: March 2004 – March 2005

- **Numbers increasing** — projections show us growing beyond our physical plant within two years
- **Begin to define branding and niche** — “modern medicine at an old-fashioned pace”
- **Focus on office efficiencies**
- **Late 2004** — begin searching for property for second office/partner

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Our Story...

Year Three: March 2005 – March 2006

- **March 2005** — secured contract on second location
- **May 2005** — signed first licensing agreement with like-minded physician
- **Summer 2005** — the “talk”
- **August 2005** — the letter (the sequel)
- **October 2005 to present** — the transition
- **February 2006** — second office opens
- **August 2008** — received \$500K funding for third location

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Transition Letter – The Sequel

August 1st 2005

Dear Patients & Friends,

Almost three years ago, I left my traditional practice in search of a better way of practicing medicine. The inadequacies that I felt as a physician were not just imagined or approached a patient base of 4000, seeing close to 30 patients a day. Many of you who have followed me out of that chaos continue to remind me of that history. Out of pure desperation and a promise never to return to a high volume practice, I joined up Access Healthcare in its current form. Although the idea of our filing insurance to slow down the pace was radical here in South Carolina in late 2002, many other desperate physicians were designing similarly innovative practices around the nation with the sole goal of increasing physician accessibility and reducing patient volumes.

In March of 2003, we opened the practice with fewer than 100 patients with the mission of improving patients accessibility to their physician in the way of less waiting time, longer face-to-face time, same-day visits, 24/7 availability, email, phone consults and the result of the house call. And the practice was a huge success. We appeared on the front page of the Post & Courier the day we opened and have subsequently been the focus of dozens of newspaper articles and television news pieces largely focusing on that improvement on access. A survey that we sent out after our first year in practice revealed a 97% patient satisfaction rate with the practice.

Now a little over 2 1/2 years later and with 15 times the patients with which we started, I am approaching a similar dilemma to that which I faced in my former life namely, what to do with the demands from the exponential growth of the practice.

Earlier this summer, I made the difficult decision to limit my practice to 300 patients beginning November 1st, all of whom will be under an annual retainer plan. Only by doing this will I be able to continue to give the focused, dedicated, personalized service to those folks who remain with me. For those folks who can't or do not want to make the transition, Dr. David Robinson will be available to see you on the same pay-as-you-go basis to which many of you have already been accustomed. David and I have a long history together dating all the way back to college and he is one of the few physicians in Charleston to whom I would entrust your care.

Additionally, so that I can be everything for those limited patients without charging anything above the plan price, we are extending my availability to 24/7 and including all of the in-house labs and procedures that we perform in the office for all three plans. You will also notice our efforts to simplify our plans substantially and have designed family plans to give families incentive to join the practice together.

I appreciate that some of you will not be pleased with these changes. To you, I can only promise that my motivation for making these changes is to indefinitely provide the highest level of personalized care that you are already receiving and never to head back in the direction of feeling inadequate about addressing my patients' needs.

There will be a few other changes around the office as well as Nicole heads up our new Mount Pleasant office. Lu heads back to nursing school and Stacy goes back to work for Blackbaud. Many of you have already met Jason Perley, who has been working for us since February and Mary Ruth Hurst who joined the practice as a registered nurse just last week.

Please see the attached sheet which describes our new plans in detail. I encourage you to contact Nicole by email @ nicole@letsimplify.com, by telephone, or in person at the practice if you wish to discuss these plans in any more detail. As always, I will also remain available for and will welcome feedback from you during this understandably confusing transition.

Thank you once again for your continued support of the practice.
Get prepared to receive this letter. You can absolutely count on more internists and family doctors doing what these folks are doing." - Dr. John Santa, director of the Consumer Reports health ratings center

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The Product...

www.LetsSimplify.com

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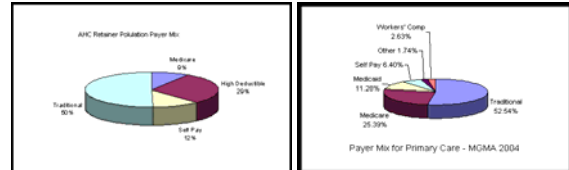
Outcome Measures: Comparison — Practice Management

	Former Practice	Retainer Practice
Patients/Day	30-35	12-15
FTEs/Physician	17/3	5/2
Staff Name Recall	90%	100%
IT Investment	Minimal	\$60,000
Dictation Costs	\$25,000/yr	\$0
Startup Investment	\$30,000	\$125,000

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Outcome Measures: Patient Demographics

Insurance Payer Mix



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Outcome Measures: Comparison — Patient Care/Work Flow

	Traditional Practice	Retainer Practice
Dr/Patient Relationship	Poor	"Re-establishing" Relationships
Special Skills	Mater of Apology Art of Interruption	Focused on Patient Care
Documentation	2 Hours Dictation Daily	"Point of Care" Technology
Work Flow Environment	Chaos and Entropy	Order and Accountability

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Outcome Measures: Practice Finances (9/2008)

	Traditional Practice	Access Healthcare
# Patients	3000-5000	301
Retainer Revenue/Patient		\$1,375
FFS Revenue/Patient	\$248	\$132
Gross Revenue/Year	\$799,355	\$543,000
Net Collections %	72.8%	99.8%
Net Revenue	\$582,031	\$542,000
Overhead %	57.5%	70%
Profit to Physician	\$247,300	\$162,600

Based on 2007 MGMA report on 2006 data

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Outcome Measures: Comparison — Intangibles

	Former Practice	Retainer Practice
Physician Disposition	Increasing irritability Desk kicking Increasing BP	Less weekday irritability
Job Security	None	"Ownership"
Office Hours	M to F: 8 - 6 Sat: 9 - 1	M to F: 8 - 6 Sat: 9 - 1
Call	Telephone triage 24/7	See patients 24/7
Malpractice Threat	Tenuous	Contained
Recurrent Dreams	Men in suits	Promoting retainer medicine nationally

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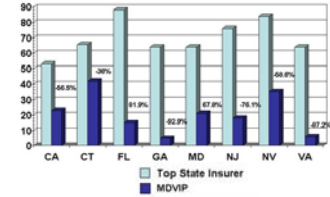
Outcome Measures: Quality of Care

MDVIP Hospital Utilization Healthcare Statistics

What does all of this mean for patients? Patients in MDVIP affiliated practices are admitted to the hospital at dramatically lower rates than non-MDVIP patients. Reductions in hospitalizations are up to 65% for Medicare beneficiaries and up to a staggering 80% for those with commercial insurance. The results are scientific, not anecdotal and are because MDVIP physicians have the time to have much closer relationships with their patients.

MDVIP 2005 Hospitalization Rates

Compared to Top Performing Health Plans by State



Disclaimer: Based on a comparison of hospitalization rates for MDVIP affiliated physicians vs. commercial and Medicare admissions in 2005.

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Surrogate Markers for Success

- Casualty of the traditional system
- Strong patient following
- Gratification delay/Investment-minded
- Business-minded — systems and work flow orientation
- Value-chain — adds value
- Eager to regain boundaries
- High risk tolerance
- Committed — financially, professionally, emotionally, philosophically
- Grounded — financially, professionally, emotionally, philosophically
- "Second order change" — abandon old beliefs and embark in new territory
- Clinically sound — relationship-oriented doctor

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