Flexible Practice Approach Has Something for Everyone

Hybrid form of concierge care translates into happy patients—and physicians.

BY JENNIFER SILVERMAN
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Cardiologist John Levinson, M.D., has a multifaceted approach to health care.

In 2001, he established the first "concierge" practice in New England. But unlike other practices of this type, Dr. Levinson runs a "hybrid" practice that cares for retainer and regular insurance patients. Plus, he still finds time to see patients in the hospital.

This seems like an ambitious way to practice medicine, but in an interview, Dr. Levinson insisted that his hours have never been more manageable—and his patients are happier than they used to be.

Traditionally associated with high fees and a limited and wealthy patient base, concierge care—now often called "retainer care"—is morphing into a number of different types of practices, according to Matthew Wynia, M.D., an internist and director of the American Medical Association's Institute for Ethics.

Some practices are offering special programs for the indigent or providing various payment options for their patients. Or, in Dr. Levinson's case, they're providing specific types of care, such as cardiology/primary care.

The seeds of Dr. Levinson's practice evolved from the complaints of one very ill cardiac patient who had been under his care at Massachusetts General Hospital, Harvard Medical School, Boston, for several years. The patient ran a large corporation. In 2001, after an extended hospital stay, "he came into my office furious. I was sitting my desk, wondering if I'd done something wrong." It turned out the patient was angry with the insurance company.

"He'd gotten the explanation of benefits statement which said the insurer had paid 25% of my charges." Most doctors in Massachusetts get around 25%-30% of their charges, he said.

"But the bottom line was this patient felt he would not have made it through that hospital stay if it weren't for me, and he was worried about me working too hard. He wanted me to slow down so I wouldn't die before him, and he wanted me to be his primary care doctor, not just his cardiologist."

While his practice initially started with this one patient in mind, it eventually turned into several practices, catering to different types of patients.

"The way my day works is, I drive to the hospital at 5 in the morning, see my inpatients until 8 a.m., then have a regular office day," where he sees his retainer patients, along with the regular patients who are on Medicaid and other types of insurance. "That's one of my values, to accept patients into my practice regardless of whether they can pay or who's paying," he said. At the end of the day, he goes back to the hospital to check on in his inpatients.

Overall, his practice includes approximately 7,500 patients, 40 of whom are retainer patients. There are two groups among the retainer patients. The first group uses Dr. Levinson as the primary care physician. Upon request, he later developed a cardiology-only retainer practice. "Some—about 25—use me for primary and cardiology care and the others are just cardiology patients."

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Those who want primary and cardiac care pay a higher annual fee than do the cardiac patients, he said. He would not disclose the fee, but said the retainer patients generally pay the fee annually.

"For every patient in my practice, retainer or otherwise, myself or another cardiologist is always available 24-7. That, of course, is the law in this country; it's only appropriate that patients get their doctor or some covering doctor when they need them. The difference with retainer care is there's never a covering physician between me and the patient. I'm personally available 24-7. They can arrange for a Saturday house call. When they make a routine visit, the appointments are always longer for patients in the retainer practice."

This doesn't mean he neglects his regular patients, he said. Retainer patients know they might have to wait if they make a same-day appointment and he is busy treating an indigent patient in his regular practice. "I don't skip lines ethically."

Dr. Levinson said he now has more time for all of his patients. "Oddly, I'm more available for everyone. I'm more relaxed in each session." With more time for patients, it's like taking care of friends and family, he said.

Retainer practices have often been criticized for "double billing" patients—charging an access fee on top of regular services covered by insurance. According to BlueCross BlueShield of Massachusetts, "If you're an active member of our network you can't charge an access fee to patients," Chris Murphy, spokesman for BCBS in Massachusetts, said in an interview. To charge such a fee, the physician would have to charge for services beyond the insurance company, he said.

Legislators in Massachusetts on several occasions have introduced a bill to limit these types of practices, requiring that any preferred-provider arrangement contain a provision barring the physician from charging an access fee to a covered person.

Dr. Levinson insists that his concierge fee pays for services not covered by the insurance contract, or by Medicare.

It pays for 24-7 access, which includes access at unusual times of the day, "but even if they come to my office for a normal medical visit, I'd bill [their insurer] for medical care provided." In other words, his fee does not cover medical care.

As for the Massachusetts legislation, "so far it hasn't gone anywhere," Dr. Levinson said.

At the time of the interview with Dr. Levinson, the Government Accountability Office was planning to issue a report on the impact of retainer medicine on Medicare.

"We are hopeful it will show that retainer care is a very small part of American health care without any significant impact across the board," he said.

And indeed, the GAO's report, issued in August, concluded: "The small number of concierge physicians at the time of our review, along with information from available measures of access to services, suggests that concierge care does not present a systemic access problem for Medicare beneficiaries at this time." ■

Quality Measures Up in JCAHO Hospital Data

BY ALICIA AULT
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A set of process measures established by the Joint Commission on Accreditation of Healthcare Organizations has helped hospitals to improve performance, according to a study of the first 2 years of implementation.

The study, by Scott C. Williams, Psy.D., and his colleagues at the commission, found that improvements were made in 15 of 18 standardized measures and that there was no deterioration of quality in any of those areas (N. Engl. J. Med. 2005;353:255-64).

In 2002, the commission began measuring performance in the 18 measures at 3,377 of 4,644 hospitals accredited by the organization. Nonparticipating hospitals either did not offer the services being measured or had an average daily census of fewer than 10 patients. The facilities could choose to submit data on at least two of the following conditions: acute MI, heart failure, pneumonia, and pregnancy and related conditions.

They did not track the pregnancy measures, as two of the measures applied to rare events, and the third, vaginal birth after cesarean section, is controversial, the authors wrote.

The study covered hospitals that submitted data from the third quarter of 2002 to the second quarter of 2004—a total of 3,087 out of the 3,377 hospitals initially identified as study participants. Of those, 1,473 submitted data on heart attack measures, 1,946 on heart failure, and 1,797 on pneumonia.

One of the measures looked at death in the hospital after acute myocardial infarction, and the other 17 assessed processes of care.

There was no improvement in the death measure, but the authors said most of the improvements in the process measures being assessed would not have had an impact on mortality. And there was no significant improvement in the mean time to thrombolysis for patients with acute MI or in mean time to administration of antibiotics for pneumonia.

Hospitals that started with a lower baseline performance improved more quickly than did those with higher initial ratings, but this result was not necessarily expected, the authors noted. "Such hospitals may be less likely to focus on quality or make an effort to improve performance than their counterparts with a higher level of performance," they wrote.

For acute MI, researchers looked at measures such as whether aspirin was given within 24 hours of admission and prescribed at discharge, whether an ACE inhibitor was prescribed at discharge for patients with left ventricular systolic dysfunction, and the mean time from arrival to thrombolysis or percutaneous coronary intervention.

For heart failure, hospitals were tracked on whether they had given patients smoking cessation counseling and discharge instructions on medication, diet, weight, and worsening of symptoms, and whether an ACE inhibitor was prescribed at discharge for patients with left ventricular systolic dysfunction.

For pneumonia, the commission monitored whether there was an oxygenation assessment within 24 hours of admission and whether pneumococcal screening, vaccination, or both had been given at discharge, or if blood specimens were cultured before starting an antibiotic.

By the end of the study, more than 90% of MI patients at most hospitals received aspirin at admission. Although only 74% of patients received ACE inhibitors at discharge at the lowest performing hospitals, 83% received them at the highest performing facilities.

The biggest improvement was seen in offering smoking cessation counseling. Rates went from a range of 1%-7% at the lowest performing hospitals at baseline to a range of 57%-68% at the study's end. At high-performing facilities, however, rates dropped from an 80%-98% range at baseline to a range of 74%-85% at the end.

Even after improvement, pneumococcal vaccination rates were still low, ranging from 35% in the lowest performing hospitals to 66% at the highest performing facilities.

The authors noted that one potential drawback of the study was its reliance on self-reported data, which could introduce bias. And, they said, the data should not be viewed as static. The picture could change as public reporting of hospital data becomes more prevalent and pay for performance spreads. ■