Bright Spots in Family Medicine and Primary Care

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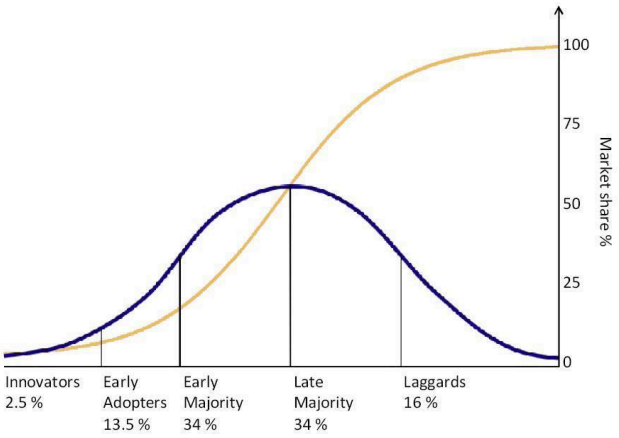
Preface

In the FMEC, we believe Family Medicine is critical to the health of the nation. We're working to achieve the full potential of Family Medicine.

If Family Medicine achieves its full potential the United States will have a primary care driven system. Those interested in population health and reducing the cost of care will have found the country in a much healthier place.



We believe the social adoption curve (above), which has been validated scientifically in many domains throughout our economy, shows a pathway to change.

If we can find the innovators in primary care and especially in Family Medicine and create opportunities for the early adopters to learn of these innovations, the change process can begin. Beginning in 2008 we searched for, vetted and showcased Family Physicians and General Internists who are true innovators.

This is the first in a series of documents that describe the work of the innovators and sharing these documents broadly is an attempt to draw the attention of early adopters.

This document would not have been written without the enthusiastic involvement of Ally Abel, MD. In our Innovator Network meeting in 2019, Dr. Abel, then a medical student, volunteered to support the Innovators Network. Her enthusiastic support got the wheels rolling. She became an active co-partner conducting the first set of interviews and writing up the summaries.

Ron Cichowicz, formerly a new reporter in Pittsburgh, PA, has been a co-writer on a number of the documents. It has been a fun collaboration

These materials are intended for all those who want to learn in-depth about the Family Medicine movement. For those who think that Family Medicine is about sore throat and runny noses, you will be surprised. For those who think Family Medicine is not intellectually challenging, think again. What you will discover in these innovators is that there is a whole host of the "best and brightest in medicine" working actively as Family Physicians. Their adaptive capacity and commitment to improve health care

delivery are impressive. Enjoy the stories.

What is a Bright Spot?

A bright spot is a project that stands out from the crowd. There is a great deal of strong work being done in primary care that is effective and impactful. Individual patients, families and even communities benefit. We search for projects that are innovative… they break through the usual approaches to primary care and demonstrate what we call the "promise of primary care". They answer the question… What would primary care be like if it was properly structured and funded? What results might we see?

As Dr. Ian McWhinney, one of the intellectual founders of Family Medicine, said… *Our destiny as general practitioners is to save from collapse the health care systems of the western world.*

It is with this spirit that we search for bright spots in primary care that demonstrate the potential to renew and transform our non-systems of care into care that serves people and communities while reducing the unnecessary health services that are harmful and costly. We carefully vet each project that comes to our attention in terms of its effectiveness, sustainability, scalability and its potential to create disruptive innovation. A bright spot is a primary care driven innovation that can move us toward a primary care driven system in this country.

Many, but not all, of these Bright Spots came to our attention through the FMEC Innovators Network. Some of the Bright Spots were recommended by leaders across the field of Family Medicine. Most of these projects are known to only a few close associates of the innovators. We also know that the set that is in this document is an incomplete set. There are many more Bright Spots out there. It's time to showcase what is possible and to launch the process that will move the innovations to those looking for solutions and who hope and believe that something better than what we have now is possible.

In what follows you can choose your preferred learning method. Each bright spot began with an interview with the project leader. You can scan the QR code and it will take you to the interview which is housed on the FMEC podcast or YouTube channel. The interviews lasted between 30 minutes to one hour. Second, you can ignore the recording and read the article that summarizes the interview. Most articles are 5 – 6 pages in length. Really pressed for time, read the highlights of the project that are listed in the text box.

Did I mention that the innovators welcome questions from those who wish to learn more about their work? We have not put the email addresses of the innovators to print but they are referenced near the end of each recorded interview.

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An Open Letter to John McPhee

Dear Mr. McPhee,

I opened my New Yorker magazine and was excited to see a piece written by you. Awesome I thought; he's still alive! What a find! I have been thinking about your for some time. I wanted to let you know what's become of the Family Practice revolution.

I am a great fan of your book *Heirs of General Practice*. No one did a better job of appreciating and communicating the energy and abilities of Family Physicians. When your book came out in 1984, it was an immediate success within the Family Practice/Medicine community across the United States. (the name was changed in 2003). While your book focused on the Maine Dartmouth Family Medicine Residency Program, you were describing the vitality of the more than 250 Family Medicine residency programs that were active in the country at that time. For all those who thought (wished) Family Physicians was a fad, there are currently 729 Family Medicine Residency programs graduating abou0t 4500 Family Physicians per year.

Daniel Onion, MD, an internist, was the program director and Fred Craighie PhD was the behavioral medicine faculty member at MDFMR. Both were outstanding examples of leaders in the Family Medicine movement. There were a number of internists, pediatricians, and other specialists who jumped on board the Family Medicine movement during the founding era. These leaders did not have the opportunity to choose a specialty like Family Practice when they completed their medical school educations. But they recognized the need for Family Physicians and lent support to the revolution.

Not sure if you knew this but Family Practice/Medicine was (and is) the only specialty that required that a behavioral medicine professional be present in each program. Likewise, at that time, Family Practice was the only specialty to require re-certification every seven years. Both requirements reflected the founders' vision of what it takes to become and maintain competence as a Family Physician and both these requirements added dynamic energy to the Family Medicine movement. \

You captured so many of the core elements of the revolution in your writing. I often wondered if the fact that your father was a general practitioner helped you to understand what these docs believed and practiced. They were a courageous and determined group.

I use the term revolution because that is exactly what Family Practice was about. Here are the words of Dr. Ian McWhinney one of the intellectual founders of the Family Medicine movement

This I Believe
By Ian McWhinney

> "Our destiny as general practitioners is to save from collapse the health care systems of the western world. I use the term general practitioner because it is only by being generalists that our discipline can survive. Our discipline is unique in medicine. All the other fields describe themselves in terms of technologies or disease entities. We describe ourselves in terms of relationships – especially the doctor-patient relationship. It is customary for patients to join our practice before we know what illnesses and problems they will have. Our commitment to patients is to care for them whatever

illness they bring to us. That is why we must be generalists. If we allow our discipline to break up into a hundred pieces, it will die."

The founders who launched the new specialty and the "first responders" – the medical students who embraced Family Practice during the early years and who rejected the traditional specialties – were a rugged lot. They had a passion for care of patients and families and were willing to respond with vigor to the unmet needs in their patients and in the communities they served. As G. Gayle Stephens, MD, one of the other intellectual founders stated… *"Family Medicine is Primary Care with Soul!"*

As you learned Family Practice was a grass roots movement that challenged the hegemony of the current model of care that had become moribund and inwardly focused. Rather than focus on the needs of the population, the traditional model was trapped in its core assumption that real physicians were physician-scientists. The physicians' core obligation was to expand the science that informs their work and to eradicate disease.

Family Medicine is the last major innovation within the house of medicine. Like most innovations it was disruptive to the dominant culture. It also threatened the financial interests of a number of the medical specialties. Within the house of medicine and especially in academic medicine, a firm conviction held that general practitioners needed to disappear. There would be no need for them and besides they were embarrassing to the profession. A real doctor was a man (and it was mostly male) of science. Physicians were to focus on their area of special interest by building "clinics" that provided a home for their scientific endeavor with their patients serving as subjects of their work.

In your book you shared a quote from one of the old guard in medicine…" if the old-time family doc had been meant to survive, he would have appropriately adapted in the evolution of American medicine". In 1984 and to a lesser extent today, the academic elite wished Family Medicine would vanish. They still try to talk students out of their specialty choice if the student is interested in becoming a Family Physician.

You pointed out that in one medical school Family Practice was in the basement and you had to get a key to the room to gain admittance. Family Practice was equated with "Band-Aid medicine". In one point you stated "the old doc of the magazine cover-magician, counselor, and metaphysician - had been replaced by technicians with machines and clipboards. " You can learn more about this loss in a book written by a cardiologist Benjamin Lown, MD (he was also a Nobel Laureate). *The Lost Art of Healing* was his attempt to attract his sub-specialist colleagues back to the core of their profession. Did they listen? No more than they listened to Sir William Osler, MD. Instead Family Medicine became the home for those medical students drawn to the physician as healer ethos.

The hope in the sub-specialty community was that Family Practice would blow away. In one place you stated…"other physicians don't know what the role of the family practitioner is. Other physicians tend to think, family practitioners can't know everything; therefore, they know nothing. The role of the family practitioner is not to know everything but to be a primary care physician to a family, to provide continuity of healthcare from cradle to grave – a unique role in our society." The core assumption was that good doctoring was based on how much a doctor knows. This might be true if you believed that the physician as scientist is the ideal.

The reaction of those who are current leaders in the house of medicine in many places has not changed. This message below was shared with me by John Geyman, MD one of the founders of Family

Medicine who is still active and writing today. I had shared with him a description of the paradigms that are currently operative within the house of medicine.

From John Geyman, MD

> Today, already a decade after the *Breaking Point* book, it seems to me that the situation between family medicine, general internal medicine and general pediatrics has not changed at all. Sub-specialization of the latter two remains very high and med-peds residencies never took off very much. There are a number of strong family medicine departments training broad-breadth family physicians, such as here at the University of Washington, but their impacts nationally are still way short of the need.
>
> Your description of the history and dynamics between the three specialties is still spot on. Moreover, I think that primary care itself remains under-recognized, under-funded and neglected among policy makers that still value more specialized care above the essential elements of primary care. As is now obvious, the COVID-19 pandemic has exposed system problems of our health care system, including shortages of primary care, unaffordable care, and systemic racism, as my attached article in press for the *International Journal of Health Services* describes.
>
> Bottom line, your piece is still unfortunately accurate in describing ongoing political and cultural problems within U. S. medicine.
>
> All the best to you and keep up your important work. John

The founders and first responders believed that the old-time family doc was meant to do more than survive. As the revolution grew, they were energized by their vision of transforming the U.S. healthcare system. They felt a sense of obligation to their patients and the communities they served and they believed American medicine should deliver something better.

One of the biases in academic medicine claims that Family Medicine is not intellectually challenging. As you'll see when you read these Bright Spot interviews, it is actually much more intellectually challenging then many of the sub-specialty fields in medicine.

When you wrote about Family Practice, most of the graduates of our Family Medicine Residency programs completed their training and began to practice in the community. They almost all cared for their hospitalized patients and their patients in nursing homes. Most either secured a bank loan and opened their new office or they joined an existing practice.

As these physicians matured and as the future cohorts of Family Physicians emerged in their clinical, academic and research activities, they began to adapt and to respond to unmet needs. It has been said by many that a Family Medicine residency graduate is "an undifferentiated stem cell" who adapts to the needs of the patients/communities she/he serves. Indeed, adaptive capacity is one of the hallmarks of a Family Physician.

I encourage you to read the Bright Spot stories that describe what these pioneers have accomplished. From eliminating the need to hospitalize frail elders in the last three to five years of their lives to creating neighborhood health stations to building a network that serves 1,000 community based independent Family Physicians who care for more than one million patients. These pioneers have gone beyond the vision of the founders. And yet, what is at the core of their work is rooted in the vision and dreams of the founders. Just as we humans are made of the stuff of stars, re-formed to grow in our current world, these

bright spots make visible the core philosophy and values of Family Medicine that is transforming healthcare in our country. The movement has not stalled, it just takes a long time to create a primary care driven system in a culture that uses health and suffering to create wealth and that loves technological fixes and especially a culture that does not trust physician leadership.

Thanks for your support of the movement.

We both are aging and my hope is that we both and all other people in our country have access to a well- trained Family Physicians as we move to our next frontier.

By the way, you might be interested in learning that the Family Physicians who you featured in your book are still active. Their passion for caring for patients and their communities keeps them active to this day. Wouldn't it be fun to hold a reunion with them? I think you would still find them to be physicians who are proud of their work and who care deeply for the people and communities they serve.

Drs. David Thanhauser, Sue Cochran, Sanders Burstein, David Jones, Terrence Flanagan,
Ann Dorney, Paul Forman

Bright Spots Interview #1

An independent primary care network dedicated to helping communities thrive during a time of considerable uncertainty: Interview with Dr. Christopher Crow

Written by Allyssa M. Abel, MPH, MS4 at Albany Medical College, @allymay82
Edited by James P. Cunneen, MS Candidate at the Eck Institute for Global Health, Notre Dame

Overview

A vision driven Family Physician leader with a commitment to serve his community attracted a team of like-minded colleagues who lead the planning of the Catalyst Health Network (CHN)

They developed a management services like organization that serves as a hub and spoke model. CHN is committed to transforming the health and well-being of communities through the power of relationships. It was created specifically to help independent physicians stay independent

CHN now supports just under 1,000 primary care doctors and serves more than 1.5 million patients across Texas. It is an independent network of primary care practices that promotes "intimacy at scale," with the end user's best interest in mind.

They have built a model that extends the care team so that each practice/doc/team is able to take care of more and more patients, not less.

CHN is able to serve more and more families without increasing the burden and burnout rate among their physicians? Their management philosophy: Our priority is that everything has to be net-positive financially; everything has to be net-positive on time that [our providers and staff] are putting into their work; everything has to be net-positive clinically, and finally everything has to be net-positive from an ego standpoint. Net-positive outcomes in all four categories are not optional; they are required.

Therefore, if a tool or resource hits all the time, clinical, and ego marks, but it causes a financial loss, then that tool or resource does not work and will not be implemented. If a tool or resource hits the clinical, ego, and financial marks, but providers must spend an extra hour a day to use it, then it will not work either. CHN prioritizes creating net-positive changes in these four categories, always putting the best interest of his providers, staff, and patients first.

CHN is able to anticipate challenges (like a hurricane or a pandemic) and create the support systems to help their member practices respond to the challenge.

They created a central pharmacy that works closely with their members.

They created a value-based prospective payment model that keeps cash flowing during difficult times.

They carefully select new physicians where there is value alignment with CHN values and philosophy of care.

Dr. Christopher Crow is a family physician by training. In our recent podcast episode with him, he reflected upon his childhood in Hillsboro, Texas, outside of Dallas. In the small Hillsboro community, there were only three family physicians. These physicians not only saw patients in their exam rooms, but served as local politicians, faith leaders, and as support staff on the sidelines of every Friday night football game, which the entire town attended. These physicians were jacks of all trade, respected community members. Although he did not realize this until later in his life, they were ultimately the reason he decided to go to medical school after completing an undergraduate degree in zoology. They also were his role models regarding how a physician should care for his/her community beyond the office doors.

He completed his medical education at the University of Texas Southwestern Medical Center in Dallas, TX and St. Paul Hospital Family Medicine Residency Program

When Dr. Crow finished his family medicine residency, it was not his plan to become the founder and president of Catalyst Health Network, one of the largest innovative primary care networks in the United States. He chose to become a community-based Family Physician. After beginning his medical practice, Dr. Crow became aware of the enormous cost savings independent physicians could have on the health systems. According to Dr. Crow, independent practices charge 30% less than large integrated hospital systems. Inspired to learn more, Dr. Crow went on to earn his Executive MBA from the University of Texas. He described the experiences as if someone was “taking a blindfold off. I was able to see concepts and understand jargon that I didn’t have access to before.” Dr. Crow started to envision better healthcare delivery. Combining his business acumen with his physician leadership skills, he began to work with a team of skilled visionaries and they developed a vision of a better health delivery model. Although founded only six years ago, Dr. Crow’s Catalyst Health Network now supports just under 1,000 primary care doctors and serves more than 1.5 million patients across Texas.

In one of his famous metaphors, Dr. Crow describes Catalyst Health Network as the NFL with the individual primary care practices as the teams, and each primary care provider as a quarterback on the field of medicine. What is so unique about an independent network of primary care practices is that it promotes “intimacy at scale,” with the end user's best interest in mind.

With regards to the direct primary care (DPCs) clinics that are now popping up independently across the US, he makes an interesting point. Although many doctors are in favor of this new model, he finds it reasonably problematic. “I actually find it very much provider-centric wrapped into patient-centric marketing.” Dr. Crow points out that most DPC models limits the number of patients a physician serves, which is antithetical to community wellness. He asserts his health network model is precisely the opposite; what the country needs is an extension of the care team to be able to take care of more and more patients, not less.

How is he able to serve more and more families without increasing the burden and burnout rate among his physicians? His answer to this question may be obvious but is rarely articulated and put into practice so eloquently. “Our priority is that everything has to be net-positive financially; everything has to be net-positive on time that [our providers and staff] are putting into their work; everything has to be net-positive clinically, and finally everything has to be net-positive from an ego standpoint.” He goes on to explain net-positive ego to us:

> “What I mean is they have to feel like they’re getting good feedback from any of the resources, tools, people, and technology that we’re integrating into the practice that they themselves, their staff, and their patients interact with. If they’re getting positive feedback, then that reinforces that behavior to continuously use and engage with those tools and services as we bring new things on board.”

Net-positive outcomes in all four categories are not optional; they are required. Therefore, if a tool or resource hits all the time, clinical, and ego marks, but it causes a financial loss, then that tool or resource does not work and will not be implemented. If a tool or resource hits the clinical, ego, and financial marks, but providers must spend an extra hour a day to use it, then it will not work either. Dr. Crow prioritizes creating net-positive changes in these four categories, always putting the best interest of his providers, staff, and patients first. This ideology is inspiring, and people across the country are starting to take notice.

What else makes Dr. Crow's primary care delivery model so unique and one that should serve as an example for other communities in America? Well, Dr. Crow describes in detail Catalyst Health Network's unmatched adaptive capacity and forward-thinking approach to both the health-side and business-side of medicine. The network is URAC-accredited (www.urac.org/) and unlike any other health network in the US, has a trifecta of certifications in care management, transitions of care, and community pharmacy. These characteristics, he says, have afforded the doctors within his network the ability to respond swiftly to the COVID-19 crisis we are currently facing:

> "We're able to look out on the radar and predict in how many days and where the hurricane might hit. As it gets closer and closer, it becomes more evident where it's going to hit, its strength, and potential damage. So about three weeks ago, we started to realize there was a hurricane out there, and that it was going to hit our practices with a brunt force that they have never seen in their careers."

Two weeks ago, the network was able to start a hotline for patients. They immediately set up drive-through testing and are now testing hundreds of patients per day. By offering widespread testing very early in the Covid-19 crisis, they have been able to keep all physicians and staff out of quarantine. One month ago, approximately 15% of the network's primary care physicians and providers were on telehealth platforms, seeing only about 1% of their volume virtually. Today, 92% of all Catalyst practices have fully implemented the internal telehealth platform using their own personalized EMR systems. Entire care teams are working remotely with more than half of Catalyst Health Network's patient interactions are occurring virtually. The central pharmacy, filling over 1000 scripts per day, is working to deliver medications directly to patients, so they don't have to visit chain stores and put themselves at risk. "I'm not going to sugar coat this," Dr. Crow prefaced, "but having a crisis has exponentially increased physician practice engagement in what we're doing and the model we built. Everyone is starting to see the future in our model."

Dr. Crow's holistic care model also includes plans for an upgraded patient payment model. He points out that there has long been a misalignment of the current way we pay for our healthcare and how it is delivered. This is especially evident within primary care. He uses the metaphor of "putting one foot in each canoe" when discussing the current transactional, reactional, fee-for-service model used to finance healthcare across the country, in contrast with the long-term, relational, proactive nature of primary care delivery. The two just do not line up or support each other in any productive way. Now, Catalyst Health Network practices are implementing of more prospective, value-based payment models. Dr. Crow predicts that this will help with not only a cash infusion during this current state of medical need, but also create an economic environment where primary care practices are fully supported and can thrive in the future. (for the reader: Prospective, value based payment means the practices are paid in advance of service based on their ability to manage the quality and cost of care)

Another lesson to be learned from Dr. Crow and his network of healthcare providers is that, from the beginning, they have all committed to avoiding financial support from private investors. This refusal has

allowed the system to be dynamic with their choices and respond to new situations, like this crisis, for instance, without having to worry about investor interests. Freedom to choose their own path and creatively solve challenges as they arise is another reason Catalyst Health Network has grown into a national leader in the primary care arena. As a result, their efforts are being shared widely by the Texas Academy of Family Physicians. Catalyst's leadership in this time of crisis has earned it a seat at the table as a consultant for the American Academy of Family Physicians with regards to COVID-19 response planning.

In all organizations the culture of the organization drives performance. Dr. Crow has created a culture that both doctors and businesspeople want to be a part of. Before bringing new people in, Dr. Crow performs what he likes to call a "soul biopsy." If the new persons share similar values with that of the Catalyst Health Network, then they are welcomed onto the team. If you have ever seen him in the media, Dr. Crow emphasizes the four pillars that must be in balance for a community to thrive: healthcare, education, civic government, and jobs. His purpose ever since becoming a doctor has been to help communities balance these pillars. "When you have a purpose like that, that's deep in your bones, and you start to spread that to like-minded people who see and understand the problems, who want to spend their time and energy week after week to make a dent in that, you get a pretty darn strong culture."

How does one become so passionate about the promise of primary care? It's simple. First, he had early family physician idols who were outstanding community leaders. Second, there is rigorously studied, published evidence that primary care is beneficial. "We know that primary care physicians, if you have one, you live longer. You know you spend less money on healthcare. You know you have more good days at work than bad days. I mean, that's a pretty significant outcome that is reproducible worldwide, so why wouldn't we prescribe that for everyone?"

It has been a decade since Dr. Crow transitioned from full-time doctor treating individual patients, to savvy physician leader focused on strategically providing the very best, affordable care to more than a million people. He is a true healthcare pioneer and leader. Only now, amid the COVID-19 pandemic, does he feel that American healthcare is within months of a completely new healthcare business model with primary care as the focus. He does not shy away from admitting it is the COVID-19 crisis, and their need to respond, that has pushed his network onto the vision that they had initially set out to achieve a decade ago.

Please do not hesitate to follow @DrCCrow or @catalystHN on Twitter. Also, visit catalysthealthnetwork.com for more information and to view their COVID-19 self-assessment tool. All content, Dr. Crow assures us, is open to the public.

If you or a colleague is a family physician-leader who has helped to recreate or streamline healthcare delivery on a local or national level, we'd love to highlight you or someone you nominate in our "Bright Spots" podcast series. Please email Laurence.Bauer@fmec.net with your nominations/questions/comments. Thank you so much!

Bright Spots Interview #2

ChenMed offers affordable and accessible concierge care for the elderly: Interview with Dr. Daniel McCarter

Written by Allyssa M. Abel, MPH, MS4 at Albany Medical College, @allymay82
Edited by James P. Cunneen, MS Candidate at the Eck Institute for Global Health, University of Notre Dame and Laurence Bauer, MSW, MEd - FMEC

Overview

ChenMed as a high-touch primary care group. one of the largest networks of practices in the United States providing high-quality care for seniors. ChenMed takes full financial risk for their patients.

ChenMed has grown to include more than seventy primary care offices in ten states east of the Mississippi

ChenMed offers concierge level medical services for low- and medium-income seniors. Older folks with complex chronic medical conditions are their focus.

A ChenMed primary care physician leads a team of medical professionals to provide whole person care for a panel capped at 450 patients. Each patient is promised at least one visit per month and sicker patients are seen more frequently.

ChenMed primary care practices are placed in underserved areas and patients are exclusively covered by Medicare Advantage. Whether their loved one (the patient) needs a doctor once per month or every day of the week, the cost remains the same In most markets it is a $0 premium Medicaid product

The physician led teams at each of the seventy ChenMed sites are structured a little differently, but are variations on the same basic theme: full spectrum care. For example, behavioral health services are offered at every location,

Care teams are constantly changing and adapting in response to data about patient needs. Specialists recruited to the ChenMed primary care package include cardiologists, endocrinologists, infectious disease specialists, and nephrologists.

If a patient requires hospitalization, ChenMed's care team includes a case manager who visits and stays in close contact with that patient while in the hospital. The care manager acts as the liaison between the ChenMed primary care team and the hospitalist team. The care manager acts as a personal in-hospital advocate, like a lawyer representing a client. It is also the case manager's duty to schedule a follow-up appointment within 72 hours of the patient's discharge. If a patient has any issues making it to that follow-up appointment, the case manager will go as far as to send an Uber to the hospital for the patient to be transported directly to the primary care office on the way home.

ChenMed also employs community case managers to help patients who do not necessarily need to visit the office to see a physician.

Each doctor has a cell phone, and most of the time, it's the patient's personal doctor who answers when the patient calls.

~~The physician culture at ChenMed = Our values are love, accountability, passion, and we've recently~~ added a fourth one - fun.

ChenMed offers a range of services to support their physicians that promotes collaboration and accountability.

The onboarding of new physicians is slow and methodical. New ChenMed doctors spend two weeks training. They spend a third week being on-boarded at their new site.

"MD Help" is a service offered to ChenMed providers. This service allows doctors to email an interesting patient presentation to a group of ChenMed doctors and specialists in search of a second opinion

ChenMed patients experience 1/3 fewer hospital days, 1/3 fewer ED visits, equating to 1/3 lower cost. When compared to other patients in the same zip codes. The Admission data is not risk adjusted. Though if you take Risk adjustment into account they have over 50% lower hospital admissions. ChenMed patients demonstrate up to 41% increase in the use of maintenance medications for diabetes, high blood pressure, and high cholesterol. Patient satisfaction surveys show promising results too.

Early Life

Dr. Daniel McCarter grew up in a small southwestern town in Virginia. He attended University of Virginia's medical school and family medicine residency thereafter. During this time, he met Dr. Lewis Barnett, one of the founders of family medicine. Dr Barnett was chairman of the University of Virginia Department of Family Medicine. Dr. McCarter has fond memories of attending Dr. Barnett's Sunday lunches hosted by Dr. Barnett and his wife at their home. "The Sunday lunches were quite legendary," Dr. McCarter explained during our interview. They were regularly attended by Dr. Barnett's students, residents, and colleagues, and the conversations were energizing. Dr. Barnett became quite the role model for Dr. McCarter. Upon graduating from residency, Dr. McCarter was recruited by Dr. Barnett himself to stay at the University of Virginia.

For the next twenty-seven years, Dr. McCarter spent half of his time as a faculty member and the other half he spent running his own rural practice in Nelson County - Stoney Creek Family Practice. Interested in integrating technology into his workflow, Dr. McCarter was one of the first physicians within the University of Virginia system to implement electronic medical records in 1990.

Three years ago, Dr. McCarter made a drastic career change. He became a chief medical officer of the Richmond Virginia Market for ChenCare a ChenMed Company which is a multistate primary care group. He works under the direction of Gordon Chen, MD Chief Medical Officer for the ChenMed Company. In May of 2019, he was promoted to National Director of Primary Care Advancement. Although he still thinks of himself as a country doctor, he now practices in an urban area helping lead one of the largest network of practices in the United States providing high-quality care for seniors.

What is ChenMed?

We treat them like part of our family, and very often they treat us like part of their family.

Dr. McCarter describes ChenMed as a high-touch primary care group. ChenMed was founded by Dr. James and Mary Chen as a solo private practice thirty-five years ago in Miami, Florida. Today, ChenMed has grown to include more than seventy primary care offices in ten states east of the Mississippi: Florida, Georgia, Illinois, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Virginia.

Primary care doctors help patients of all ages, experiencing problems of varying acuity, with ranging abilities to pay. ChenMed offers concierge level medical services for low- and medium-income seniors.

Older folks with complex chronic medical conditions are their focus. A ChenMed primary care physician leads a team of medical professionals to provide whole person care for a panel capped at 450 patients. Smaller patient panels than the national average of 2,300 allow patients to get the attention they need and deserve . Each patient is promised at least one visit per month and sicker patients are seen more frequently.

ChenMed primary care practices are placed in underserved areas and patients are exclusively covered by Medicare Advantage. Since ChenMed is fully capitated and has a robust indigent care program there is never a worry about copays or paying additional fees. Whether their loved one (the patient) needs a doctor once per month or every day of the week, the cost remains the same In most markets it is a $0 premium Medicaid product. So basically as patients sign up for Medicaid this is included as part of their program.

This allows for optimal transparency in cost of care, something rarely found in today's healthcare system.

The physician led teams at each of the seventy ChenMed sites are structured a little differently, but are variations on the same basic theme: full spectrum care. For example, behavioral health services are offered at every location, however the type of behavioral health professional on the team may differ. "In some areas it's licensed professional counselors; [in] some areas it's clinical social workers; in some markets we have a psychiatrist." The decision to hire one type of behavioral health professional over the other is rooted in needs assessment data.

Care teams are constantly changing and adapting in response to the data. For instance, cardiology is now included as a part of ChenMed's primary care package. This happened after determining 25% of patients carry a diagnosis of heart failure and 65% of patients carry a general cardiac diagnosis (if hypertension is included). In response, ChenMed hired one to two cardiologists for each market, splitting their time among a few sites. Other specialists recruited to the ChenMed primary care package include endocrinologists, infectious disease specialists, and nephrologists. Having these specialists "in-house" is advantageous because it offers care teams expert opinion from a colleague, without the hassle of sending out for full-blown consultations. It's both better for the primary care team and better for the patient.

It is common for patients to feel disempowered when they enter the hospital. If a patient requires hospitalization, ChenMed's care team includes a case manager who visits and stays in close contact with that patient while in the hospital. The care manager acts as the liaison between the ChenMed primary care team and the hospitalist team. The care manager acts as a personal in-hospital advocate, like a lawyer representing a client. It is also the case manager's duty to schedule a follow-up appointment within 72 hours of the patient's discharge. If a patient has any issues making it to that follow-up appointment, the case manager will go as far as to send an Uber to the hospital for the patient to be transported directly to the primary care office on the way home. The major role of the care manager is thus to ensure a smooth transition of care, and to reduce the likelihood of a readmission to the hospital.

ChenMed also employs community case managers to help patients who do not necessarily need to visit the office to see a physician. If a patient is having difficulty keeping all his/her medications organized, for example, the community case manager will visit the patient's home to help. Many times, patients also do not need these total all-or-nothing home health services offered by home health agencies. Instead, they simply need someone to come by and check on them, making sure that their medication boxes are filled correctly. The community case manager is ChenMed's much appreciated go-to person for tasks like this.

In many practices all too often, a patient calls the doctor's office and is unable to speak directly to the physician. This is not what happens at ChenMed. Each doctor has a cell phone, and most of the time, it's the patient's personal doctor who answers when the patient calls.

The physician culture at ChenMed

Our values are love, accountability, passion, and we've recently added a fourth one - fun.

ChenMed offers a range of services to support their physicians that promotes collaboration and accountability. ChenMed sites have weekly meetings where care teams talk about complicated and/or hospitalized patients, and how to safely transition them to a lower level of care. It's like being back in a teaching environment, Dr. McCarter reflects, learning from complex medical cases. It is also meant to promote camaraderie.

The onboarding of new physicians is slow and methodical, in line with ChenMed's culture of promoting physician wellness. New ChenMed doctors spend two weeks training. They spend a third week being on-boarded at their new site. During their fourth week with ChenMed, new physicians begin seeing patients on their own. The patient panel starts off small, and it is ramped up slowly to maximum of 450 patients total. Each time a new physician meets a new patient, they are given 40 minutes for that visit to promote getting to know each other.

"MD Help" is another widely used service offered to ChenMed providers. This service allows doctors to email an interesting patient presentation to a group of ChenMed doctors and specialists in search of a second opinion. Additionally, the physicians from all sites tune into a monthly continuing education and team-building program, usually centered around physician wellness. Past topics have included burnout, nutrition, and most recently COVID-19.

The Business of ChenMed

Unlike most primary care models implemented across the nation, the ChenMed model is one that sustainably makes money. This gives ChenMed the ability to pay very competitive wages and makes realistic the vision of expanding across the United States, becoming America's leading primary care provider for seniors. Since 2011, ChenMed has doubled their size every 2.5-3 years. Currently, they are ramping up to add another twenty offices in two additional states. In five years, Dr. McCarter projects that ChenMed will have 500 offices and about 2000 physicians.

Outcomes Delivered

Dr. McCarter feels so strongly about the promise of ChenMed's model of care because it has produced substantial outcomes. He explained that ChenMed patients experience 1/3 fewer hospital days, 1/3 fewer ED visits, equating to 1/3 lower cost. When compared to other patients in the same zip codes. The Admission data is not risk adjusted. Though if you take Risk adjustment into account we have over 50% lower hospital admissions. Furthermore, ChenMed patients demonstrate up to 41% increase in the use of maintenance medications for diabetes, high blood pressure, and high cholesterol. Patient satisfaction surveys show promising results too.

ChenMed takes full financial risk for their patients. In effect CMS gives the insurer $1.00 to take care of the patient for a year. If the patient signs up with us, the insurer gives us $0.85 and all of the risk. So the reason that we provide the services is that with the robust primary care keeping patients healthier and out of the hospital that is where our bottom line income comes from. So, if a patient calls and says there sugar is high and we can send an Uber to pick them up for $15 and bring them to our office where they get some IV fluids, some insulin and some office labs. Why would we ever tell them we can't help them and they have to call 911 for a $1500 ambulance ride and a $5000 or more ED visit and possibly an admission on top of that it is unduly stressful for the docs. Then all of the staff in the office work to

manage the medical costs and clinic costs for their center. If they do better than an achievable goal that is set, everyone shares in this in varying percentages. This is where incentives come from.

As for how doctors are paid—they are paid on a straight salary, working 5 days a week and 3-4 weeks of call per year. We currently do not have our centers open on the weekends. So the schedule is reasonably steady. Even with

Current ChenMed CEO Dr. Christopher Chen has bigger plans that go beyond his primary care network. He envisions an entire healthcare ecosystem that works together "to reduce both admissions and readmissions, improve medication adherence, changing patient behaviors, coordinating care, and raising quality outcomes." To do this, he proposes the idea of crowdsourcing as a way of gathering innovative delivery methods from a broad range of individuals and institutions into an "innovations database." This database would include methodologies that work and did not work. Both are important to include. This database would expand upon the Centers for Medicaid & Medicare Services (CMS) Accountable Care Organizations Learning Network, as well as the Agency for Healthcare Research and Quality (AHCR) Innovations Exchange. It would be similar to Canada's Best Practices Portal for Health Promotion and Chronic Disease Prevention .

COVID-19 preparedness and response

Dr. Jason Lane, National Medical Director for Clinical Strategy and Outcomes and an infectious disease doctor at ChenMed, has led the preparedness efforts and response for all seventy ChenMed sites. He began planning for this pandemic to hit back in January. In late February, the sites rapidly converted to telephonic and video office visits. With a capitated payment system, ChenMed is not paid by number of patients seen per day and thus does not need to worry about any revenue short falls during this time, like some fee-for-service practices. At the peak of the COVID pandemic, most ChenMed care teams are seeing 80-90% of their patients virtually. As Covid activity dropped it went up to about 50% face to face, now it is back to about 65% virtual care. Each market flexes up and down based on the Covid activity in their market. For the 10-20% of patients who need to be seen face-to-face by a physician, They have kept all offices open, flexing up and down staffing and amount of in person care based on covid activity. Cleaning occurs every 1-2 hours.

They also screen everyone who enters the building – patients, delivery people, and staff – by taking temperatures and asking about symptoms and exposure risk. In addition, we have been doing universal masking for everyone that enters one of our centers and have been fortunate to be able to procure robust levels of PPE to help our doctors and staff stay safe.

Every patient is getting called once a week by their primary care team to see how they are doing in terms of their loneliness and social isolation and to makes sure any unmet needs are addressed. If a patient is too afraid or feels unsafe going to the grocery store, the ChenMed care team will make arrangements with one of the local food banks to get food. If a patient is running low on toilet paper, the care team will make arrangements to get toilet paper delivered straight to that patient's doorstep.

Fortunately, ChenMed can still hire doctors and they have not abandoned their plans for expansion. However, Dr. McCarter admits he is uncertain what primary care in the United States in general will look like once this crisis subsides. One thing is for sure though: ChenMed will continue to grow and serve as a national leader in the care of seniors and healthcare innovation.

If you or a colleague is a family physician-leader who has helped to recreate or streamline healthcare delivery on a local or national level, we'd love to highlight you or someone you nominate in our "Bright Spots" podcast series. Please email Laurence.Bauer@fmec.net your nominations/questions/comments. Thank you so much!

Bright Spots Interview #3

A Federally Qualified Health Center that serves 100,000 patients in Upstate New York: Interview with Dr. John Rugge

Written by Allyssa M. Abel, MPH, MS4 at Albany Medical College, @allymay82
Edited by James P. Cunneen, MS Candidate at the Eck Institute for Global Health, University of Notre Dame

Overview

Hudson Headwaters Healthcare Network (www.hhhn.org)

The growth of Hudson Headwaters Health Network began with John Rugge, MD's stumble into the north country in the Adirondacks. As a Family Physician he adapted to the needs of the community. He partnered with a local leader and applied for a federal grant to launch a Federally Qualified Health Center.

The expansion of federal financial support afforded Dr. Rugge the opportunity to expand the HHHN patient care team, to provide full-spectrum care. Added to physicians and PAs were support staff including advanced practice nurses, care managers, behavioral health providers, community pharmacists, and most recently, medical sub-specialists. This team-based approach led to the revamping of the health center architecture. Instead of a physician working within the isolation of a personal office, the "pod" became the central working space in each health center. Pods are open, brightly lit spaces where team members work together. Pods bolster communication in real time where providers can be on cue for one another, and where teams develop optimal care for patients.

Current Size - 19 health centers; 100,000 patients; $100+ million annual revenue; 90+ physicians; 90+ advanced care clinicians: a dozen+ behavioral health staff: several dozen care managers; a dental practice + a dental mobile service; imaging centers.

HHHN has created a seamless system that allows for smooth transition of care between hospitalists and community family doctors. This is achieved through the augmentation of technology and the role of the care managers. The electronic medical record (EMR) system is the same at all nineteen health centers, as well as the local hospitals. When a patient is admitted, all hospitalist notes are simultaneously synced to the primary care doctor's EMR system. Additionally, the hospital discharge planners are trained to communicate with HHHN's outpatient care managers.

HHHN also created a protocol to help doctors determine the need for follow-up after hospitalization. For those who require extra care, care managers make home visits "to ensure compliance, to assure that there is consistency, and to ensure that they don't go home and start taking both sets of medications from pre-hospital med list and post-hospital med list."

Hudson Headwaters employs two community pharmacists, with hopes of adding more

They have access to the national 340b pharmacy program. This gives patients access to affordable, reduced priced prescriptions allowing HHHN to purchase medications at the same low prices offered to the military and veterans.

The culture of each HHHN center is defined by the community it is situated in. On a number of occasions, HHHN turned to the community-at-large for support.

Each center has a patient advisory group. The people in each community feel a sense of ownership in their Center.

Finding physicians who support one another, and work together is key to their success. They prioritize bringing in physicians who have different interests and skill sets. "It can be a new interest in MAT (medication-assisted treatment for addiction), the expertise in the care of HIV, it can be interest in palliative care, willingness to do house calls… all components that have helped make us who we are

They developed a relationship with Albany Medical College and the University of Vermont. Their students and residents are trained at HHHN. They recently created two Family Medicine Residency programs in nearby upstate New York. This helps them in their recruitment effort.

Early Life

Forty-six years later, Dr. Rugge is still living and practicing medicine in "this little swath of the Adirondacks".

Dr. John Rugge grew up modestly, the son of a dairy farmer from central New York. As a young man, John was always searching for deeper meaning, which originally lead him to divinity school. Upon discovering he wasn't particularly interested in religion, he dropped out made his way to medical school (Yale University School of Medicine) He planned on becoming a psychiatrist, still interested in searching for that deeper meaning. Two weeks into medical school though, he began to worry medicine was too much like religion. All specialties were divided, all too similar to different religious denominations. Later, John discovered primary care and family medicine (He completed his residency training at Albany Medical Center) – a career path that would allow him to do bit of everything.

During medical school, John found himself canoeing the wild rivers of Labrador, Canada. Canoeing was his pastime, his way of escaping the rigor of school and life. Quickly, this casual hobby turned into an expertise, and he found himself with the opportunity to write about his canoeing experiences. John took a break from medicine for a few months to memoir his adventures in Labrador alongside paddling companion James West Davidson. To focus on this book, John made his way to the beautiful Adirondack Mountains in upstate New York, the perfect writer's sanctuary. *The Complete Wilderness Paddler* was published in 1982. (To our knowledge, this book remains the definitive writing about canoeing whitewater in an aluminum canoe)

Dr. Rugge has very fond memories of his travels and time writing the book. He remains a passionate canoer to this day, and regularly spends mornings in his canoe on the Hudson headwaters. Appropriately, "Hudson Headwaters" is the name Dr. Rugge would give the network of community health clinics he eventually founded.

While writing, he searched for work as a physician in the region. To his surprise, a whole generation of general practitioners were preparing to retire. With no one to replace them, it left the community with a shortage of doctors. Dr. Rugge had not intended to set down roots in the area. He laughed as he confessed, "I felt guilty to leave." Forty-six years later, Dr. Rugge is still living and practicing medicine in "this little swath of the Adirondacks". He is also now semi-retired, which means "[I] only working 40 hours per week."

Dr. Rugge first tried to get a job as a physician in the emergency room of Glens Falls Hospital. He was under the false impression that a physician could just show up to any medical establishment and begin working. Much to his surprise, this was not the case. A few weeks later, Dr. Rugge found work as a medical preceptor, supervising four physician assistant (PA) students at the Chester Health Center, Chestertown, NY. Chestertown had a population of about 1,200 and all three of its community physicians had just retired. Dr. Rugge observed physicians retiring across Adirondack region, leaving communities desperate for medical care.

Dr. Rugge was concerned even more by the fact that 45% of the area population lived below the poverty line, and many families were uninsured or covered by Medicaid. The whole region needed something new. Dr. Rugge began to envision a healthcare system that would best serve families most burdened by poverty. This vision began to take shape when Dr. Rugge received a phone call from Susan Halloway a woman who had just moved to the area. She was curious about his thoughts regarding the federally qualified health center (FQHC) program as a way to improve healthcare in the Adirondacks. He confessed that he had never heard of it. Three weeks later, the pair were submitting a grant application to fund their own community health center. Chester Health Center became upstate New York's first FQHC, which threw Dr. Rugge into the role of a young physician leader of the community health movement.

From 1976 to now, the Chester Health Center grew to become the Hudson Headwaters Health Network (HHHN). Today, the network includes nineteen sites supporting almost a hundred physicians, PAs, nurse practitioners, and other allied health providers. The Hudson Headwaters catchment area stretches from northern Saratoga County all the way up to the Canadian border. Not only do they serve the 1,500 people now living in Chestertown, but over 100,000 people living across the Adirondacks.

The Beginning of Hudson Headwaters

The foundation of all of this was community support.

Large reforms in small towns can often face resistance. At the time Dr. Rugge was establishing Hudson Headwaters, changes to local education infrastructure were overwhelmingly voted down. In contrast, the community was immensely supportive of the idea of overhauling primary care infrastructure.

There was a clear need for healthcare and renovating healthcare delivery. Transitioning from solo practices to government-supported community health centers was unanimously embraced. There was a collective recognition of the need to find and retain new doctors. Dr. Rugge's full-spectrum community health center model held the promise of a viable and sustainable way of doing just that.

The Chester Health Center was established in 1976, in an old A&P Store (supermarket). It was a traditional primary care office, made up of a few exam rooms, an x-ray suite, a personal office for the

doctor, a waiting area. It also housed a team of PAs who worked directly with a single physician in caring for patients. But over time, the patient care team expanded and diversified, in order to address more effectively the medical and social needs of the population being served. This marked the humble beginning of what would become the Hudson Headwaters FQHC Network.

A New Team-Based Care Model

The expansion of federal financial support afforded Dr. Rugge the opportunity to expand Hudson Headwaters' patient care team, to provide full-spectrum care. Added to physicians and PAs were support staff including advanced practice nurses, care managers, behavioral health providers, community pharmacists, and most recently, medical sub-specialists. Naturally, this team-based approach led to the revamping of the health center architecture. Instead of a physician working within the isolation of a personal office, the "pod" became the central working space in each health center. Pods, Dr. Rugge explained, are open, brightly lit spaces where team members spend their days together. Pods bolster communication in real time where providers can be on cue for one another, and where teams develop optimal care for patients.

Dr. Rugge has long believed in distributing responsibility amongst various clinicians more evenly than traditionally allocated. The physician is no longer the only important player in primary care, as this is evident at Hudson Headwaters. Dr. Rugge has crafted primary care into a more robust, team sport. Instead of nurses simply taking vital signs and leaving the door open for the doctor, they were now tasked with carrying out all preventive services, including preventive screening. This allowed physicians to focus their efforts on making diagnoses, giving treatment, and establishing trusting relationships that are "binding and empathetic and motivating."

Dr. Rugge admits that he was skeptical about the role of care managers at first. But he was quickly sold on their central role in primary care from day one:

> "On my first day with a new care manager, I had a patient call who was bipolar and diabetic, and saying he had a problem. He had an altercation with his wife the previous night. She called the police and there was a protection order, and he wasn't being allowed to go back home. But how was he going to get his medicines? What about his insulin? What was he going to do? Well, one thing to do is end up in the ICU with diabetic ketoacidosis. Instead, we had a care manager who worked with the sheriff. He got him into his home, found an alternative spot for him to stay while the order was reviewed. And that's the kind of thing that happens over and over again. Not only because of fights, but because of poverty, or hardship, or lost jobs, or maybe a coronavirus."

Hudson Headwaters has created a seamless system that allows for smooth transition of care between hospitalists and community family doctors. This is achieved through the augmentation of technology and the role of the care managers. The electronic medical record (EMR) system is the same at all nineteen health centers, as well as the local hospitals. When a patient is admitted, all hospitalist notes are simultaneously synced to the primary care doctor's EMR system. Additionally, the hospital discharge planners are trained to communicate with Hudson Headwaters' outpatient care managers. Hudson Headwaters also created a protocol to help doctors determine the need for follow-up after hospitalization. For those who require extra care, care managers make home visits "to ensure compliance, to assure that there is consistency, and to ensure that they don't go home and start taking both sets of medications from pre-hospital med list and post-hospital med list."

Today, Hudson Headwaters employs two community pharmacists, with hopes of adding more (pending funding). They are responsible for medication review and management for the network's nineteen sites,

and they are available both electronically and by phone. These pharmacists act primarily as community educators, not only for patients, but for physicians as well. Having a good relationship with the team, they do not hesitate to reach out to the prescriber with suggestions or to ask for clarification. Dr. Rugge explains that patients look to all clinicians for validation and understanding. “The community pharmacists can provide input that is simply impossible for any one physician, any one prescriber, to have at their fingertips or in their heads.” Many times, the pharmacists are the ones putting patients’ minds at ease. They are the ones explaining why a particular medication is being prescribed and which side effects the patient should be wary of. This has a calming effect because patients know the pharmacists at Hudson Headwaters are well informed and care deeply.

Another advantage of being a patient at Hudson Headwaters, regarding medications, is the national 340b pharmacy program. This gives patients access to affordable, reduced priced prescriptions. Available to all FQHCs, the 340b program allows Hudson Headwaters purchases medications at the same low prices offered to the military and veterans. As a result, Dr. Rugge’s patients are offered the most affordable medication options possible.

A Unique Healthcare Culture

We regularly hear ‘thank god you’re here’.

The culture of Hudson Headwaters is defined by the community it is situated in. A deep sense of having a large supportive network like Hudson Headwaters is not the norm for most small mountain towns. Patients often run into their doctors at the grocery store, adding a layer of intimacy to patient healthcare. A few years after receiving his first federal grant, Dr. Rugge began attending town board meetings. He wanted to get the word out and explain what the Hudson Headwaters FQHC Network was. He made it a priority to have quarterly meetings with political leadership, as well as local pharmacists, local ambulance squads, and other community groups to show them what he was doing and ask them for their help. “How can Hudson Headwaters do better? What have we missed?” Dr. Rugge was uncomfortable leaving these issues to chance. He actively sought input from the community and fostered these longitudinal connections. Doing so increase his own awareness of and adaptability to the ever-changing needs of all community members.

On a number of occasions, HHN turned to the community-at-large for support. A strong loyalty bond between each community and its health care center has developed. When a facility needed to be built or upgraded, HHN’s community partners worked to raise funds to support the effort. From bake sales and other community events, the community supported their health center. Under Dr. Rugge’s leadership, patient advisory groups formed. This goes beyond the usual roles for patients on the FQHC Board.

Dr. Rugge believes “finding physicians who support one another and work together is really key”. With that philosophy at the root of his recruitment strategy, he has grown the health network without it becoming a bureaucratic mess of red tape. He prioritizes bringing in physicians who have different interests and skill sets. “It can be a new interest in MAT (medication-assisted treatment for addiction), the expertise in the care of HIV, it can be interest in palliative care, willingness to do house calls… all components that have helped make us who we are.” Dr. Rugge hired a family physician with a special interest and advanced training in sports medicine who tends to take care of all their orthopedic cases. Hudson Headwaters also has an Women’s Health/Delivering Babies service housed at a local hospital, doing everything from deliveries (including c-sections) to hysterectomies. Dr. Rugge has built a culture that fosters opportunities for a diverse group of doctors to thrive. He understands that bringing in the right people is the only way full-spectrum primary care can be successfully achieved.

When asked about leadership within the organization, Dr. Rugge commented on doctors and their affinity to collaborate:

> "Leadership among physicians happens in a really interesting way. In my experience on the administrative side, people really need hierarchy. They need to know who is reporting to who and what the pecking order is. And for physicians it tends to be the opposite. During my tenure, we came to have not one, but three chief medical officers, and they were kind of interchangeable… they work as a group and think together." "We also developed a "rule of two" – if two of the medical directors agreed on doing something, they implemented the new idea/change. In a large primary care network you need to be adaptive and nimble in your management style"

Dr. Rugge never wanted to give up patient care to be a full-time leader of the Hudson Headwaters Health Network. Even as chief executive officer, he still spent 35-40% of his time seeing patients. As the network grew, he appointed three other practicing physicians to share the role of chief medical officer. In keeping with Hudson Headwaters team mentality, all major decisions were arrived at by consensus not executive order. If there's something going on important enough to affect the network, it required consensus to be sure it was in the best interest of the patient.

The Outcomes

Recently published data supports Dr. Rugge's novel vision of healthcare that Hudson Headwaters provides. For patients with acute conditions, Hudson Headwaters has a 17-fold reduction of unnecessary hospitalizations compared to patients from other counties in upstate New York. For patients with chronic conditions, there is a 34-fold reduction. This didn't just happen in a year of two, it happened after decades of refining a longitudinal, full-spectrum, team-based primary care intervention, and gaining the trust and loyalty of whole communities. A federal report released last year ranked Hudson Headwaters in the top 1% for quality of care among all FQHCs across the nation.

Leading the Way in Medical Education

Primary care is special in that it goes beyond the science, into the art of care.

Since precepting PA students in the 1970s, Dr. Rugge has had an affection for education and inspiring the next generation of healthcare leaders. In his efforts to expose more medical students to primary care, Hudson Headwaters begun to host medical student rotations. Twenty years ago, Dr. Rugge and Albany Medical College collaborated to build a 4-week Hudson Headwaters experience for third year medical students during their Internal Medicine rotation. It has since become a very popular option among Albany Medical College students. In line with Hudson Headwaters' supportive model, students receive free housing while rotating at the Glens Falls location.

In 2019, Hudson Headwaters also started an innovative partnership with the The Robert Larner, M.D. College of Medicine at The University of Vermont. Together, they have created a year-long educational experience, accepting four Vermont medical students to spend their entire third year with Hudson Headwaters and giving them the responsibility of their own patient panel. This kind of educational exposure to primary care can prove to any student, Dr. Rugge asserts, that medicine is more than just the hands-on delivery of care. It goes beyond that. This kind of exposure is even useful for students who decide to go into a different specialty. The goal is to instill confidence and excitement so students can go out and achieve their careers aspirations as physicians.

Conclusion

The emotional support for healthcare and the feelings of people being connected to it are just enormous, and [that] has to be mobilized. And with that it flows like the river, like the headwaters.

Leading this effort and building Hudson Headwaters into what it is today was by no means apart of Dr. Rugge's life plan. However, this path has led him to become a bright spot in US healthcare. He saw an opportunity with GPs leaving an underserved area to build a completely new and revolutionary healthcare system for thousands of people. For that, we thank you Dr. Rugge!

Bright Spots Interview #4

Proactive community-based care for frail elders that eliminates the need for hospital admission: Interview with Dr. Daniel Hoefer

Written by Allyssa M. Abel, MPH, MS4 at Albany Medical College, @allymay82
Edited by James P. Cunneen, MS Candidate at the Eck Institute for Global Health
University of Notre Dame

Metrics for the Transitions Program

The Transitions program began in 2007 and, at any point in time, serves between 170 – 260 patients.

There is a 56% reduction in all cause ER visits and hospitalizations and a 71.5% reduction in cost

Patients with CHF as a group average 3.5 hospitalizations per year; patients with CHF in the Transitions program average less than 1 hospitalization during the last year of their life

In 2007, 63% of CHF patients in the U.S. died in the hospital. Only 3 patients served by the Transitions program t died in the hospital hat year

In well-designed comparative studies, patients served by the Transitions program with cancer, COPD, HF and Dementia all showed statistically significant lower inpatient costs

Through the Transitions program, deaths in the hospital was measured in single digits vs the usual average of 50% of elders dying in hospitals.

By moving aggressive care upstream via community based palliative medicine, we have proven that the vast majority of people never need to see the inside of the hospital during the last year+ of their life. The revolving door of hospitalization should be considered an archaic residual of a bygone era

With elders, we know what's coming and we use medical/clinical science and our understanding of aging to improve patient outcomes.

Dr. Daniel Hoefer is a board-certified family physician with a passion for caring for frail elder patients. Other than the four years he spent at Eastern Virginia Medical School, he has lived in Southern California all of his life. After completing his residency through UCLA's North Ridge Family Medicine program, he took his first job at a not-for-profit regional health system based in San Diego called Sharp HealthCare. Twenty-seven years later, he remains with Sharp HealthCare as Chief Medical Officer of Outpatient Palliative Care.

Dr. Hoefer led numerous home health and hospice service initiatives since beginning his career as a family physician. After a decade or so of working with medical teams in these settings, however, he came to realize with great horror a specific skill lacking in him and in his colleagues: how to recognize pre-terminal patients and the potential harms caused by continuing traditional care. In medicine, we call this skill effective prognostication. It is with this realization that Dr. Hoefer turned his professional energy to filling this gaping hole in American health care. In 2005, he and his administrative partner Suzi Johnson, MPH, RN created an outpatient palliative care program meant to offer at-home advanced illness management for pre-hospice patients. They named it the Sharp Transitions Program.

Beginning of Sharp Transitions

Sharp Transitions was emerging as a new model of care at a time when ninety percent of palliative medicine was being practiced in the hospital. Dr. Hoefer and Ms. Johnson's vision for community-based palliative care services was therefore one that had not been fully explored before. What drove their desire to change how they cared for patients in the last 3-5 years of life? Dr. Hoefer gives us the answer:

> *"My passion comes from the fact that I never liked the way we treated patients at the end of life when I began healthcare. We are paternalistic, make patients dependent on us versus self-reliant and worst of all, reactive instead of pro-active in their care. When we know what is coming for 90% of late stage disease- it is archaic to wait for people to get sick and then to treat them. As well, I do not accept a healthcare system which wants, lets or needs for people to get sick to finance itself. Enough people need reactive care. We do not need to add to that archaic practice more than is necessary."*

He was disturbed by the fact that many of his hospice patients at the time "had literally been admitted 10 or 15 times" right before being referred to hospice. No one should have to go through that many hospitalizations near the end of life. Instead, they should be able to live peacefully at home and know they are safe there. This was the premise for Sharp HealthCare's new "Transitions" program.

The Sharp Transitions Model

Palliative medicine is complicated.

Sharp Transitions is in the national spotlight. It has won award after award, including the Heart Health Prize… Why is it so special?

- Sharp HealthCare is a regional health care system with 4 acute care hospitals3 specialty hospitals, 5 urgent care centers, 3 affiliated medical groups, and a health plan.
- All patients are Medicaid managed care.
- There is incentive to reduce cost of care. Since they receive a fixed among of money per member per month. . The incentive at the system level is to invest in primary care so they can save on the downstream expenses

- Dr. Hoefer has learned that when patients are hospitalized, they decline quickly, more quickly than if they were able to stay at home. It's better for the patients and the system.

What is their "secret sauce"? First, they employ an evidence-based process of prognostication that most primary care doctors fail to use. And second, their dedication to being a co-management service. No doctor wants to give up the patient that they have been caring for decades. So Sharp Transitions co-manages the primary care physician or sub-specialty physician who referred the patient to them. . The Transitions team is an extension of a patient's physician. They work with the referring provider to manage the patient in the patient's preferred place of residence.

The Transitions Program delivers care through an interdisciplinary team (IDT) – medical director, administrative director, nursing administrative director, and the team itself, built up of nurses, Advanced Practice Nurses, doctors, social workers, chaplain, and pharmacists. The IDT meets with the patient and the patient's family to discuss the patient on admission and for recertification to help maintain consistency between goals of care and the care actually provided.

On any given day, the Sharp hospice and palliative care teams now manage approximately 170 - 250 patients in total. They offer "a lot of educating, a lot of teaching, and a lot of personal in-home care for patients."

"With Medicare Advantage and shared risk contracting, we can anticipate when the patient would start using the hospital as a tool for decompensation management". So they engage the patient before they go to the hospital.

They can do this with any contract that involves shared risk; it gets tricky with fee for service.

Their care process involved four tools.

1. Professional and home management
2. Evidence-based prognostication
3. Professional care for the caregiver
4. Advanced care planning

A Paradigm Shift

"Perhaps the most powerful process we use, that is rarely taught anymore, is evidence-based professional prognostication."

"I can tell you right now that most people believe you cannot prognosticate effectively. And I am telling [you] that this is not true, they just need to learn some basic tools to become more effective prognosticators."

Dr. Hoefer is frustrated by the concept of preventing readmissions. He believes we should be preventing first admissions.

Many physicians do not conceptualize dying outside of the hospital as an appropriate standard of care. It's hard for people to get past the idea that the hospital is not a necessary tool for the most aggressive patient management.

"The most important skills a physician can have."

There are 3 categories of prognostication:

1. Event prognostication – what's the next event in the expected series of events? We should understand disease decline just as we understand childhood development!! There is plenty of data in the scientific literature to spell this out.
2. Probability prognostication – answers questions like how likely are you statistically to develop delirium when you're in the hospital? When you look carefully at the scientific literature you can describe the likely impact of medical interventions
3. Time prognostication – this refers to the expected timeline of events in the next period of time.

Impact of the program:

Examples of prognostication and preventing admissions:

They have chosen one disease, congestive heart failure, and got so good at proactively managing heart failure, they were able to decrease primary admissions for heart failure exacerbation. In the last 15 years, we've decreased the primary admission rate by 90-94%. Also if our patient does get admitted, they are a third less likely to be readmitted.

- For COPD, they give emergency kits to all COPD patients on the first program day. It contains a nebulizer, steroids, antibiotics, and are placed in the medicine cabinet just waiting for the first sign of an exacerbation because the evidence is clear: the sooner you start steroids and antibiotics, the quicker the exacerbation resolves and the less likely you are to be hospitalized. Hospitalization has dropped by over 60% for Transitions patients for COPD exacerbations.

We doctors cause hospital induced delirium, it's preventable with proper proactive management. The best management is to avoid the hospital completely. Delirium is a side-effect of hospitalization in the advanced elderly.

SAVINGS

Wisdom for the future of medicine

Dr. Hoefer remembers being in medical school in 1986, when students were taught a paternalist style of medical decision-making. Since then, the healthcare industry seems to pride itself because it's gone from being paternalistic to hospital centric. But the next step it to move from hospital centric to patient centric. We need to move all of that professional enthusiasm and aggression in healthcare much further upstream to anticipate what is coming for our patients to keep them from needing us, and not relying on them to finance our system.

This will require a culture change which is harder to do than introducing a new medication or a new procedure. But once people realize this, once more seniors start to demand this culture change, that change will occur.

I implore the healthcare community to understand the stages of an elder's lifecycle.

- With physiological and cognitive reserve= healthy geriatric patient, the research is beneficial to you
- Once you lose this reserve, the current research is no longer beneficial to you.
- Manifest signs of being pre-terminal – the research in this group is even less

- By 2035, 20% of population will be over age 65, only 6% of RCTs specifically look at 65 yo and older. Only 0.1% of randomized control trials look specifically at 75 and older.
- Most of our current scientific studies deliberately exclude older patients with cognitive and functional impairments, those who are institutionalized in assisted living or nursing homes, people with multiple comorbidities
- Most of the patients he serves are a part of the exclusionary criteria
- We cannot just extrapolate from younger healthier populations

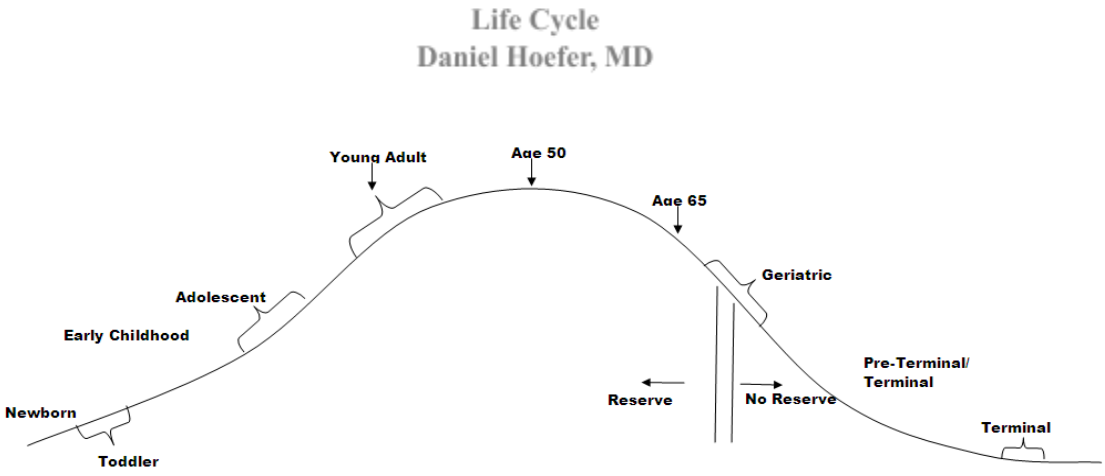
We need to update how to manage chronic disease and hospitalization in patients who are pre-terminal. – what we do now is archaic and not adequate. It must be updated.

It's a constant educational process, medicine.

We are all trained in the acute care model of disease: once you are broken, we will fix you. Now medical training is shifting to proactive management. Proactive management comes at a cost. Medical groups and patients will benefit. Hospitals will not, especially if they are fee-for-service. They will suffer economically.

Goals for the future:

The transition program is a part of the future of healthcare. It's community-based palliative medicine. Dr. Hoefer's personal philosophy is that "it is not our patients' responsibility to get sick so that we can finance ourselves or feel good about our professional skills as physicians. We should be doing everything we can to keep our patients from needing us. That's good healthcare. Not the other way around."



Bright Spots Interview #5

A Neighborhood Health Station Model of Primary Care with Michael Fine, MD

Dr. Fine wants everyone to know

"I grew up in a culture that helped me to understand that it is unethical to profit from someone else's misfortunes".

"I think most Family Physicians became physicians, at least in part, to be able to protect their families from some of the harms caused by our health care system."

Overview

We created two Neighborhood Health Centers serving about 100,000 people in Rhode Island

A Neighborhood Health Center brings together all of the health related services in a community that are needed to care for 90% of the population while caring for 90% of the problems of the people served

Our work has reduced adolescent pregnancy by 55% over the last few years. It has also reduced EMS runs by 20 to 30%.

150 people have quit smoking

And we've only just begun

Dr. Fine was born in the Bronx, NY and grew up in New Jersey. He was the grandson of immigrants from Russia and Poland. He learned early in life that he had a passion for communities.

He began his career as a community organizer. He was a VISTA Volunteer serving as a community organizer on 167th Street and 3rd Avenue in the South Bronx. In those years much of the Bronx had become a waste land. Poverty and drugs had created wide spread destruction. He worked out of the Martin Luther King Health Center a flag ship of community health center's in the New York City area. The center was staffed by residents from the Montefiore Medical Center. Montefiore brought three medical specialties to the center including internal medicine, family medicine and pediatrics residents. It was here that he learned about Family Medicine and the important role that Family Physicians could play in addressing the health issues in a community.

He began to think that he might do well as a physician. One of the Family Medicine residents in the center was Neil Calman, MD who Dr. Fine knew from his childhood. The two renewed their friendship and it

reinforced Dr. Fine‘s decision to go onto medical school and to pursue a career as a Family Physician. He was accepted into Case Western Reserve University medical school. He and his wife Carol, also a Family Physician, were accepted into the Brown University Family Medicine Residency program in Providence, RI.

Dr. Fine practiced for 16 years in urban Pawtucket, Rhode Island and rural Scituate, Rhode Island, after serving as a National Health Service Corps Scholar in Hancock County Tennessee, the then fifth poorest county in the US. He is the former Physician Operating Officer of Hillside Avenue Family and Community Medicine, the largest family practice in Rhode Island, and the former Physician-in-Chief of the Rhode Island and Miriam Hospitals’ Departments of Family and Community Medicine.

Dr. Fine created Health Access Rhode Island (HARI), which was one of the first direct primary care practices in the U.S. HARI allowed patients of the practice who lost their insurance to maintain their relationship with the practice for a very low monthly fee.

Currently Dr. Fine is the chief health strategist for the city of Central Falls, Rhode Island. He is also the Health Liaison Officer for Pawtucket, Rhode Island. Between the two communities he’s helping to lead the effort to care for about 100,000 people.

Dr. Fine developed the concept of a neighborhood health center. It’s a single clinical entity that can provide care for 90% of the population and provides 90% of the health services that are needed. He believes this is an outgrowth of his vision as a family physician. Family Medicine can take care of 90% of the needs of 90% of the population - something he calls the 90/90 project.

The first neighborhood health station opened three years and serves a suburban/rural population

The Central Falls neighborhood health station open last June. It serves an urban population.

The neighborhood health stations include the medical, urgent care, dental, mental health/behavioral health, substance abuse, optometry, lab, x-ray, physical therapy and pharmacy services. It’s a federally qualified health care center that is funded through its federal grant. The cost based reimbursement model allows for funding those services that struggle for financial support.

Each center has a single electronic medical record shared by all the services within the neighborhood health center. This shared record can be used to great effect to make sure that everyone in their respective towns gets the preventive services they need. It is also be used to help identify emerging problems.

The neighborhood health stations are open from 8 AM to 8 PM Monday through Frida. Also there are hours on Saturday with plans to open up on Sunday in the future.

One of the most powerful innovations was bringing in the mental health and behavioral health professionals, the community health workers and the nurse case managers into each service area within the neighborhood health station.

By bringing all the players together they were able to look at public health issues like smoking and diabetes in a way that no single practice or entity could do on its own.

The community health workers will go out to a patient’s home and follow up with patients to make sure

there are no issues impairing their ability to use the medicines that are prescribed for them and to identify unmet patient needs.

There is an interdisciplinary team meeting each week which allows for team communication and problem-solving.

They are well-connected with the emergency medical services, the housing authority, the police, probation and parole and even the schools are connected.

Dr. Fine believes they have developed a collaborative culture because…"we all recognize that we are here to serve the community. Everyone in the neighborhood health station is paid through a salary basis so there are the competitive urges that can create fractures between the various groups".

"We study our numbers very carefully". Each week we review reports that help us to see how our community is doing and where there are issues that need attention. This provides a vehicle for measuring our progress.

We believe "any door is a good door". The docs are happy if someone with Red Eye, for example, goes to an optometrist without having to see the physician first. If someone goes to the dentist and their high blood pressure is identified, the dentists have no difficulty having that cared for by the physicians. We are all in this together.

We did have to go through a period of transition. We had some issues with the initial mental health behavioral health professionals who weren't ready for the full collaboration that we embrace. But new people have come on board who are excited by our organization's culture. We also believe in meeting people where they are rather than forcing them to come to us for service.

Results

We have reduced adolescent pregnancy by 55% over the last few years. We've reduced EMS runs by 20 to 30%. 150 people have quit smoking …"which we think is a pretty big deal long-term".

The city increased the tobacco purchasing age to 21. It's the first city in Rhode Island to do so.

We've organized walks around the city.

In response to the COVID-19 crisis we quickly modified our operations and created a "clean" and a "dirty" building. The dirty building is where people known to be exposed to the virus are seen. We set up a respiratory clinic with testing.

There was a huge drop off in volume but we believe through our telemedicine and other services that we are keeping people away from the hospital. We are also learning how to treat various problems over the phone including UTI, and pharyngitis.

When asked …"Based on your experience to date what would you recommend for others who want to follow in your footsteps". Dr. Fine stated that those who want to replicate this model should start in their own communities. "Get connected with your local government. Family physicians can be a powerful ally of those who care about the health of their community. Don't wait for someone else to do it".

He also stressed that it's important for family physicians to get over the fear of losing their jobs. He believes they need to have courage and understand their own value. Family physicians need to see the value of their own approach to care and develop the courage of your convictions.

Background

Dr. Michael Fine, MD holds the titles of Health Policy Advisor to Mayor James Diossa of Central Falls, Rhode Island, as well as Senior Population Health and Clinical Services Officer at Blackstone Valley Community Health Care.

In addition, Dr. Fine served in the cabinet of Governor Lincoln Chafee between February 2011 and March 2015 as the Director of the Rhode Island Department of Health. In that position, Dr. Fine oversaw a broad range of public health programs and services, including 450 public health professionals and a budget of $110 million per year. Dr. Fine's career as both a family physician and a manager in the healthcare field has been focused on healthcare reform and providing care to the underserved population. Before his confirmation as Director of the Rhode Island Health Department, Dr. Fine was the Medical Program Director at the Rhode Island Department of Corrections, which oversees a healthcare unit servicing nearly 20,000 people per year, along with a staff of over 85 physicians, psychiatrists, mental health workers, nurses, and other health professionals. Dr. Fine was also a founder and Managing Director of HealthAccessRI, the United States' first statewide organization making prepaid, reduced fee-for-service primary care available to people without employer-provided health insurance.

Michael Fine is a writer, a community organizer, a Family Physician, and a public health provocateur. Dr. Fine's career as both a Family Physician and manager in the field of healthcare has been devoted to healthcare reform and the care of underserved populations

He currently serves on the Boards of Crossroads Rhode Island, the state's largest service organization for the homeless, the Lown Institute, the RI New Leaders Council and RICARES.

Dr. Fine is a past President of the Rhode Island Academy of Family Physicians and was an Open Society Institute/George Soros Fellow in Medicine as a Profession from 2000 to 2002.

He is the author for three books, including *Health Care Revolt: How to Organize, Build a Health Care System, and Resuscitate Democracy – All At The Same Time, Abundance*, a novel, and T*he Nature of Health*.

Bright Spots Interview #6

Qliance: A Disruptive Innovation that Inspired Physicians and Patients

Written by Allyssa M. Abel, MPH, MS4 at Albany Medical College, @allymay82
Edited by James P. Cunneen, MS Candidate at the Eck Institute for Global Health, University of Notre Dame

Overview

Dr. Garrison Bliss an internist practicing in Seattle, asked his niece if she would be interested in leaving the FQHC where she was employed to join him in growing his innovative monthly membership fee model. This was the birth of Qliance, Inc. The first Qliance clinic opened in the spring of 2007 in Downtown Seattle.

Qliance clinics are designed to address approximately 90 percent of the issues for which patients seek a doctor's care, including all routine primary and preventive care. This includes women's health services, pediatric care, urgent care, wellness education, ongoing chronic disease management, select onsite procedures and diagnostics, as well as coordination of outside specialist and hospital care by a Qliance provider

The payment model was simple. Patients could pay a monthy membership fee individually or an employer could pay for them.

Qliance was interested in: What puts this person at risk? What influences their health choices? What are the patient's social determinants of health? Finding the answers to these questions during the initial visit allowed providers at Qliance to set realistic goals based on personal, financial, psychological factors.

Qliance was a proof of concept. To patients, it showed that comprehensive, high-quality healthcare could be affordable. It showed that an inexpensive monthly membership fee, between $40 and $80 per month based on age, could sustain a primary care practice.

Qliance provided individual care, care for employer plans, union plans, Medicaid, and health benefits exchange plans. The practice started with one patient in 2007, and peaked at 4500 patients in 2015, Qliance had seven locations in the Puget Sound area with 20 medical providers and 130 employees.

Qliance, offered a program called “Access to Active.”. Employers automatically enrolled all employees in the “access” mode, which was a 24/7 Qliance telehealth option. These employees were never forced to use Qliance primary care services, but they at least had access to telehealth if they pleased. They remained “access” members until they expressed interest in using Qliance as their primary care home. At this point, they simply filled out an online health questionnaire to become “active” members, and the fee would increase for the employer

Qliance’s patient population suffered significantly less hospitalization days and less advanced radiology study utilization. Patients also showed an increased rate of prescription utilization, which could mean they are more complex patients and better equipped to fill and take their medications as prescribed.

Qliance examined insurance claims data from 2013 and 2014 for approximately 4,000 Qliance patients covered by employer benefit plans, and compared the cost of their care to that of non-Qliance patients who worked for the same employers. The results revealed a savings of $679,000 per 1,000 Qliance patients on total claims –19.6 percent less than the total claims for non-Qliance patients during the same period. The savings were driven by a marked reduction in expensive emergency room visits, inpatient care, specialist visits, and advanced radiology, which more than made up for the higher investment in primary care for Qliance patients.

A 2014 assessment of Qliance's patients' experience, conducted using the national CAHPS survey, placed Qliance above the 95th percentile in overall patient satisfaction, well above the 90th percentile nationally.

PART 1 - QLIANCE, Inc.

Why Family Medicine?

Dr. Erika Bliss’s current undertaking is running Equinox Primary Care, a single-physician, community-based, direct primary care practice in Seattle. Before this, she was CEO of a large, employer-based, direct primary care network called Qliance, which operated for a decade serving thousands of families in Washington State.

However, early in life, Erika had not considered medicine as a profession. After studying history in college, she completed a Master’s in Latin American Studies and traveled to work with a nonprofit working on domestic violence issues.

Erika found fulfillment in community organizing. She enjoyed spending her time on local, broad-based improvements in health. But her interest in medicine blossomed only after interviewing two female doctors in Mexico as part of her master’s thesis. Their passionate discussion about their work inspired Erika. They seemed to have this natural ability to establish rapport with people affected by domestic violence. Upon returning to the US, she dove headfirst into pre-med courses, found physician mentors, and soon was accepted to University of California San Diego (UCSD) for medical school.

During her medical education, Erika became profoundly aware of the inequality and injustice of the US healthcare system. She began to ask: how can the US be such a wealthy country yet have such a maldistribution of resources? At UCSD, she realized people were being segregated in the very spaces where they were receiving medical care. As a consequence of this alarming realization, Dr. Bliss decided she would focus her career addressing the inequality of our medical system.

More specifically, she envisioned providing medical care in a place where everybody, from all walks of life, could come and feel safe. She promised herself that she would help all her patients feel like they matter, are respected, and are treated with dignity. Whether rich or poor, they could all sit down together in the same waiting room and receive high-quality healthcare in the same place. She decided that practicing low-barrier, comprehensive primary care as a family physician was the most effective way to achieve this.

Early life as a doctor

From the very beginning, Dr. Bliss was a systems-level thinker. During her residency at Swedish Family Medicine in Seattle, Dr. Bliss enjoyed her shifts in the continuity clinic. There, she began to find practical solutions to use in her future primary care practice. She began to see that healthcare could be used not only to take care of sick people, but also as a vehicle to improve society.

During her residency, she found the domination of the fee-for-service model to be disturbing. Fee-for-service incentives encouraged rapid fire, physician-centered visits. Upon graduating from residency, Dr. Bliss was recruited to be a site director of a community clinic in Seattle. It was a Federally Qualified Health Center (FQHC). Dr. Bliss reflects that she felt unprepared for and overwhelmed by this new leadership role, but was hopeful that by transitioning to a community-based FQHC, she would escape the exploitation of the fee-for-service world. Little did she know, dysfunctional fee-for-service incentives distort care at even the most altruistic organizations.

The system forced physicians to care for complicated patients with little resources and inadequate time. On top of that, there was enormous stress in maintaining funding and proving value to funders in the FQHC setting. The more she learned, the more Dr. Bliss became disillusioned by medicine.

Wrong-doings of fee-for-service

Within the fee-for-service framework, Dr. Bliss explains, doctors are incentivized to conduct short visits and to see more patients in order to pay the bills. Given time constraints, primary care doctors find it difficult to effectively care for their patients. This is why primary care providers often have to refer patients to specialists for medical conditions that are well within their scope of practice.

To add insult to injury, churning patients through office visits as quickly as possible drives up the cost of care for practices because it forces them to hire more staff to support doctors as they try to get through the visits faster.

The fee-for-service model sends patients the wrong message. They are misled into thinking that the more tests and studies performed, the better the care. Good clinical reasoning and the detective work that supports it, Dr. Bliss laments, is hard to do within the constraints of the fee-for-service system. There is simply no time.

It's no wonder patients get nervous and fear that their doctors did not hear or listen to them. It's no wonder they want to see a specialist for a second opinion. Primary care doctors have been stripped of their ability to explain, step-by-step, personalized solutions. In Dr. Bliss's opinion, the fee-for-service model is detrimental to all parties and is totally unsustainable.

The humble beginnings of Qliance

Dr. Garrison Bliss, Erika's cousin, was an internist practicing in Seattle when Erika was beginning her career as a family physician. His private clinic, established in the late 1990s, used a modest monthly fee model ($65 per month) to deliver care outside of the insurance system. . On a phone call one evening, he asked Erika if she would be interested in leaving the FQHC to join him in growing the monthly fee model. He believed this model could fix what ails the primary care system. Dr. Erika Bliss accepted his invitation.

This was the birth of Qliance, which is considered the pioneer of large-scale direct primary care practices in the United States. The first Qliance clinic opened in the Spring of 2007 in Downtown Seattle.

The model was simple. Patients paid a monthly fee, much like a gym membership, that covered all primary care services: office visits, phone visits, telehealth visits, texting/messaging, and procedures. Dr. Bliss jokes that the monthly fee covered "anything [doctors] can do with our heads or our hands." EKGs, spirometry, and basic labs were also included. They set up the agreement so that people could pay individually or an employer could pay on a patient's behalf.

Patients were scheduled for longer visits, compared to typical primary care appointment length. New patient visits lasted one hour. During this hour-long visit, the nurse practitioner or physician, both of which were utilized at Qliance, took a comprehensive medical, family and social history. Qliance valued the ideal of taking care of the whole person - their mind, body, spirit, and connectedness.

Qliance was interested in: What puts this person at risk? What influences their health choices? What are the patient's social determinants of health? Finding the answers to these questions during the initial visit allowed providers at Qliance to set realistic goals based on personal, financial, and psychological factors. Dr. Bliss never wanted to put patients in a situation where they felt coerced into saying "Yes, Doctor,"

right before they walked out the door and found themselves completely unable to follow recommendations, something that is fairly common.

Fixing a broken system

"One major lesson that Garrison taught me is that, when patients do not do what we tell them to do, or they keep coming back to us with the same complaint... when things don't resolve, that's our failure not theirs. We didn't do our job. We didn't find out what's really wrong, what's really bugging them. We didn't find out why they can't comply with what we're saying. [Rather than] the noncompliant patient, we're [actually] a non-effective doctor."

Dr. Bliss kept this piece of advice in mind while helping to grow Qliance, creating enough time for doctors during their visits to identify the upstream cause of patients' health concerns and to discuss practical ways of addressing them.

Qliance was a proof of concept. To patients, it showed that that comprehensive, high-quality healthcare could be affordable. To doctors, it showed that an inexpensive monthly membership fee could be sustainable for a primary care practice.

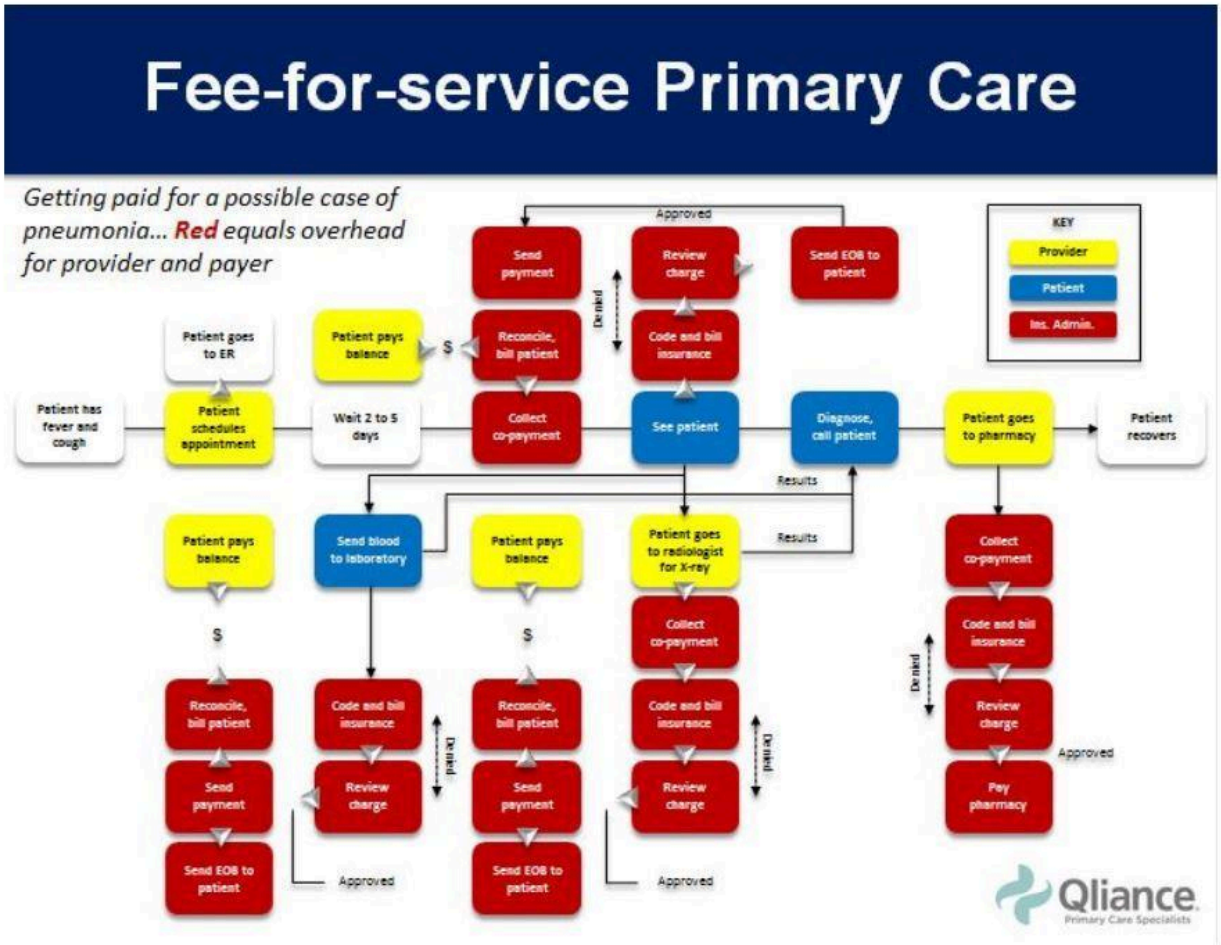
If a referral was needed, the primary care provider coordinated and ensured seamless transfer of information to and from the new specialist. Alternatively, if a sign or symptom did not require specialty care, the primary care doctor had time to reassure the patient and answer any questions, reducing costly referrals whenever possible.

The foundation upon which Qliance was built was a thorough evaluation, which required adequate time. The idea was simple, not super high tech, and had very little overhead cost. Many times, a minor intervention or a watch-and-wait plan was perfectly acceptable, as long as there was assurance and close follow-up.

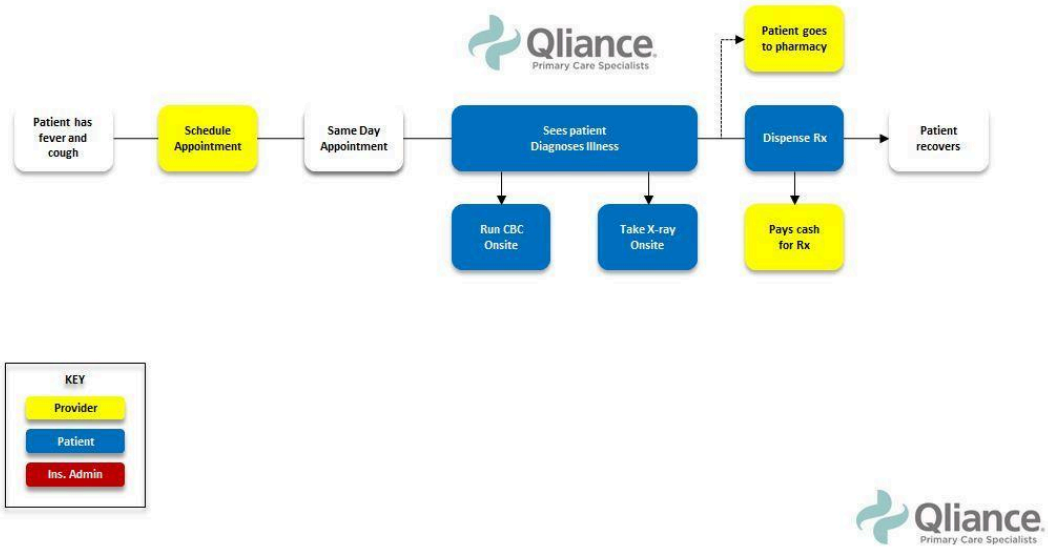
Qliance brought primary care back to the basics by making doctors available to their patients. People loved this kind of care. The membership fee was between $40 and $80 per month based on age. So it was readily available and inexpensive.

The Value of a Monthly Membership Payment Model

At the core of Qliance was a new payment model for primary care. The insurance-based Fee for Service model of payment produces complexity without added value. The complexity creates lack of transparency in the billing for services. It also creates "administrivia" that add to the burden of delivery primary care services. The image below shows all the steps involved from the patient requesting a visit to the patient recovering from an episode of care when the payment model is based on the FFS model.



The next image shows what happens to this complexity when all steps related to insurance are eliminated. This is the power of a monthly membership fee. Doctors can focus on the most efficient way to respond to the patient's needs and they do not have to jump through hoops in order to get paid. .



The size and scope of Qliance

Qliance provided care through individual membership, employer-sponsored plans, union plans, union plans, Medicaid, and health benefits exchange plans.The practice started with one patient in 2007, and peaked at 45,000 patients in 2015, before it disbanded in 2017. This peak occurred one year after the implementation of the Affordable Care Act, at which time, Qliance had seven locations in the Puget Sound area with 20 medical providers and 130 employees.

Dr. Bliss credits agreements with large employers like Expedia and Comcast, as well as unions like the Seattle Fire Fighters, for Qliance's quick growth. What also helped was their partnership with a Medicaid managed care company in Washington State.

In the last few years of Qliance, Dr. Bliss began to offer a program called "Access to active." Most employer customers opted for this program. Here is how it worked.

Employers automatically enrolled all employees in "access" mode, which was a 24/7 Qliance telehealth option. These employees were never forced to use Qliance primary care services, but they at least had access to telehealth if they pleased. They remained "access" members until they expressed interest in using Qliance as their primary care home. At this point, they simply filled out an online health questionnaire to become "active" members, and the fee would increase for the employer.

The overarching goal of this "access to active" program was to offer primary care services to large groups of people, without requiring any initial sit down appointment.

Challenges

In the beginning, it was difficult to measure the impact of the monthly fee model. Dr. Bliss reflects upon how challenging it was to gain access to cost and outcomes data for her patient population. Since Qliance worked outside of the payer system with a disparate group of people, the data was simply not available.

Another challenge Dr. Bliss encountered was that payers such as insurance companies saw Qliance as a threat. They did not want Qliance taking complete control of patient care. Therefore, they were unwilling to cooperate and offer cost of care data. Throughout their ten years in business, Qliance tried to work with insurance companies to get them to understand the long-term benefits of this model, and before even opening for business in 2007, had to work with the Washington State Legislature to get a law passed making it legal for doctors to do a monthly fee model without regulation by the insurance commissioner.

The data: partnerships with large employers

Dr. Bliss had limited cost and outcomes data until she began working with large employers. Access to robust datasets was made possible by partnering with employers who used insurance companies as third-party administrators rather than as true insurers. In other words, these employers were completely in charge of their own health data.

Once this data was analyzed, it became clear that Qliance's patient population had significantly fewer hospitalization days and less advanced radiology study utilization. Patients also showed an increased rate of generic prescription utilization and medication compliance.

Another metric analyzed by Qliance was "use of specialty services." One of the major overarching goals of primary care is to decrease the need for specialty care. Qliance patients indeed required less specialist referrals than other primary care offices. However, when physical therapy is categorized as specialty care, interpretation becomes muddy. For instance, physical therapy for a musculoskeletal injury when possible is preferable to orthopedic surgery with respect to rehabilitating people and keeping them healthy while reducing cost. Making specialist referrals, therefore, was not necessarily an act that Qliance providers were actively trying to avoid. More referrals to physical therapists instead of orthopedic surgeons may be a good thing, Dr. Bliss explains.

The data: relationship with Medicaid managed care

The formation of a shared savings relationship with Medicaid allowed Dr. Bliss to finally serve people of all backgrounds and socioeconomic statuses in the same practice. This had been her goal since medical school.

The Medicaid population is more diverse than the employer population, yet similar outcome patterns emerged as previously seen among employer data - huge reductions in hospital days and radiologic studies. All this comes back to the lengthened doctors' appointments at Qliance - actually having enough time to properly evaluate, ask questions, examine thoroughly, and discuss follow-up with the patient.

Adequate time with the patient at Qliance facilitates decreased need for expensive imaging like CTs and MRIs. Qliance workflows decreased dependence on testing modalities that are oftentimes unnecessary and do not add value to the workup. The overall cost of care for Qliance's Medicaid patients was significantly and consistently below the expected cost. With consistent results across the board, Qliance regularly received Medicaid savings bonuses. Doctors at Qliance took pride in taking care of people, using good clinical judgment, and they reaped Medicaid rewards as a result.

The Impact of the Qliance Model on Service Use

2010 data

Type of Referral	Qliance # per year/1000**	Benchmark*	Difference
ER Visits	56	158	-65%
Hospitalizations (visits)	34	53	-35%
Hospitalizations (in days)	105	184	-43%
Specialist Visits	670	2000	-66%
Advanced Radiology	300	800	-63%
Surgeries	22	124	-82%
Primary Care Visits	**3540**	**1847**	**+92%*** **

*Based on regional benchmarks from Ingenix and other sources.

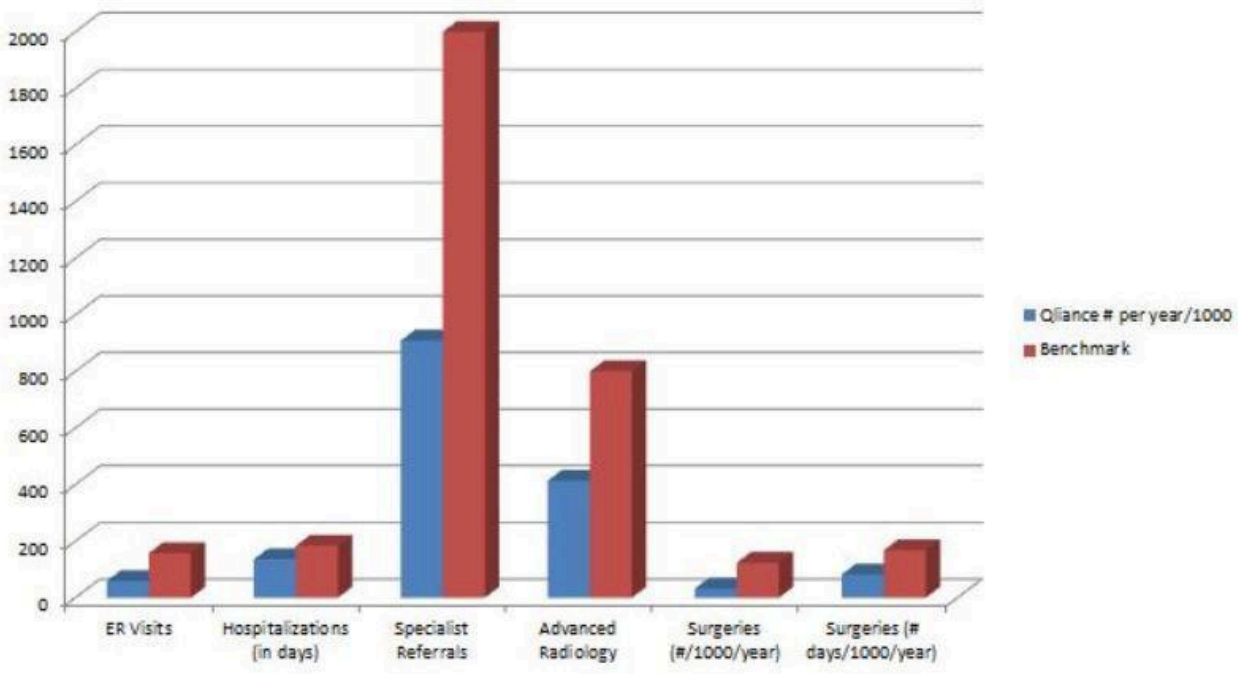
**Based on best available internal data, may not capture all non-primary care claims.

***Note that Qliance visits are 2-4x as long as typical FFS visits, so actual primary care utilization is 4-8x the national average.

Source: Qliance Medical Group non-Medicare patients, 2010 (n=3,088)

Impact of Qliance on Health Services and Cost of Care

Qliance reduced the use of unnecessary health services and it reduced the overall cost of care for their panel of patients. It was a disruptive innovation that inspired many physicians to join the DPC movement.



Maintaining humanity in medicine

Dr. Bliss served as both a family physician and CEO for Qliance. As a doctor, what made her most proud of the organization is that she was able to touch many peoples' lives and make them realize that they mattered. At Qliance, she remembers seeing a few people out in her waiting room, some rich, some poor, and thinking "Wow, I've achieved my dream." This was the greatest success of Qliance, in Dr. Bliss's personal opinion.

Qliance demonstrated that doctors, many of whom were Family Physicians, can take care of everybody, from all walks of life. The clinic need not be fancy. In fact, Qliance was not. It was nice, clean, and attractive, but by no means extravagant. Every patient, no matter their background or health insurance status, was greeted and welcomed and felt cared for. This led to huge improvements in their lives and in their health.

Dr. Bliss reminisces about Medicaid patients breaking into tears and expressing how they had never been treated this way before. Not just in a healthcare setting, but anywhere. It makes Dr. Bliss sad that this is the society we've created to live in, but extremely gratified because she had the ability to create a space where folks feel like they matter.

Although she wishes the Qliance model could have continued to thrive, at least she was able to realize that this kind of care is possible; that it's not that hard. That all it takes is social and political will to make this happen in the United States.

PART 2: EQUINOX PRIMARY CARE

Creating new opportunities

Qliance closed its doors in the spring of 2017. At this point, Dr. Bliss could not imagine going back to the fee-for-service payment system. It was a system that simply would not allow Dr. Bliss to take the kind of care that she had learned how to do. "It was direct primary care or die for me," Dr. Bliss laughs.

What had attracted Dr. Bliss to the practice of family medicine in the first place was the idea of comprehensive care of individuals in the context of their families and communities. There's this awareness among family doctors, she tells us, that we do not live in isolation and we are not just a collection of organs. Instead we are whole beings who operate in socioeconomic contexts, always. She was also attracted to the linkage to public health and environmental concerns, which serve as the foundation of the family medicine specialty.

So she opened a solo practice called Equinox Primary Care. Not surprisingly, most of her patients from Qliance followed her to this new clinic.

Dr. Bliss continued with the direct primary care model and kept her practice workflow, once again, very simple. She provides care from the comfort of a small office in Downtown Seattle, still chooses not to take insurance, and has one medical assistant who works with her 80% of the time. Currently, her practice is full, consisting of a socioeconomically, generationally and racially diverse patient panel.

Dr. Bliss has really enjoyed the shift from being a CEO of a fairly large company with lots of stressors, to being a solo practitioner totally focused on the joys of direct patient care. She is able to provide comprehensive outpatient primary care, with half of her visits in-person and half conducted through telemedicine. This comes from a lesson she learned at Qliance: Once you know a patient well enough, much of the care for that patient can shift to virtual services.

COVID-19 response

Because telemedicine was already so central to her practice, Dr. Bliss and her medical assistant were able to swiftly respond to the COVID-19 crisis. Equinox's monthly fee model also afforded them complete control over revenue and care delivery. They were there to care for their patients in a very efficient, virtual way. There was no threat of having to shut down, like the fee-for-services practices of so many of her colleagues.

Since Equinox is a monthly membership practice, it did not take a hit in terms of revenue. Dr. Bliss was able to reassure her patients almost immediately. She did not have to worry about how to keep her doors open or if she was going to keep her assistant employed. Even if the patients lost their jobs, Dr. Bliss promised her patients they would continue to receive care through this crisis.

From the beginning, Dr. Bliss's patients have scheduled their own appointments online. When COVID-19 hit, all Dr. Bliss had to do was notify her patients that Equinox was offering phone and video visits only for the foreseeable future. Dr. Bliss said this was an easy transition.

While working from home, Dr. Bliss already had knowledge accumulated from years of telemedicine experience to monitor all of her patients virtually - by passing photos back and forth or through home blood pressure measurements for instance.

Dr. Bliss recalls a virtual visit with a mother and inconsolable infant recently. During the visit, she instructed the nervous mother to tug on the baby's ears, tap on his sinuses, and then press on his belly to check for flinching and distinguish between an earache, sinus infection, or reflux. Dr. Bliss also watched the child breathe in and out to assess how comfortable he was. Dr. Bliss was then able to easily make the diagnosis and offer treatment.

This, Dr. Bliss tells us, just proves that physicians do not necessarily have to complete a hands-on physical exam and listen to the lungs of every patient. If doctors know their patients well, they can also rely more on patients' personal judgement about symptoms. If I am worried about a particular patient," Dr. Bliss states, "I just check in with them daily via phone or video."

Understanding what can be watched remotely versus what cannot be is critical at this time, and Dr. Bliss has grown her expertise over the years. Only two Equinox patients needed to be seen in-person during the month of April for non-COVID-19 issues, of more than 400 virtual visits that were conducted. Dr. Bliss made special trips into the office for these encounters.

A clinic without wall: the future of healthcare

With some capacity left in her practice, Dr. Bliss aso offered a new telemedicine-only membership. She invited new members to her practice for $25 per month, hoping this would be a low enough cost as to not be a barrier to care during the COVID-19 pandemic. This would give new members unlimited access to Dr. Bliss via phone, video, and texting. She would serve as either the primary care doctor or supplemental primary care doctor for people who could not easily get in to see their regular provider. The goal was that, amidst the chaos and overburdened health systems, patients would not postpone or avoid important preventive and acute care.

Anecdotal evidence has demonstrated this was a welcomed option for patients. In general, the public is becoming more aware of the fact that healthcare does not have to start with this face-to-face, one-on-one, in-person visit with the doctor, and it can be overly difficult, costly and time consuming to "establish care" or to gain access to care only through in-person visits.

Why is the in-person visit a gate we require patients to get through? A consequence of this barrier is that patients avoid the healthcare system until they have a need. When they finally have a need, they have to wait on a primary care opening. When they have to wait, they ultimately decide to go to an urgent care or an emergency department. Then, they have to work with a doctor they don't know. Urgent care and the emergency department are also more expensive settings.

We have created a system where patients sometimes wait until it's too late to seek our help. We are failing these people. Why not set up a channel, in the lowest possible barrier kind of way, so people feel they have some sort of primary care relationship and that it's there for them to tap into when they feel they need it?

This was the impetus for implementing a telehealth "access to active" program at Equinox during the COVID-19 crisis. Dr. Bliss was able to advertise this through her patients. Many patients decided to sign up friends and family members. Some even paid for membership of loved ones for whom they were concerned - living in isolated areas, didn't have doctors, or parts of overburdened health systems where

there wasn't good access. Twenty new members signed up as “access” members, and half of them had connected with Dr. Bliss to become “active” members.

Change on the horizon

“Primary care telehealth,” the kind of ideal telehealth Dr. Bliss speaks of, is different from the telehealth we’re most familiar with. The problem with stand-alone telehealth services is that patients are connected with a random provider. You tell them your problem, they give you advice, and then you say goodbye and never speak to them again. There is no continuity or health record that keeps track of your wellness over time. This is how details are missed or lost in translation, leading to suboptimal care. This model also does not connect you back with your primary care doctor. The model that Dr. Bliss speaks of is directly with the primary care doctor. If done on a larger scale, in one system, then even if your PCP is not available, the person you're speaking to is connected with your PCP and can communicate back to them.

Telehealth memberships hold the promise of unclogging our clinics and breaking down their walls. This is what the future of medicine needs. It could be a more cost-effective, comprehensive way to get people good primary care in this country without having to build a whole bunch of clinics. It could be a way of better utilizing our existing primary care workforce and, all the while, building a bigger primary care workforce.

Rather than requiring everyone to go through the formality of an in-person visit to establish care, anyone should be afforded the privilege of establishing care via telehealth. This is how we can get all parties up to speed. This is how we determine who actually needs to come to the clinic for care.

If primary care moves in this direction, clinics will become “population health managers.” This is what we see happening during the COVID-19 crisis. Doctors are filtering through people by necessity, determining who needs to come in, and giving specific directions on how to come in. Others, who sound like they are fine, can stay at home. People whose status teeters between needing to come in and stay home, can stay at home with specific instructions and a follow-up plan.

Others who sound fine, but request to be seen, can always come in and be seen. We’ve been forced into an orderly utilization of resources, which we have refused to do in the past. The monthly fee model facilitates this. It's not magic. It’s just a business model that allows for better organization and utilization of resources for care to do what we are now being forced to do in society.

Hope for the future

If you look around the world at any social change moment, at any great new system brought into being, it never happens because people think it's a great idea or that they should do it. It only happens during times of great upheaval. Some deeply ingrained systems have to break in order for new, more equitable systems to come into being. Dr. Bliss thinks this is the situation we are experiencing now.

While this is a terrible situation to experience, a global viral pandemic, it is throwing into clarity the shortcomings of the American healthcare system and potentially giving us the opportunity we need to make some tremendous changes. Dr. Bliss hopes that American political leaders will recognize this opportunity and push for some fundamental changes that will make the experience of healthcare better for everybody.

Bright Spot Interview #7

Mr. Daniel Spiller

What role should a family physician play in helping individuals manage their health care and its related cost?

Recently, Larry Bauer, chief executive officer of the Family Medicine Education Consortium, discussed this topic with Dan Spiller, retired director of health and welfare with the Mead Corporation. Other participants in the conversation were Consultant Jed Constantz and Ally Abel, a fourth-year medical student at Albany Medical College.

Doctor Knows Best: Balancing Health *Care* and Health *Cost*

Lessons Learned from How One Company's Unique Approach

Overview

Dan Spiller, former director of health and welfare for the Mead Corporation in Dayton OH wanted to reduce the costs of health insurance for their employees. Following a series of conversations with Dr. Reid, the idea surfaced to focus care management on "the people who knew the patient the best"—the primary care physician.

Typical managed care plans often provide a strong incentive for primary care physicians not to stay involved with sick patients. Dr. Reid, however, espoused a theory that by correcting the under-utilization of primary care, a resulting decline in overuse of specialty and hospital care is created.

"Why don't we simply focus this on the primary care physician and run everything through him/her,'" Mr. Spiller recalled. "We don't have to have a contract with a family doctor. The doc will just do what he was trained to do and will become an advisor for all medical care. She/he can determine what needs to be outsourced to a specialist. We were seeking a very personal kind of a relationship and that's what family doctors do. We were looking at primary care physicians as a medical director for each community of patients".

The plan was christened the Mead Health Alliance, to be managed by Dr. Reid's company, which developed strong communications with the primary care physicians identified by employees. The plan drew inspiration from primary care gatekeeper models, yet remained unique because it was less restrictive. The plan used clinical rather than administrative controls to manage utilization and pricing.

The Mead Corporation, headquartered in Dayton, Ohio, launched the plan in 1990 as a pilot program for 600 employees. Employees and their enrolled family members were encouraged to have a primary care physician and were required to consult with that doctor before seeking any other care. Called the Primary Care Pathway, the plan featured no physician discounts and no contracts with doctors.

We educated covered individuals on the role of the family doctor and the importance of a relationship with him/her. Those employees using the Primary Care Pathway paid a set and relatively small fee per visit; the plan then covered all other primary care services. Not having to pay a deductible for primary care was particularly popular with enrollees.

Employees did have a deductible for specialty care. If the employee or enrolled family member sees the primary care physician *before* visiting a specialist, they paid the deductible and the plan picked up 80 percent of the cost of specialist care.

The pilot program was deemed a success, showing a 15 percent drop in healthcare costs, with the biggest savings from reduced hospitalization and emergency room visits. Based on that success, the decision was made to offer it in 1994 to all its employees in 46 states.

In a study that compared the two years prior to the introduction of the plan (1992-93) and the first four years of the plan's implementation (1994-97), the Mead Health Alliance average cost per salaried employee was down 9 percent, at a time when average per-employee medical plan costs for all U.S. salaried and hourly employees increased about 22 percent. Comparing 1992-93 to 1995-96 in six hospital admissions categories showed total preventable admissions dropped by 16 percent. Even while the national trend for hospital stays was declining, Mead employees did better than the norm. Average length of stay also continued to decrease.

History is filled with examples of ideas that were ahead of their time. An example of this for primary care physicians occurred in the early and mid-1990s, when the Mead Corporation opted to apply what has been called an "out-of-the-box" approach to the healthcare program provided to its employees and their families. The effort would prove successful and the lessons learned might possibly help improve healthcare delivery today.

And it all began by chance.

"It was just luck or happenstance that I met Dr. Bob Reid," recalled Dan Spiller, former director of health and welfare for the Mead Corporation.

At the time, Dr. Reid, an internist, was running an organization he founded called the Commonwealth Health Alliance out of Charlottesville, Virginia. As Dr. Reid's approach to managing health care became clear, Mr. Spiller liked what he heard.

"We had managed care, but it wasn't working," said Mr. Spiller. "For one thing, a lot of our people were in rural communities, where networks of any kind just didn't hardly exist, except through Blue Cross." Following a series of conversations with Dr. Reid, the idea surfaced to focus care management on "the people who knew the patient the best"—the primary care physician.

Typical managed care plans often provide a strong incentive for primary care physicians not to stay involved with sick patients. Dr. Reid, however, espoused a theory that by correcting the under-utilization of primary care, a resulting decline in overuse of specialty and hospital care is created.

"Dr. Reid and I said, 'why don't we simply focus this on the primary care physician and run everything through him/her,'" Mr. Spiller recalled. "We don't have to have a contract with a family doctor. The doc

will just do what he was trained to do and will become an advisor for all medical care. She/he can determine what needs to be outsourced to a specialist. We were seeking a very personal kind of a relationship and that's what family doctors do.

"In a sense, we were looking at primary care physicians as a medical director for each community."
A fee-for-service health plan described as the antithesis of typical managed care in the mid- 1990s, the program was christened the Mead Health Alliance, to be managed by Dr. Reid's company, which developed strong communications with the primary care physicians identified by employees. The plan drew inspiration from primary care gatekeeper models, yet remained unique because it was less restrictive. The plan used clinical rather than administrative controls to manage utilization and pricing.

The Mead Corporation, headquartered in Dayton, Ohio, launched the plan in 1990 as a pilot program for 600 employees at its Michie Company in Charlottesville, Virginia. Employees and their enrolled family members were encouraged to have a primary care physician and were required to consult with that doctor before seeking any other care. Called the Primary Care Pathway, the plan featured no physician discounts and no contracts with doctors.

At the time, statistics showed that about half of the people in the U.S. did not have a family physician and this program sought to reverse that trend, for a number of reasons. Not only would it help to address the aforementioned challenge of few networks in rural areas, but it would encourage more connections between primary care physicians and patients, considered a critical bond for the delivery of health care. "In a sense, we were educating covered individuals on the role of the family doctor and the importance of a relationship with him/her," said Mr. Spiller.

Those employees using the Primary Care Pathway paid a set and relatively small fee per visit; the plan then covered all other primary care services. Not having to pay a deductible for primary care was particularly popular with enrollees.

Employees did have a deductible for specialty care. If the employee or enrolled family member sees the primary care physician *before* visiting a specialist, they paid the deductible and the plan picked up 80 percent of the cost of specialist care.

"You started by seeing your family doc with any condition," Mr. Spiller said. "That's where you start. He/she'll recommend someone if needed. But you did not have to follow her/his advice to get a higher benefit level. You were free to see the subspecialist of your choice once you had first seen the primary care doc."

The pilot program at the Michie Company was deemed a success, showing a 15 percent drop in healthcare costs, with the biggest savings from reduced hospitalization and emergency room visits. So based on that success, the Mead corporation made the decision to offer it in 1994 to all its employees in 46 states. "We decided this program was as good as we thought it was and everyone should have it," said Mr. Spiller. "The Mead Health Alliance applied to every salaried employee in the company and we covered all employees and all families. It wasn't completely noncontributory but the contributions we so light we virtually covered all employees and family members."

By just about any measure, the Primary Care Pathway was an unqualified success.

In a study that compared the two years prior to the introduction of the plan (1992-93) and the first four years of the plan's implementation (1994-97), the Mead Health Alliance average cost per salaried employee was down 9 percent, at a time when average per-employee medical plan costs for all U.S. salaried and hourly employees increased about 22 percent. Comparing 1992-93 to 1995-96 in six hospital

admissions categories showed total preventable admissions dropped by 16 percent. Even while the national trend for hospital stays was declining, Mead employees did better than the norm. Average length of stay also continued to decrease.

“We didn’t publish the goal for the program,” Mr. Spiller said. “We had determined through MedStat and some databases that primary care was getting about 6 percent of the medical care dollar and our goal was to drive that 6 percent to 12 percent. We didn’t run the program long enough before (Mead) being acquired by another company to get up to the 12 percent but we were going in that direction.”

While dramatically reducing healthcare costs and minimizing the aggravations associated with insurance companies, evidence showed that employees’ health status improved because of the Primary Care Pathway. Reportedly, hospital stays became shorter and less costly, with treatment being done in the inpatient setting.

“The goal was to keep people healthy,” Mr. Spiller said. “It wasn’t just a cost-cutting thing. It was trying to provide the best medical care we could for the money we spent.”

Mr. Spiller said that, despite mostly positive results, the program did face some challenges. Most notably, it was the administrative process between Dr. Reid’s group and the Mead Health Alliance’s claims payer who adjudicated the claims.

“This became clumsy,” said Dr. Spiller. “That was an extra step. It was a cumbersome and unnecessary way to do it.”

The uniqueness of the clinically run Mead Health Alliance was both its strength and its weakness when it came to administration, because the claims payer wouldn’t change its protocols for a single client. “We had to cobble something together that eventually led to the phasing out of the program,” he said. “Without the proper administration, this wasn’t going to work well.”

Reflecting on the program he helped to lead, Mr. Stiller acknowledged that today Third-party Claims Administrators could offer a cure to the administrative vs. clinically run program dilemma. Yet when asked if what he helped pioneer more than two decades might deserve another look today, Dr. Spiller was cautious.

“You’ve got to remember, we were in the papermaking business, a hugely capital-intensive business,” he said.

Dr. Spiller added that, while payroll concerns are a minor issue for companies such as his, that is not the case for everyone. For Mead, health care represented a small fraction of their overall costs. He acknowledged that while what he was saving the company did impact the bottom line, the net affect was *relatively* insignificant.

“But the goal was the clinical issue: are we going to have a healthier workforce? That was the selling point. It wasn’t the money,” he said.

Bright Spot Interview #8

David West, MD A Locally Owned, Non-Profit HMO improves care while it reduces cost

The evolving nature and importance of family physicians and their role in the U.S. healthcare system has become a hotly debated topic. Recently, Larry Bauer, executive director of the Family Medicine Education Consortium, discussed this topic with Dr. David West, a family medicine specialist in Grand Junction, Colorado. Other participants in the conversation were Dr. Pat Tokarz, a Family Physician from Alexandria, Va., and Ally Abel, a fourth-year medical student at Albany Medical College.

Standing at the "Junction" of What U.S. Healthcare Is and What It Could Be

Overview

A group of real physician leaders got together and started the Rocky Mountain HMO, which was one of the first federally qualified, not-for-profit HMOs in the United States. The physicians wanted to build a health system that would truly service the whole community.

The Rocky Mountain HMO was committed to offering the best and most efficient care to everyone. It enrolled Medicaid patients, thus ensuring they had the same access to doctors, specialists and hospitals as a commercially insured patient. Ths made the Medicaid patients less likely to use the ER for their urgent care.

The physician would get paid the exact same rate for a Medicare patient, a Medicaid patient or a privately insured patient.

Family Physicians serving Grand Junction established the idea of a "medical home"—the concept that every HMO patient needs to sign up with a primary care physician—long before the term was in widespread use.

The doctors involved with the administrative activity for the HMO were compensated for their efforts. These included sitting on a medical review committee. They would go into other doctors' offices and review their charts for the quality of care. Other committees were set up to measure vaccination rates or mammography rates, for instance. But nobody was expected to do this work for free.

All the key players in providing healthcare services were not-for-profit and talked and spoke together

Seven interrelated features of the health care system may explain the relatively low health care costs including: leadership by the primary care community; a payment system involving risk sharing by physicians; equalization of physician payment for the care of Medicare, Medicaid, and privately insured patients; regionalization of services into an orderly system of primary, secondary, and tertiary care; limits on the supply of expensive resources, including specialists, beds, and equipment; payment of primary care physicians for hospital visits; and robust end-of-life care.*

According to the Dartmouth Atlas of Health Care, average per capita Medicare spending in Grand Junction was $6,599 in 2007 — 24% lower than the national average and 60% below high-cost Miami. In 2005, Grand Junction had only 60% as many coronary-artery bypass surgeries in its Medicare population as the national average, 55% as many inpatient coronary angiography procedures, and 61% as many inpatient days during the last 2 years of life.*

Spending most of his professional career in the relatively small municipality of Grand Junction, Colorado, nonetheless Dr. West and his colleagues sent ripples throughout the country with their innovative ideas regarding the critical role Family Physicians can and should play in how health care is managed and delivered in the United States.

Born in Sacramento, California, Dr. West spent much of his young life "on the road." Because his father was in the Air Force, the West family relocated often, and young David attended a number of different grade schools, including one in Ankara, Turkey. He earned a Bachelor of Science degree in biochemistry from the University of California-Davis, then enrolled in the UCLA School of Medicine.

"I went to an MD-PhD program with the goal of becoming a researcher in an academic medical center," he recalled, "until I discovered clinical medicine. I loved everything I took as a third- and fourth-year student and I saw Family Medicine as a kind of new movement in America. This was in the early '70s and so I saw it both with the spirit and vigor of wanting to help remake American medicine."

Dr. West completed his training in the University of Colorado School of Family Medicine residency program. While there, he was recruited by Dr. Roger Schenkel to help start a Family Medicine residency program in Grand Junction. Dr. West accepted, joining Dr. Ed Ellenwood to form the two-member faculty.

It wasn't long before it became clear that Drs. Schenkel, Ellenwood and West, along with other dedicated and forward-thinking professionals, would create something very special in that little corner of western Colorado.

A Culture of Innovation, Cooperation … and *Success*

To begin with, the family residency grew into an unqualified success. It started by graduating four residents per year. That number eventually increased to six and today it stands at nine. Equally rewarding, Dr. West said with pride, "Two-thirds of them end up staying in Grand Junction, Mesa County."

While the residency program was taking root, something else was beginning to sprout among the Family Physicians of Grand Junction: an idea on how to work together to improve the delivery of health care in their community.

"Family physicians in the early 1970s were the predominant group of doctors in Mesa County," said Dr. West. "And they heard about this new federal program to form HMOs. A group of real physician leaders got together and started the Rocky Mountain HMO, which was one of the first federally qualified, not-for-profit HMOs in the United States. That was really key — to have an insurance company that was not-for-profit and community based."

Dr. West credited Dr. Schenkel and Dr. Ellwood for leading this effort, with help from some specialists, including an orthopedic surgeon and a dermatologist. Also, according to Dr. West, some factors unique to the region helped nurture the fledgling initiative.

"I think a key thing that helped us as well was the geographic isolation," Dr. West said. "Grand Junction is the largest city between basically Denver and Salt Lake City, Utah and it's about 250 miles over mountain passes to get to both of these areas. It's become the shopping center as well as the medical center for western Colorado and eastern Utah."

In this isolated healthcare "laboratory," the physicians wanted to build a health system that would truly service the whole community. *Their* community.

“We also were small enough and far enough away that I think the big for-profit insurance companies, at least in the ‘70s and ‘80s, weren’t that interested because there weren’t that many people to be insured,” Dr. West said.

Dr. West said that from its inception, the Rocky Mountain HMO was committed to offering the best and most efficient care to everyone. They did not want to imitate the practice employed in many big cities, where Medicaid patients, stigmatized for not paying well, are directed to a neighborhood health center or county hospital. The Rocky Mountain HMO enrolled Medicaid patients, thus ensuring they had the same access to doctors, specialists and hospitals as a commercially insured patient. To this day, Dr. West points to that decision as one that brought him great satisfaction.

“I’m proud of the fact that for all these years in Grand Junction that Medicaid patients could go to any primary care physician they wanted to and those primary care physicians in turn could refer to about 85 percent of the specialty doctors in town and to either of the two hospitals,” Dr. West said. “I would say in my private practice in the 1980s and ‘90s, about 90 percent of my Medicare, Medicaid and privately insured patients were part of this nonprofit Rocky Mountain HMO organization. (The physician) would get paid the exact same rate for a Medicare patient, a Medicaid patient or a privately insured patient.”

Dr. West added that this applied to specialists as well.

“I would congratulate my specialty colleagues that they would reduce in certain ways the fees they got paid to make up for the difference that the HMO would lose with the state contracts with Medicaid or the federal contracts with Medicare,” he said.

Along with the Family Medicine residency program and the not-for-profit Rocky Mountain HMO, Dr. West said Family Physicians serving Grand Junction established the idea of a “medical home”—the concept that every HMO patient needs to sign up with a primary care physician—long before the term was in widespread use. This meant that before a patient saw a specialist, the primary care doctor—which in Grand Junction was about 80 percent Family Physicians and the remaining 20 percent Internists or Pediatricians—had to sign a referral. This created, *de facto*, a medical home-type model.

“Retrospectively, we were blessed by having the right number of specialists,” said Dr. West. “When I got to this community, there were very few subspecialists and we ‘kind of grew’ one cardiologist and one gastroenterologist and one neurologist but kept predominantly, Family Physicians as the key members of the medical group. Per my studies on reports I did in the 1980s and 1990s, we had twice as many Family Physicians as was typical of the rest of the country.”

Dr. West said that doctors involved with the administrative activity for the HMO were compensated for their efforts. These included, for example, sitting on a medical review committee.

“They would go into other doctors’ offices and review their charts for the quality of care,” he said. “Other committees were set up to measure vaccination rates or mammography rates, for instance. But nobody was expected to do this work for free.”

Caught in a Downward Spiral

Despite so many successes, the organization found itself caught in a downward spiral caused primarily by four factors, according to Dr. West.

One was Rocky Mountain HMO becoming Rocky Mountain Health Plans.

“They started doing business over the entire state of Colorado,” he recalled. “I wasn’t a part of that, but I see that instead of having our health plan and great communications with all the area players, by becoming bigger it became more like a corporation and they were later bought by a for-profit health insurance company.”

Changes in Medicaid struck the second blow.

There was a backing down on Medicaid,” Dr. West said. “The reality was, you got paid the same whatever your specialty for a Medicaid or private pay patient, but they had to reduce those same fees and I think that meant a lower reimbursement and that created the problem that exists all over the country.”

Third, hospitals were given the opportunity to hire their own physicians.

“When I came to Grand Junction, hospitals could not hire physicians,” Dr. West said. “But those laws were changed and hospitals—including our local hospitals—began not supporting the independent physicians and became more aggressive in hiring their own physicians.

“I think that has been quite damaging.”

The fourth impediment reflected the changing nature of the primary physicians’ workday.

“Primary care physicians are so much office-based today they don’t go to the hospital to see their patients, they don’t deliver babies near as much, they don’t even attend meetings near as much,’” he said. “It’s kind of both an attitudinal change and what financial realities have done this to primary care.”

Lessons Learned …. And Hopes for the Future

For the Grand Junction healthcare community to enjoy the success it did, first and foremost, communication throughout the system was critical.

“(What was) so critical about Grand Junction is all the key players in providing healthcare services were not-for-profit and talked and spoke together,” Dr. West said. “The Mesa County Physicians’ Independent Practice Association – MCP IPA – were the key players in the area, representing 85 of the doctors. They would be involved in negotiation of prices. But everyone talked to everyone and you had good leaders of all the organizations.

“So, for instance, in 1993 the two hospitals, the IPA, Rocky Mountain Health Plans, and all got together and said, instead of all of us having our own separate little hospices, let’s put together one for the whole community and did so, as a not-for-profit hospice. I think most people in the field say it’s the best hospice care in the United States.”

Another key player, according to Dr. West, is the Hilltop Community Services providing care for chronically ill patients and other special services like access to early obstetric care.

“Having the key players in our community being nonprofit and to communicate with one another on a regular basis has been a real key to success,” he said.

Dr. West recalled there was a time when the efforts undertaken in Grand Junction garnered positive publicity and interest from healthcare organizations, physicians and even government leaders across the nation, although he admits that “sadly, I cannot say that I’ve read about any of them making the dramatic changes that are needed to put the doctors back in control of our health system and to make health systems smaller and more locally run.”

But that reality hasn't caused Dr. West to stop dreaming of a day when America's healthcare system becomes more efficient and effective; or of a way to make this dream come true.

"I always said I that I think that I could sit down with a group of 10 Family Physicians and devise a much better healthcare system than the one we all practice in today," he said. "But sadly, these redesigns are being done by economists and bankers and politicians. It should be doctors out there and we need to do that, but how to get that done I don't know."

Yet, while Dr. West says he's not sure how to fix the whole healthcare system, he does have some suggestions for improvement.

"I think that all healthcare entities in the country should be locally run and not-for-profit,'" he said. "The idea that you're running a health insurance company to make profit for stockholders is just abhorrent to me and we're the only country on earth that does that to my understanding."

Secondly, Dr. West said, doctors should remain very much involved with the administration of healthcare systems and play an instrumental role.

"To me it's just part of the ethics and we need to look at the entire reimbursement schemes of all of medicine'" said.

Additionally, Dr. West said that throughout his entire now almost 50-year career in Family Medicine, he believes the fact that that so many specialists and so few primary care physicians are trained needs to be changed.

"That's just crazy to me," he said bluntly.

Dr. West admitted that such positive changes likely will not be easy to obtain. He doubts the ability of the next generation of physicians to take up the challenge because, "Today's younger people are beaten down by student debt. They are more likely to accept the status quo. It's too expensive to start your own practice so I don't fault the young people of today."

Dr. West said that, if he were a young physician who wanted to promote change, he would put his efforts into reforming the American Medical Association, the American Academy of Family Physicians and the Society of Teachers of Family Medicine.

"These groups have let us down by not being much more proactive," he said. "The voice of medicine is absent despite the fact that medicine consumes 20 or 22 percent of our gross domestic product and by far is the biggest business on earth."

Dr. West said he believes that only a very dramatic, probably government-led, reform is going to get America out of what he calls the healthcare mess the country is in today.

"Hopefully doctors can play a much more active role," he said. "You have to have local decision making, local control, local quality and all of that needs to be part of a new and better American healthcare system. Designing health care for Wyoming is a whole lot different than designing health care for Los Angeles or New York City."

- Low-Cost Lessons from Grand Junction, Colorado, Thomas Bodenheimer, M.D., M.P.H., and David West, M.D .n engl j med 363;15 nejm.org october 7, 2010

Bright Spot Interview #9 - Family Medicine and the World Bank with Jules Duval, MD

Bright Spot Interview #10 - Family Medicine and the World Bank with Patricia Evans, MD

What are the unique potential challenges facing an organization seeking to build a healthcare program for employees who hail from around the world? Recently, Larry Bauer, chief executive officer of the Family Medicine Education Consortium, discussed this with Dr. Jules Duval and Dr. Patricia Evans of MedStar Health.

Title: The World Bank and MedStar Health Partnered to Create an Integrated Care Delivery System

Overview

The World Bank employs 14,000 employees in D.C. and 12,000 around the world from more than 140 countries; the majority of which work in Washington, D.C. It is a self-insured organization.

Dr. Jules Duval a Family Physician with health care management leadership in large organization was hired. When he arrived at the World Bank, it had a small urgent care clinic serving mainly as a convenience to staff. It was becoming essentially a primary care clinic

Full-time staff under the medical insurance plan number about 9,000 covered in the Bank's D.C. Headquarters, while another 6,500 overseas based staff are on international insurance with a different third-party administrator. The population served also includes retirees and dependents. Those covered are not required to go to an in-network specialist.

The World Bank believed that an onsite primary care capability would help to get people more connected, in a more structured way, to their health and their health needs and to get them the care they need. "So, the mission at that point was for me to look into it and see what we could do to develop that kind of capability," he said.

A first step was to conduct an internal study to see what it would cost to build that capability versus the expense of engaging an outside vendor. After concluding that an external center of excellence could better provide a better solution at lower cost, Duval conducted a competitive request for proposal process which resulted in MedStar Health being awarded the contract.

We decided that we would provide the space and allow MedStar to come in and just do their work and bill our plan as a fee for service just as they would anywhere else. They literally came as a piece of MedStar cocooned inside the Bank. They work in the space, see people who come in for appointments, and then they bill Bank insurance just as any other external primary care clinic would. They have their own IT system which is completely separate from the Bank's thus guaranteeing patient confidentiality, and they do not get paid any fixed costs whatsoever. Their entire income stream comes only from services rendered, and that is how they make their money.

MedStar's Dr. Patricia Evans, a Family Physician for more than 20 years, led the effort to put into place: a five-year plan for how they would meet their anticipated staffing needs. But the response to the clinic was so robust that they accelerated the five-year plan and completed it in the first two years.

They started off with Dr. Evans and two nurse practitioners and just got overwhelmed quickly" Evans said.

They provide full spectrum Family Medicine services at the World Bank (minus obstetrics). "We do well care for children and adults, and well as routine well woman care", she said. "We also perform minor surgical and dermatologic procedures, insert IUDs, do colposcopy and endometrial biopsies, and acute sick visits for children and adults. So, it really is a full spectrum clinical practice."

The primary care clinic has a behavioral health specialist, a social worker by training, as well as a psychiatrist onsite one-half day a week.

"There were some bumps in the beginning because people were shifting from what was a walk-in convenience

World Bank Makes Major Investment in Its Employees' Health

For many U.S. companies, it is difficult enough to communicate the language of health care and healthcare coverage to employees. So, imagine the added challenge faced by the World Bank, which employs literally thousands of individuals from more than 140 countries, the majority of which work in Washington, D.C., when it tried to do just that.

The bulk of that challenge fell to Dr. Jules Duval, who joined the World Bank at a time when the organization was focusing on ways to improve the health and safety of its work force.
Duval, who credits his "country doctor" grandfather's example for his choice to become a Family Physician, attended medical school at the University of Vermont under a U.S. Air Force scholarship.

Duval said he experienced the administrative aspect of medicine while serving in the Air Force. While he honed his clinical skills during his residency at Andrews Air Force Base (AFB), he served 3 years as part of the Fourth Fighter Wing at Seymour AFB in North Carolina, and 2 years as part of Air Force Materiel Command at Hanscom AFB in Massachusetts. After his wife earned her law degree during his tenure with the Air Force, the couple moved to Washington, D.C.; there Duval accepted a position as Medical Director of Occupational Health Services with the Smithsonian Institution which was looking for a physician to create a workplace wellness program.

After nine years at the Smithsonian where he and his team both successfully launched that initiative and were awarded the American College of Occupational and Environmental Medicine's Corporate Health

Achievement Award, the first for a federally funded government agency, Duval was offered a position as Senior Medical Officer at the World Bank Group. The international organization whose mission is to eliminate extreme poverty and to boost shared prosperity wanted to start a program similar to the one he had established for the Smithsonian, only on a global scale. Up until the time Duval arrived at the World Bank, it had no internal safety program.

"My new boss Dr. Brian Davey, who left his position as Medical Director for the United Nations in New York to take over as the Director of the Bank's Health Services Department, wanted to create an integrated health and safety program, and part of that was to better manage health, safety, and environmental risks," said Duval. "We focused on the health piece first. A lot of that had to do with proving the value proposition of both a wellness program and an onsite primary care capability." When Duval arrived at the World Bank, it had an urgent care clinic with rather small capability and serving mainly as a convenience to staff.

"What I found was really happening is they were turning the urgent care clinic into essentially a primary care clinic," Duval recalled, adding that the employees were developing attachments to the doctors and nurses at the clinic. "But what I recognized very early on is that we were not properly resourced to provide the full primary care experience."

Duval added that the World Bank believed that an onsite primary care capability would help to get people more connected, in a more structured way, to their health and their health needs and to get them the care they need.

"So, the mission at that point was for me to look into it and see what we could do to develop that kind of capability," he said.

A Partnership Formed with MedStar Health

Duval said a first step was to conduct an internal study to see what it would cost to build that capability versus the expense of engaging an outside vendor. After concluding that an external center of excellence could better provide a better solution at lower cost, Duval conducted a competitive request for proposal process which resulted in MedStar Health being awarded the contract.

Taking the necessary time to go through this process carefully bore real fruit. "As it turned out we ended up with a most efficacious and ingenious outcome," Duval said. "We decided after a lot of analysis and study that we would provide the space and allow MedStar to come in and just do their work and bill our plan as a fee for service just as they would anywhere else. They literally came as a piece of MedStar cocooned inside the Bank. They work in the space, see people who come in for appointments, and then they bill Bank insurance just as any other external primary care clinic would. They have their own IT system which is completely separate from the Bank's thus guaranteeing patient confidentiality, and they do not get paid any fixed costs whatsoever. Their entire income stream comes only from services rendered, and that is how they make their money."

Duval, now Chief Medical Officer and manager of several new health services-/program-related contracts said these changes make perfect sense for the World Bank Group. "The Bank is an international financial institution, and while it wants its staff to have good health care, it is not the Bank's role to provide that care directly.

Because the Bank rates all of its contracts based on financial risk (i.e. the risk of having to pay for deliverables not produced or services not rendered), Duval is also fond of referring to the MedStar contract as a zero-dollar contract. "We're not actually paying MedStar anything other than what they would be paid in any other clinic they run around the local area which is an agreed upon fee for services that they provide." he said. "They pay for their own overhead and we provide the field of play, that's it". Duval said MedStar has carved a nice niche for itself inside the World Bank. "They are getting themselves somewhat wedded to the DNA of the Bank," he said. "Even during COVID-19, the MedStar staff is going

to the clinic every day conducting virtual consultations that are now at a level comparable to the patient volumes they saw when the Bank was open for business".

The Program Hits the Ground Running

MedStar's Dr. Patricia Evans, a Family Physician for more than 20 years, led the effort to put into place: a five-year plan for how they would meet their anticipated staffing needs. But the response to the clinic was so robust that they accelerated the five-year plan and completed it in the first two years.

"We started off with me and two nurse practitioners and just got overwhelmed very quickly," Evans said. "Currently we have four physicians and one nurse practitioner. And our staffing needs might increase again when the World Bank staff fully returns to the building after the COVID-19 crisis."

Evans explained that the World Bank is not subject to OSHA, HIPAA, nor technically any U.S. regulations because the enjoy diplomatic immunity, unlike MedStar Medical Group.

"As a good citizen, they (The World Bank) always adopt and try to emulate the standards that are required in the local jurisdiction," said Evans. "So, while technically we are on international ground in our physical location within the World Bank, we comply with things like HIPAA. In addition, the World Bank additionally complies with requirements like the European Union's data privacy act."

Evans explained that all of the private medical information is handled by MedStar, completely on their own network.

"Our EMR is on a different system totally unconnected to the Bank," she said.

Evans said they provide full spectrum Family Medicine services at the World Bank (minus obstetrics).

"We do well care for children and adults, and well as routine well woman care", she said. "We also perform minor surgical and dermatologic procedures, insert IUDs, do colposcopy and endometrial biopsies, and acute sick visits for children and adults. So, it really is a full spectrum clinical practice."

The primary care clinic has a behavioral health specialist, a social worker by training, as well as a psychiatrist onsite one-half day a week. "We put a lot of focus on developing mental health services initially," Evans said. "It's very helpful to have the psychiatrist for people with more complicated mental healthcare needs."

Meeting the Challenges of Culture and Choice

Starting such a program for any organization the size of the World Bank—with about 14,000 employees in D.C. and 12,000 around the world representing more than 140 different countries—would be a challenge, and that challenge was further exacerbated by cultural issues related to health care worldwide. "People come from around the world to work at the World Bank," Duval said. "And the idea of a primary care doctor is not well understood by many of them. In addition to that, many come from countries with publicly funded health care systems. When they get to the U.S. where the best health care is privately provided for a fee, navigating the U.S. health system can be really confusing."

Duval added that the World Bank's employee population is about 80 percent international, 20 percent from the U.S. and that within his own staff of about 28, only a handful are Americans. Full-time staff under the medical insurance plan, which is managed by Aetna, number about 9,000 covered in the Bank's D.C. Headquarters, while another 6,500 overseas based staff are on international insurance with a different third-party administrator. The population served also includes retirees and dependents. Those covered are not required to go to an in-network specialist.

“There were some bumps in the beginning because people were shifting from what was a walk-in convenience clinic to a more structured primary care clinic,” Duval said. “There is some tension between those who want to be able to have a walk-in clinic that’s convenient versus those of primary care where it’s appointment-driven. Some people actually do just use the MedStar clinic for urgent care. But increasingly people are transitioning to primary care provided by MedStar inside the Bank.”

Evans added “because there’s an electronic portal allowing for patients to communicate with their office from international locations, some patients that work at international locations still coordinate their primary care needs through our office when they are traveling to Washington DC for work.”

Lessons Learned and a Look to the Future

Reflecting on the World Bank initiative to date, both Duval and Evans said much has been learned on a variety of fronts. Duval says “the Bank is self-insured and that makes it more susceptible to the problem of rising health costs resulting in growth of the health plan. One of the things I admire most about the Bank is that it recognizes the importance of promoting good health among staff as the key to controlling costs. In other words, they don’t take the approach of ‘let’s see if we can just keep cutting benefits or increasing copays to see if we can get spending under control.’ They really want to invest in the health of their staff as a way to reduce healthcare costs.”

The strategy appears to be working. Duval said this year was the first time he had ever seen the phenomenon where annual costs for the year came in several million dollars lower than had been projected. “While I couldn’t immediately say definitively that this was because of MedStar, we cannot ignore the fact that this happened after we brought in an in-network provider,” Duval said. “What staff are doing is going to an in-network primary care provider, and when referrals need to be made, they are made to an in-network group of the area’s top specialists that is literally three blocks from the Bank. Staff values the services and the services cost less for the Bank. Talk about a win-win situation!”

Duval further notes that the appeal of the in-network specialty referral process has much to do with MedStar’s uniform medical record system across all of its locations. “No more carrying medical records to the specialist or waiting weeks for faxes to come back. Now staff just goes into their MedStar Patient Portal to access any health records they need. A World Bank Vice-President working in Africa with frequent return to DC asked to be interviewed for an internal Bank communication about the MedStar Clinic. In the produced video, he held up his phone and said “Because of MedStar, I can carry my medical records safely all across Africa right here in my pocket”.

“There was a really big need for primary care,” Evans said. “About five thousand, or a third of their people, did not have a primary care physician. So, while some people understood the primary care model, some people coming from other cultures just didn’t understand it. Individuals couldn’t figure out the healthcare system in the U.S. so they would wait until they returned home every three years or so. “Now three years into it, I would say there is very good buy-in.”

Evans said that another lesson—more of a shock, really—was the wide range of chronic health conditions of the employees. “I was surprised at how sick people were,” she said. “I have seen some of the highest cholesterol levels here that I have ever seen in my life. There is also a higher than average incidence of hepatitis B, related to childhood exposures in certain countries. We talked in the past year prior to this acute care crisis about a more targeted approach, kind of higher touch, on the patients that we know are higher risk.”

Even the COVID-19 pandemic provided an opportunity for learning, this time for the employees. “In a positive way, COVID-19 created a sense among people that their baseline health really matters and that

they really need to stay healthy if they want to contend with infectious diseases better," Duval said. He added that appointment based wellness visits would be the biggest goal for the next couple of years, weaning staff from walk-in/convenience care. "Appointment based primary care and bona fide same day urgent care are both important, but each has different purpose value to staff", he added. "I know MedStar can handle both with aplomb, but they can probably do it better if the two distinct offerings are in different spaces."

The experience of building this program also has brought personal insights for Duval and Evans. "I have found as I grow older that my skills as a family doctor, my understanding of the mechanism of disease, and a better understanding of how to achieve key stakeholder buy-in, to include development of solutions to address both the costs concerns of employers and the health concerns of staff, have enabled unimagined success", said Duval. "I think that's what a doctor trained in family medicine can do for an employer," Duval said. "Not having a doctor who really understands primary care there to help develop a strategy like this, it leaves them at a disadvantage."

For Evans, her experience with the World Bank hasn't exactly gone according to script. "When I first started, I thought it would be kind of interesting because the patients would be from an international community, but that it would involve care of largely healthy well-adults and I would eventually get bored. But when I got here, it was like, 'Oh, no, this is not what I expected at all, and I realized quickly that a strong primary care clinic could have a huge impact on the health of this community.' We've accomplished a lot our first three years so we will continue to build this collaborative care model, building our strength even more around coordination with the World Bank's preventive care wellness program. We have been working with the wellness program, but I don't think we've maximized a more targeted care management approach for at risk patients. I tell people my goal isn't to promote family medicine. My goal is to get to a better healthcare system so my grandchildren will inherit a better system of care. For this community, and for many others, Family Medicine is the best vehicle to get there."

"We are so proud at MedStar to be partnered with a prestigious international organization like the World Bank. As a family doctor, I am delighted to work with an organization that understood and valued what Family Physicians can offer and how a patient centered medical home can improve health, wellness, and outcomes for their employees, retirees, and dependents." James Welsh, MD, Vice President for Primary Care in the MedStar Health System.