Flexible Practice Approach
Has Something for Everyone

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

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Cardiologist John Levinson, M.D., has a multifaceted approach to health care. In 2001, he established the first “concierge” practice in New England. But unlike other practices of this type, Dr. Levinson runs a “hybrid” practice that cares for retainer and regular insurance patients. Plus, he still finds time to see patients in the hospital. The “hybrid” is a convenient and a flexible way to practice medicine, but in an interview, Dr. Levinson insisted that his hours have never been more manageable—and his patients are happier than they used to be.

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

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

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

To bestow the explanation of benefits statement which said the insurer had paid 25% of my charges.” Most doctors in Massachusetts get around 25%-30% of their charges, he said.

“But the bottom line was this patient felt he would not have made it through that hospital stay if it weren’t for me, and he was worried about me working too hard. He wanted me to slow down so I wouldn’t die before him.” Levinson, who is a primary care doctor, not just his cardiologist.” While his practice initially started with this one patient in mind, it eventually expanded into several practices, catering to different types of patients.

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

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

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

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

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

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

Retainer practices have often been criticized for “double billing” patients—charging an access fee on top of regular services covered by insurance. According to BlueCross BlueShield of Massachusetts, “if you’re an active member of our network you can’t charge an access fee to patients,” Chris Murphy, spokesman for BCBS in Massachusetts said. But the authors of a 2005 JCAHO report found that charges such as those with no significant impact across the board,” he said.

And indeed, the GAO’s report, issued in August, concluded: “The small number of hospitals that elect to provide core and improve processes of care. There was no improvement in the death rates, but the authors said that the improvements in the processes being measured would not have had an impact on mortality. And there was no significant improvement in the mean time to thrombolysis for patients with acute MI or in mean time to administration of antibiotics for pneumonia.

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

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

For heart failure, hospitals were tracked on whether they offered smoking cessation counseling and discharge instructions on medication, diet, weight, and worsening of symptoms, and whether an ACE inhibitor was prescribed at discharge for patients with left ventricular systolic dysfunction. For pneumonia, the commission monitored whether there was an oxygenation assessment within 24 hours of admission, heart failure, pneumococcal vaccination, or both had been given at discharge, or if blood specimens were cultured before starting an antibiotic.

By the end of the study, more than 90% of MI patients at most hospitals received aspirin at admission. Although only 74% of patients received ACE inhibitors at discharge at the lowest performing hospitals, 81% received them at the highest performing facilities.

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

Even after improvement, pneumococcal vaccination rates were still low, ranging from 33% in the lowest performing hospitals to 66% at the highest performing facilities.

The authors noted that one potential drawback of the study was its reliance on self-reports, data that could introduce bias. And, they said, the data should not be viewed as static. The picture could change over time. And the data, which is hospital data becomes more change as public reporting of performance becomes more common, could influence hospital behavior.