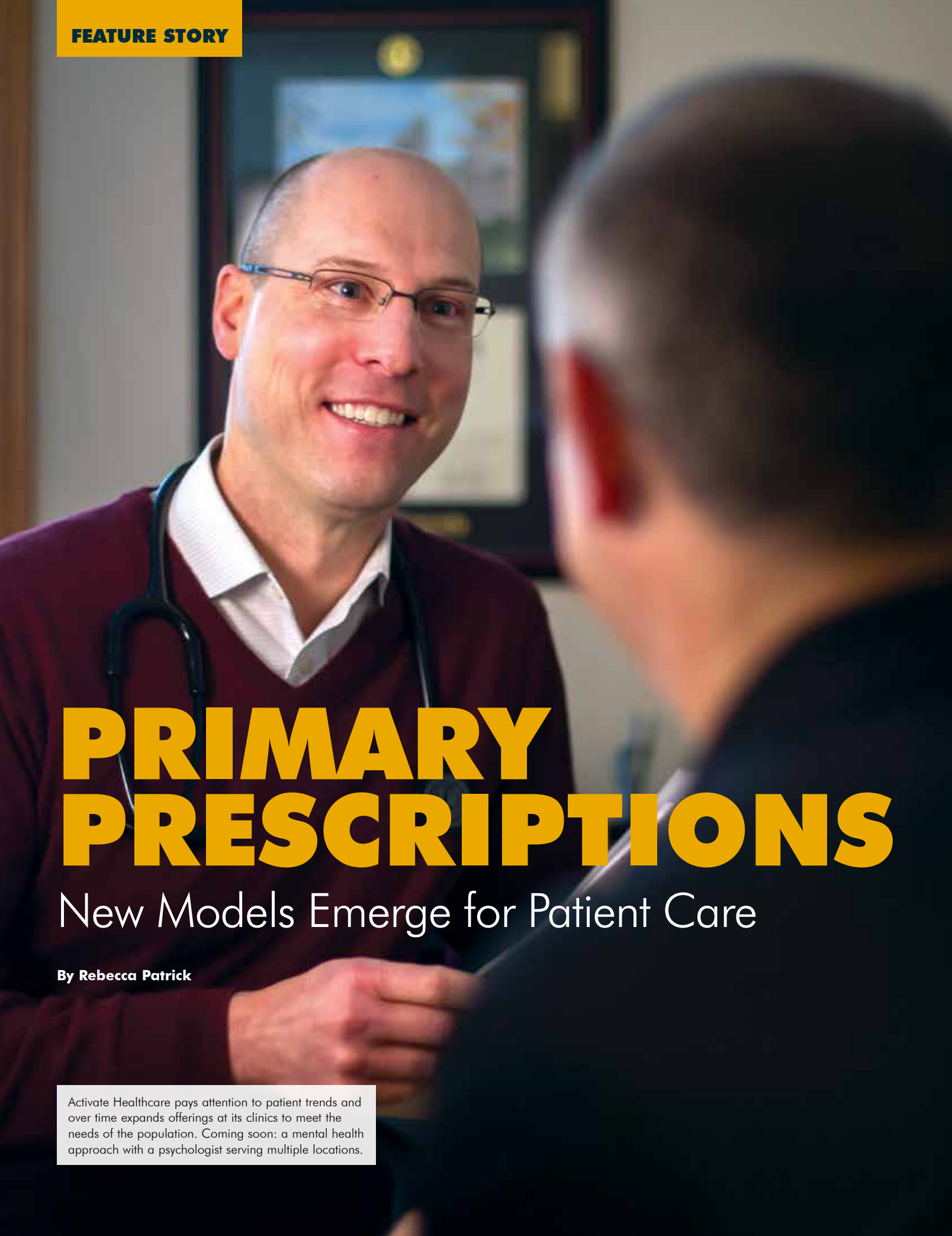
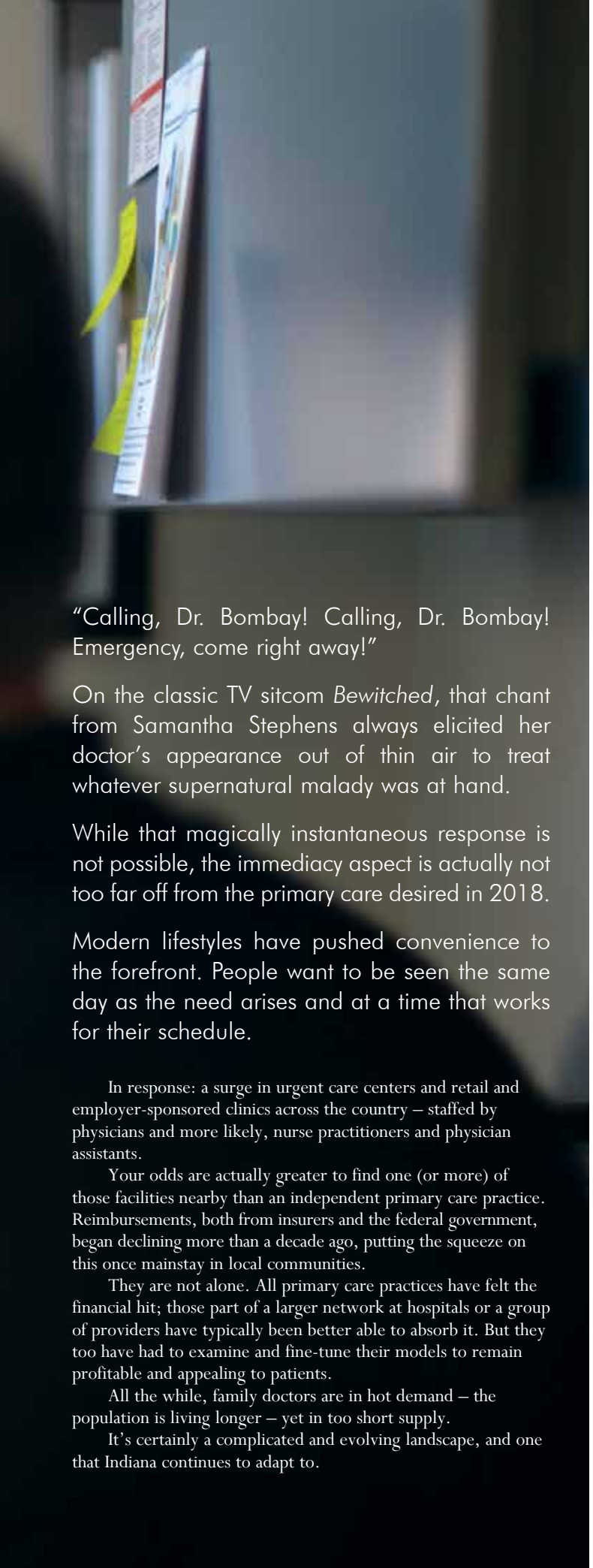


PRIMARY PRESCRIPTIONS

New Models Emerge for Patient Care

By Rebecca Patrick

Activate Healthcare pays attention to patient trends and over time expands offerings at its clinics to meet the needs of the population. Coming soon: a mental health approach with a psychologist serving multiple locations.



"Calling, Dr. Bombay! Calling, Dr. Bombay! Emergency, come right away!"

On the classic TV sitcom *Bewitched*, that chant from Samantha Stephens always elicited her doctor's appearance out of thin air to treat whatever supernatural malady was at hand.

While that magically instantaneous response is not possible, the immediacy aspect is actually not too far off from the primary care desired in 2018.

Modern lifestyles have pushed convenience to the forefront. People want to be seen the same day as the need arises and at a time that works for their schedule.

In response: a surge in urgent care centers and retail and employer-sponsored clinics across the country – staffed by physicians and more likely, nurse practitioners and physician assistants.

Your odds are actually greater to find one (or more) of those facilities nearby than an independent primary care practice. Reimbursements, both from insurers and the federal government, began declining more than a decade ago, putting the squeeze on this once mainstay in local communities.

They are not alone. All primary care practices have felt the financial hit; those part of a larger network at hospitals or a group of providers have typically been better able to absorb it. But they too have had to examine and fine-tune their models to remain profitable and appealing to patients.

All the while, family doctors are in hot demand – the population is living longer – yet in too short supply.

It's certainly a complicated and evolving landscape, and one that Indiana continues to adapt to.

Direct care emergence

"Over the last five to six years in particular, it became more apparent that we were running into a crisis," declares Dr. Blair Brengle, an Indianapolis primary care physician for over 25 years who previously enjoyed a small private practice with several other doctors.

"We would see the income decline each year; we would combat that by extending our hours – yet the following year, it would drop a little more. You get to the point where you can't work any more than you are working. … If we kept going, we would be running into the red sometime later this year or early 2019."

They didn't wait around for the inevitable. Two partners migrated to hospital-owned practices, but Brengle decided that option wasn't for him.

"The hospital-owned model is attractive because of the paycheck and good benefits. But I would have a hard time putting up with the demand in the high-paced environment and spending little time with patients," he determined.

Last November, Brengle joined the world of direct primary care – which is both innovative and a throwback; the latter in terms of the concerted focus on cultivating a doctor-patient relationship.

He no longer takes insurance or Medicare; instead, patients pay a monthly membership fee which guarantees them all of the services you would expect from a family doctor.

"No additional co-pays; no additional fees. They still need their health insurance for blood labs, X-rays, immediate care visits, emergency room visits, specialty referrals. We are very quick to reinforce with patients that this is not in place of their health insurance; they just don't use their insurance to pay me," Brengle explains.

The monthly fee is based on age: up to age 18 is $50; young adults (19-26) is $75, average adult is $135 and a family rate, which covers two adults and up to four children, is $370. Health savings accounts can be used to make payment.

Patients sign a one-year (repeating) contract with a 30-day out. This commitment allows Brengle, who is the only caregiver at the practice, to oversee the select group of patients.

"The advantage for the patients and me is it offers immediate access. If you are sick today, you call in and you get seen today. You are going to spend 30 to 60 minutes with me in the exam room, depending on the complexity of your visit," Brengle offers.

"You can see me as many times in a given month as need be. That could be once a month, four times a month; it could even be every day for a while.

"Whatever the patient's need is at that time, we are going to cater to that. We also have the ability to spend more time on preventative medicine and look to take care of things before they happen if you will and, in general, keep patients healthier," he continues.

Brengle is approaching 200 patients – some of whom followed him from his old practice. He will stop accepting more patients when the total reaches 550 or 600, which he anticipates occurring as soon as next year.

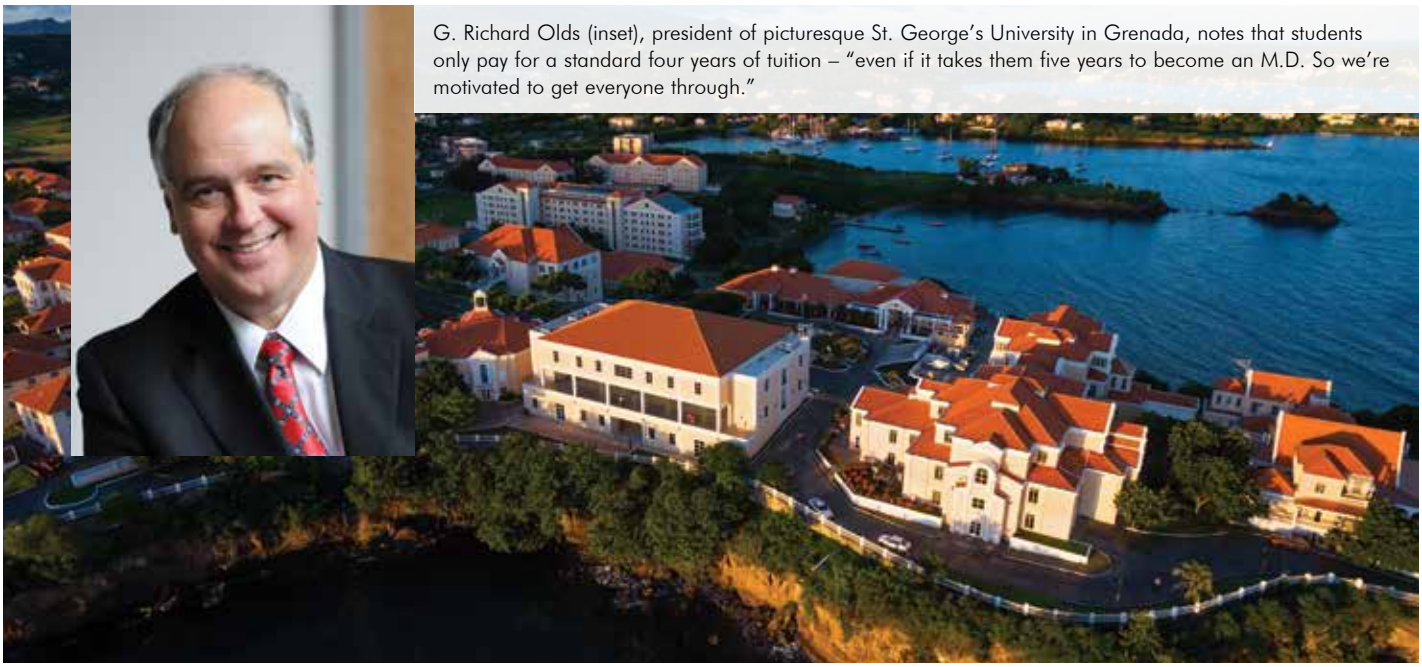
Also on the horizon, Brengle predicts, are insurance companies and Medicare developing plans that will allow patients to participate in practices like his.

"The reason it makes sense is because they are motivated by money and saving money," he asserts.

"Study after study shows that patients involved in a direct primary care practice have lower costs per year compared to patients involved in a classic model medical practice."

Practices reinvented

Carmel-based American Health Network (AHN) is a large independent physician group with approximately 300 doctors and over 30 locations throughout the state. Predominantly primary care



G. Richard Olds (inset), president of picturesque St. George's University in Grenada, notes that students only pay for a standard four years of tuition – "even if it takes them five years to become an M.D. So we're motivated to get everyone through."

focused, AHN was created by Anthem in 1994 and sold to the network's doctors four years later.

Longtime CEO Dr. Ben Park admits "it's been a struggle the last five years." But wise decisions have invigorated the group, both financially and in its service model.

Part of the boost came in late 2017 when AHN was acquired by the nation's largest insurer, UnitedHealth Group, and joined similar medical organizations from all across the United States under the OptumCare umbrella.

"We are all partners and have pooled our resources. We have a lot more expertise and a lot better financial resources to move this value-based model forward," Park notes. "It's quality first, cost of care second."

He stresses that "hitting our quality metrics and reducing costs really go hand in hand."

To help achieve those goals, several years ago AHN began deploying a team approach to care that also includes nurse practitioners and physician assistants who are assigned to each doctor. It's both cost effective, as these caregivers don't command the salary of physicians, and enables patients to receive more immediate (generally the same day) and comprehensive care.

Park acknowledges the switch initially wasn't easy for either physicians or patients.

"It was hard for our physicians to not do everything for a patient. But with the increasing demands and the cost and quality pressures, they just couldn't keep up with doing everything that needed doing.

"And patients weren't really clear what this was all about. But as we put it in place and they understood that the whole team was there to work for them, I think it's been better accepted. Both have found out how much better this works," he concludes.

Methods are also evolving at IU Health Physicians, which offers Hoosiers 47 primary care offices at or linked to Indiana University-run hospitals.

Beyond wanting to increase standardization across all its practices, IU Health's goal is to become more efficient and more inclusive of the entire team. The first step will include re-evaluating who needs to be on the team, reveals Dr. Kevin Gebke, who oversees the network's primary care service line in addition to being chair of the Indiana University School of Medicine's Department of Family Medicine.

"We recognize that all of it doesn't need to be done in a room with one doctor and one patient. A lot of it can be done as outreach. We can start using technology to do video and phone visits. We can engage our pharm Ds (those with a doctor of pharmacy) to help with some of the chronic disease management, especially around diabetes, for example. We haven't done that in the past."

More employers getting involved

Bending the cost curve for companies and conveniently satisfying employee health care needs are the calling cards of employer-sponsored on-site or near-site clinics.

Activate Healthcare Indiana and OurHealth are two operators in this space.

The former boasts 31 clinics in the state, stretching from South Bend to Evansville,

According to Dr. Kevin Gebke of IU Health Physicians, most medical students leave their training programs $150,000 to $250,000 in debt, which can factor into choosing a higher-paying specialty area of medicine instead of primary care.

Dr. Blair Brengle feels the level of service he offers now under the direct care model is similar to the old-school practice he had before "where we could call the shots and did take the (proper) time to spend with patients."

with a client base rich in schools and other government entities, in addition to labor unions. OurHealth has seven MyClinic locations in Indianapolis that serve a diverse clientele, as well as operations in five other states. Each collects a customized per-month fee from each employer.

Part of their business that's especially booming is the shared clinic model.

"In a community, there is usually one employer that's functioning as the primary sponsor of the clinic, but then the others can buy into that clinic and provide primary care services to their employers and family members that they would otherwise never be able to do on their own," shares Nathan Mowery, president of Activate Healthcare Indiana.

"It's the power of the community coming together to provide great primary care services. At last count, we have around 80 employer groups who are using those clinics."

OurHealth president and co-founder Dr. Jeff Wells touts: "We were the first company in the country to open this MyClinic approach with a network of locations." Today, dozens of employers access it.

Member employees and their families can go to any of the OurHealth or Activiate Healthcare facilities, making it convenient from both work and on the way home.

Mowery and Wells emphasize a strong wellness component and look at an employee's overall health and what makes sense for the individual.

"Our focus really is on getting the patient in for an annual health assessment, which would include biometric screenings and lab work, and go from there," Mowery begins.

"We really encourage providers to take the time necessary to listen to their patients, to understand the big picture of what's going on. That's not always what we see in health care; it can be choppy and there's no one paying attention to the total health of the individual," he insists.

"We want providers to understand what's going on with that patient's health in the clinic and then outside of the clinic as well – what specialists are they seeing, is this necessary care, the most effective care?"

Wells points out another differentiator to many primary care counterparts.

"We don't have a direct relationship with (hospitals) in this market … so when a person needs specialty care or a referral, we are able to partner with the patient to find out where is the best place to go based on your individual need in terms of convenience, quality and cost."

High levels of customer satisfaction – above the industry average – are consistent, he notes.

"Some of our customers have rock climbing walls, gyms, cafeterias – all kinds of on-site benefits, but the clinic almost without fail – if it's not number one, it's the second or third most desired benefit by those employees," Wells proclaims.

Adds Mowery: "It's a maximum impact and minimally invasive on personal schedules. They can get in and either be seen for their acute care needs or for their annual health assessment and get back to the line, back to the classroom or back to the office quickly.

"It really minimizes the disruption to the employers' work environment."

Paging doctor, doctor

The family physician pipeline has dwindled due to specialty areas of medicine being more attractive in both pay and workload.

"For our health system to work efficiently, over half have to be primary care doctors. Right now, and for the last two decades, only about 30% of U.S. medical school graduates are going into primary care; the rest are specializing," explains Dr. G. Richard Olds, president of St. George's University in Grenada.

"When you overlap that with the geographic shortage, you can see finding a primary care doctor in rural America or an under-served urban America is at a critical level. That basic formula is equally true in most developed countries."

According to the Bowen Center for Health Workforce Research and Policy at the IU School of Medicine, by 2020 Indiana is going to be approximately 2,000 primary care providers short of the actual need.

If there is good news on this front, it's that entities near and far are working to make the situation better.

Both at St. George's and in his prior position as founding dean of a new medical school at the University of California, Riverside, Olds prioritized focusing on getting the "right" candidates.

That translated to accepting qualified students from communities needing primary care physicians, as research shows those individuals are the ones with the greatest likelihood of staying in those areas and being satisfied.

While at UC Riverside, no out-of-state students were even considered for the program.

His current Caribbean location recruits from all 50 states – with U.S. residents accounting for 70% of students.

"Maybe (hospitals) will still take the bottom Harvard student in the middle of nowhere Nevada, but if they get the chance to have a kid that's coming back and fully trained, they're likely to take that student because they're local. That's what makes our students desirable," Olds contends.

This year, St. George's placed 946 doctors into residencies in the United States, with Indiana among the welcome recipients. According to Olds, that's three times higher than its U.S. counterparts.

Homegrown efforts are also – slowly but surely – moving in the right direction.

"We've been very successful in recruiting and keeping the vast majority of residents in the state. There have been years

where 100% of our graduating residents stayed," notes IU's Gebke.

"We do make sure we have representation from throughout the state … so everybody's not from the same ZIP code. You are going to have a difficult time recruiting someone to a small rural part of Indiana if they grew up in suburban Indianapolis."

Gebke, who has even proposed starting doctor recruitment in high school, is particularly excited about two recent developments.

A partnership between the IU School of Medicine and a consortium of southwestern Indiana hospitals will expand graduate medical education in the Evansville region, including a residency program based at Jasper Memorial Hospital.

In Lafayette, a new family medicine residency offering at (IU Health) Arnett Hospital accepted its first set of residents this summer; in two years, it will be at the full complement of 15.

It marks the first time either city has had such programs.

Another positive, Gebke relays, is that the compensation level has improved the last five years.

"The specialty salaries certainly haven't come down, but the primary care compensation has come up some to close that gap."

Next wave

Gebke also expects IU to step up its endeavors.

"Ideally, we will have residency training programs around the state within the next 10 years so people can stay in those areas they are committed to and are familiar with."

Olds continues to beat the drum about the importance of changing the long-standing admissions process at most medical schools to look for those "geographic matches" he detailed and prioritize qualified blue-collar students over those from privileged backgrounds.

Yet he concedes the "significant challenge" in making that occur.

"If you talk to most medical schools – and I've been a faculty member at five of them – they'll say, 'That's what those lesser schools should be doing. We're training the best and the brightest to be specialists and academic physicians.' "

Olds concludes, "But at some point as a society, especially for public medical schools, we've got to take a better look at how doctor training is solving our social needs."

Wells sees a wellness foundation as a necessity.

"I think that's absolutely going to be part of the future solution to improve health and lower the cost of health care for communities and, in our case, for businesses that we work with that are really competing globally."

Brengle believes direct primary care (and/or concierge medicine, which is quite similar) will lead a revival of primary care in the United States. It's already more prevalent on the east and west coasts.

"I think that as patients realize the value, we may move forward in this direction. And if so, you will see more young doctors want to enter into primary care. I think we will see this model sweep the nation; that's my hope."

RESOURCES: Dr. Blair Brengle, Brengle Family Medicine, at www.brenglefamilymedicine.com | Dr. Kevin Gebke, Indiana University School of Medicine, at www.medicine.iu.edu | Nathan Mowery, Activate Healthcare Indiana, at www.activatehealthcare.com | Dr. G. Richard Olds, St. George's University, at www.sgu.edu | Dr. Ben Park, American Health Network, at www.ahni.com | Dr. Jeff Wells, OurHealth, at www.ourhealth.org