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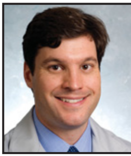

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AF Ablation May Reduce Risk of Alzheimer's, Other Dementias

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF THE HEART RHYTHM SOCIETY

DENVER — Catheter ablation of atrial fibrillation may eliminate the increased risks of Alzheimer's disease, other forms of dementia, stroke, and premature death associated with the arrhythmia, a large case-control study suggests.

"That's the really good news for our patients—if we can get rid of this cardiac condition through the ablation procedure, then we can help prevent some of these long-term problems from happening," Dr. John D. Day said at the meeting.

He and his associates at Intermountain Medical Center in Salt Lake City, where Dr. Day is director of heart rhythm services, showed in a previous 37,000-patient study that atrial fibrillation (AF) is independently associated with a 2.3-fold increased likelihood of being diagnosed with Alzheimer's disease by age 70. AF also was linked to increased risks of vascular, senile, and other forms of dementia (Heart Rhythm 2010;7:433-7).

Next, they wondered if eliminating AF through catheter ablation would cut those risks. That was the subject of the study Dr. Day presented at the meeting.

The study involved 4,212 patients in Intermountain Healthcare, a large not-for-profit health system, who had undergone catheter ablation for AF, along with two separate control groups: 16,848 age- and gender-matched AF patients in the health plan on whatever their physicians felt was best medical therapy, and another 16,848 matched controls with no history of AF. The mean age was 65 years.

The 3-year ablation success rate—defined as no recurrence of AF and no use of antiarrhythmic drugs—was 64%, with a repeat procedure rate of 28%.

After a mean 3 years of follow-up in this retrospective study, rates of Alzheimer's disease, other forms of dementia, stroke, and all-cause mortality were significantly lower in the AF ablation group than in the medically managed controls with AF, and statistically similar to controls with no history of AF. (See box, page 2.)

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Retainer Practices Can Reduce Patient Volume, Improve Care

About 3,500 U.S. physicians now practice using the concierge or 'private medicine' model.

BY MARY ELLEN SCHNEIDER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS

TORONTO — Six years ago, Dr. Jon Yardney, a general internist in Wayne, Pa., was struggling to practice primary care medicine in a way that he felt offered his patients the best care.

After 25 years in practice, his patients were getting older and their medical needs were becoming more complicated. But even as they needed more time with him, Dr. Yardney was being forced to keep visits short. On a typical day, he would walk into the exam room and greet an 80-year-old woman with 10 medical problems, who was seeing five subspecialists and taking 15 medications. Sitting next to her would be her daughter, carrying a list of questions.

After spending nearly half of the 15-minute appointment on documentation, he would have time to answer just one question. He would then ask the patient

See **Retainer** *page 5*

COURTESY DR. JON YARDNEY

"Practicing this way has been a personal revelation for me," said Dr. Jon Yardney, who now has fewer than 500 patients in his Wayne, Pa., practice.

Thinking about a change?

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Model Allows Longer Office Visits

Retainer *from page 1*

to make a new appointment to address the rest of her concerns, an appointment she probably wouldn't be able to get for another 6 weeks, he said.

"I'm watching the faces of those ladies sitting there in my office, and saying to myself, 'My God, I'm failing them,' " Dr. Yardney told physicians at the annual meeting. "This is not what they signed up for. This is not what I signed up for."

Then he saw a brochure promoting concierge-style practice. He worked with MDVIP, a national network of more than 350 primary care physicians who practice retainer-style medicine, to set up his new practice. A year later, he became an MDVIP-affiliated physician and opened his new practice with fewer than 500 patients. "Practicing this way has been a personal revelation for me," he said.

Letting Patients Choose

For Dr. Matthew J. Killion, the move to offer retainer services was driven by patient demand. He had stopped accepting private insurance, and patients started to ask about a retainer program. He decided to try it as a voluntary pilot program, letting his patients choose to join the retainer program or stay in the regular practice.

Today, Dr. Killion's internal medicine practice in Philadelphia is still made up mainly of fee-for-service and Medicare patients, but he also sees more than 100 retainer patients—a number that's growing. He said that his own experience illustrates one way for the medical profession to achieve a larger goal: changing the primary care practice model to encourage physicians to stay in internal medicine.

Over time, Dr. Killion said he would like to expand the retainer part of the practice, and he's experimenting with offering different packages based on patient needs. For example, older patients may opt to pay a higher annual fee and get more services. "It can be very individualized," he said in an interview.

The transition hasn't been a big money maker, Dr. Killion told attendees at the ACP meeting, but it has made a real difference in his lifestyle. Before accepting retainer patients, he saw 20-25 patients a day. Now he sees about 12 patients a day and still has time to pick up his kids from school and spend time with them.

The 'Private Medicine' Model

These experiences aren't unique, said Tom Blue, executive director of the American Academy of Private Physicians. For most physicians who transition from a traditional practice to a concierge or retainer model, frustration with the unsustainable primary care business model is the chief motivator. Others may feel that a high volume of patients is a barrier to providing high-quality care, Mr. Blue said.

"They just can't keep running faster and faster on the treadmill," he said.

The perception of concierge or retainer medicine is that it's a luxury medical product for rich people, driven by physician greed, Mr. Blue said—but the opposite is true.

More than a decade after the first physicians began this movement, concierge medicine can mean anything from a $25 monthly fee to a $20,000 annual retainer, he said. About 3,500 U.S. physicians now practice using the concierge model, which Mr. Blue calls the "private medicine" model, meaning that the practice offers some services that are privately funded by patients.

Mr. Blue predicts that the number of "private medicine" physicians is likely to double annually for the next 3 years. He said he has seen a lot of interest from medical students and residents, who see the practice model as innovative and more sustainable.

Darin Engelhardt, who is president of MDVIP, agrees. He said the retainer practice model provides an incentive for younger physicians to consider primary care as a profession. And he thinks that retainer-style practice has helped experienced physicians stay in practice longer. Many of the physicians who join MDVIP, he said, are at a crossroads professionally and are contemplating leaving primary care altogether.

Medical Home Advantage

But Dr. J. Fred Ralston Jr., incoming president of the American College of Physicians, thinks that the patient-centered medical home, if fairly compensated, should be able to attract and retain doctors in general internal medicine. As a care delivery model, the medical home can provide care for a greater number of patients—an advantage that will be especially important as more people gain insurance coverage under the new health care reform law, he said.

The ACP has no official position on the concierge or retainer medicine practice model. Dr. Ralston said that as a practicing physician in Fayetteville, Tenn., he understands the frustrations that drive some physicians to choose the concierge model. But for its part, the ACP position is that the patient-centered medical home is an excellent care model to improve both patient care and primary care practice.

Both the medical home model and concierge care allow physicians to spend more time with patients. However, the medical home relies more heavily on a multidisciplinary team of providers than the concierge model, and thus will allow physicians to reach far more patients, Dr. Ralston said. ■

TALK BACK

How do you view the idea of transitioning to a concierge or retainer-style practice?

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MY TAKE

New Payment Models Are Needed

As physicians face the growing challenge of chronic disease management and the need to help older patients maintain their functional status, the traditional brief office visit and physical exam are proving to be necessary but insufficient for providing effective care. My own practice would benefit from a "wrap account" approach, which would entail a flat fee and encourage patients to rely more on e-mail and phone calls for ongoing medical guidance, rather than office visits.

The spectrum of new payment models can be quite wide—ranging from the medical home to concierge care—but clearly, the fee-for-service model for face-to-face visits fails to offer incentives to develop more effective patient-physician interactions.

Our efforts to shore up the declining base of office-based physicians who know their patients well and efficiently assist them with their health needs will succeed only when payment models address the value of clinical activities that go beyond the traditional acute-care visit.

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Office-Based Treatment Effective for Opioid Dependence

BY DIANA MAHONEY

FROM THE ANNUAL MEETING OF THE SOCIETY OF GENERAL INTERNAL MEDICINE

MINNEAPOLIS — Opioid-dependent patients with a history of incarceration do well with office-based buprenorphine/naloxone therapy and have fewer interactions over time with the legal and criminal justice systems, according to a data analysis of a previous randomized, controlled trial.

"Our findings should offer some reassurance for community health care providers about initiating buprenorphine/naloxone treatment in the office setting," Dr. David Fiellin reported.

Dr. Fiellin, along with lead investigator Dr. Emily Wang and colleagues at Yale University, New Haven, Conn., performed a secondary data analysis of a previous trial of three levels of psychosocial counseling and medication dispensing along with buprenorphine/naloxone maintenance treatment in a primary care clinic (N. Engl. J. Med. 2006;355:365-74). The researchers compared demographics, clinical characteristics, and treatment outcomes for 166 adults receiving primary care–based buprenorphine/naloxone treatment, stratifying by history of incarceration as determined by the legal domain of the Addiction Severity Index.

Of the 166 patients, 52 had previously been incarcerated, Dr. Fiellin reported. Former inmates were more likely than other patients to be older, male, an ethnic minority, and unemployed. Also, they were more likely to have long histories of opioid dependence, have received methadone treatment, and have hepatitis C infection. The mean dose of buprenorphine/naloxone was 18.0 mg.

Among the previously incarcerated patients, the mean consecutive weeks of opioid abstinence was 6.2 based on opioid-negative urine samples. For other patients, it was 5.9 weeks. Mean treatment duration was 17.9 weeks and 17.6 weeks. The percentage of previously incarcerated patients completing treatment was 38%; for other patients, it was 46%.

Among patients who remained in treatment, a subsequent longitudinal analysis of self-reported illegal activity and interactions with the legal and criminal justice systems, conducted at 4-week intervals, showed that "office-based buprenorphine/naloxone treatment was associated with a statistically significant decrease in participants reporting illegal activity, from 19% to 2%, and in interactions with the legal system, from 16% to 1%," Dr. Fiellin said.

"Approximately 25% of all of those dependent on heroin pass through the criminal justice system each year," Dr. Fiellin commented. Correctional facilities provide an obvious opportunity to engage opioid-dependent individuals with treatment.

"Unfortunately, less than 0.5% of all opioid-dependent individuals receive treatment while incarcerated, and as such they are more likely to connect with services in office-based programs upon release," he said. ■

VITALS

Major Finding: Office-based buprenorphine/naloxone treatment was associated with a statistically significant decrease in participants reporting illegal activity, from 19% to 2%, and in interacting with the legal system, from 16% to 1%.

Data Source: A secondary analysis of data from a randomized clinical trial of 166 opioid-addicted individuals treated with buprenorphine/naloxone in a primary care clinic.

Disclosures: Dr. Fiellin reported no relevant financial conflicts of interest.