

# Model Allows Longer Office Visits

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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 pa-

tients, 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. physi-

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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cians 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-cen-

tered 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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# 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

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.

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. ■