

A NEW MODEL OF CHARITABLE CARE:

The Robin Hood Practice

This self-sustaining practice provides concierge care and indigent care in equal amounts. Here's how it works.

Seven years ago, I was a contented doctor in what I considered to be an above-average practice. Our group of seven family physicians earned incomes well above the national average. I had a panel of 2,600 patients and was taking six to eight weeks of vacation per year.

But our profitability came with a cost. We were passing patients through the office faster and faster, with more and more things falling through the cracks. Worst of all, many of my patients who lost their health insurance were no longer able to pay for the care they needed. I came to realize that I wanted something more for my patients and myself.

In a moment of inspiration, I decided to create a cash-only, low-overhead, technology-enabled, retainer-model practice in which I could care for patients who could afford to pay out-of-pocket for enhanced service as well as uninsured patients who could pay little or nothing at all. The practice's feasibility depended on a simple concept. I would recruit a small panel of patients willing to pay an up-front annual fee in exchange for extended patient visits (30 to 60 minutes), exceptional service, same-day access for all needs, direct access to me via electronic messaging or cell phone, and 24-hour on-call coverage. From these patients' enrollment fees, I could earn enough to spend half of my time providing primary care at no cost to uninsured patients who were ineligible for government health programs. It would be the ultimate self-sustaining nonprofit clinic. With this setup, I would regain my status as a physician whose paycheck was signed by his patients and not by third-party payers.

Formulating a plan

The more I thought about the idea, the better it sounded. I was fairly sure it would work, but I was nervous about making the leap. Then, in early 2002, my motivation

increased after reading a series of articles in *FPM* by Gordon Moore, MD, on going solo in a small, low-overhead practice. I shared my idea with another family doctor from across town. He suggested we open the practice together. I realized that a two-physician practice would remove many of the concerns I had about cross-coverage for vacation and sick days. We could also share the overhead of hiring one medical assistant.

It was time to crunch the numbers. I knew from 14 years in a mostly capitated practice that my patients visited me an average of 3.6 times per year for 15-minute appointments. To provide the quality of care that we believed patients would expect in exchange for the retainer fee, we determined that we would need to be able to provide each one (we call these patients "benefactors") with approximately five 30-minute visits per year. We figured we needed about \$600,000 in revenue per year to run the practice and pay ourselves and our medical assistant. At five visits per benefactor per year, we could see a total of 600 benefactors per year. To take in \$600,000, we would need to charge an average of \$1,000 per benefactor per year. For a breakdown of all of these calculations, see "How we did the math," on page 15.

My colleague and I began meeting weekly to outline the details of our plan. We formed a mission statement with concise goals. As practicing Catholics, we wanted the practice to have a distinctly Catholic flavor. We discussed the idea with our bishop's representative and later received a letter of his spiritual (but not financial) support. We began to contact friends and acquaintances with special skills who were willing to volunteer their time to the project: an accountant, two attorneys, a small-business consultant, an insurance broker, a priest and a graphic designer. We formed a board of directors and committed to an ambitious start date just 12 months away.

The nuts and bolts

The AAFP book *On Your Own: Starting a Medical Practice From the Ground Up* (available for purchase at <http://www.aafp.org/catalog>) provided a helpful outline for building our new practice from scratch. The attorneys on our board of directors helped us with articles of incorporation and bylaws. We applied for federal tax-exempt 501(c)(3) status as a nonprofit public benefit corporation.

Next we verified details of our status with several PPOs, Medicare and TRICARE, to be certain that when we made referrals or ordered tests for our benefactors that those providers' claims would be paid. The insurers repeatedly emphasized: "Yes, but *you* won't be able to bill us at all. Your patients will be wholly responsible for paying for your services." After a while, we quit trying to explain that we didn't want to bill insurance companies.

We developed a corporate identity, including a logo and an information pamphlet. We began designing a Web site (<http://www.stlukesfp.org>) that we would use initially for marketing and later for online scheduling, password-protected electronic messaging and patient education.

Seven months before opening, we told our respective physician partners of our plan. From our current lists of patients, we selected



St. Luke's Family Practice is governed by a board of directors that meets regularly. Pictured are (from left to right) Douglas R. Hibl; J. Peter Herrmann, MBA; Dr. Forester; Terrance P. Withrow, CPA; and John Dunn, JD.

prospective benefactors and contacted them to explain our new practice concept. Three months out, we mailed pamphlets that included an invitation to upcoming informational meetings. We held three such meetings at local churches. They were well attended, with 50 to 100 people at each. About two-thirds of attendees were existing patients. We developed a 20-minute slide presentation to

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explain the basic idea behind the practice. After we made the presentation, we answered questions for 20 to 30 minutes. Enrollment pledges began to trickle in.

At the same time, we began preparing to provide free care to the uninsured (we refer to these patients as "recipients"). We wanted to offer our services to patients for whom other forms of financial assistance weren't available, so we met with the local directors of Medical (California's Medicaid program) and our county's Medically Indigent Adult Program and developed a simple checklist that we could use to confirm that a patient is not qualified

About the Author

Dr. Forester practiced in a conventional office for 14 years before co-founding St. Luke's Family Practice with Dr. R.J. Heck in 2003 in Modesto, Calif. Author disclosure: nothing to disclose.

Since our inception, we've conducted 6,250 uninsured office visits and provided \$500,000 in free care.

■ St. Luke's Family Practice is a cash-only, low-overhead practice that provides concierge care and charity care.

■ Practice "benefactors" pay an annual enrollment fee, which covers their care as well as the practice's expenses for providing charity care.

for these or other government programs (e.g., Medicare or Veterans benefits).

Finally, we began to prepare the office itself. We decided on a modest 970 square foot space in a favorable location. We rolled the cost of our tenant improvements into a five-year lease. We selected an electronic health record (EHR), ChartWare, and began with very basic software programs for electronic patient management (Quicken and Microsoft Office). We financed the EHR and a simple computer network (one server with three desktop computers) over two years. A local medical supply company donated a significant amount of quality used equipment for startup. We were on our way.

Successes and setbacks

As our grand opening neared, we spent many nights cleaning, painting and preparing our new office. When we opened our practice on Jan. 1, 2004, we had more than 250 benefactors prepaid for the first year's care. The local newspaper wrote two articles that generated community interest. We made about 30 presentations to service organizations throughout

the community, but most important, our practice grew by word of mouth.

For the first three months, we strove to get every benefactor into the office for a comprehensive exam and entered into our EHR system. We worked out the bugs in our Web site messaging and scheduling system. Three months later we began offering services to the uninsured. After one year, we had more than 400 benefactors between us and had conducted almost 900 office visits for uninsured patients. We were able to pay all our expenses, and we each took home a net salary of \$78,000.

During the next year, the practice grew. Our net incomes in 2005 were \$178,000. Last year they were \$177,000, plus we made \$15,000 deferrals to our retirement accounts. As we finish our fourth year of operations, we have about 550 enrolled benefactors. Since our inception, we've conducted 6,250 uninsured office visits and provided \$500,000 in free care.

Our benefactors have chosen our practice for a variety of reasons. Some of them had an established relationship with my partner or me. Some wanted to support us out of a concern for the uninsured. Some were techies who loved the idea of electronic messaging with their doctor and scheduling appointments online. Many business owners and business travelers appreciated our capacity to be flexible about their appointment times and to treat them promptly.

Regardless of what initially drew them to us, our benefactors seem to like St. Luke's. After the first year, we had a 96-percent re-enrollment rate. Our billings are a snap – we send out one statement in mid-November, and by Jan. 31, we have collected over 80 percent of the year's charges with no additional effort.

Our biggest unforeseen challenge was securing nonprofit 501(c)(3) status for our practice from the Internal Revenue Service (IRS). The IRS had rules for nonprofit community hospitals, nonprofit emergency rooms, nonprofit



One of the characteristics of his practice that Dr. Forester appreciates most is not being rushed during office visits. Most visits are at least 30 minutes long.

drug treatment and counseling centers, and nonprofit educational programs, but they claimed never to have come across a nonprofit medical office. Very few nonprofit medical organizations give even 10 percent of their care at no cost, but we were giving 50 percent. We were small and different, and the IRS seemed content to bury us in unrelenting paper work and requests for further information. Our local attorneys and accountant had done about everything they could do when one of our new benefactors, a local developer who wanted to assist our efforts to help the uninsured, offered to contact a friend who was the principal of a high-powered Washington law firm specializing in charitable and philanthropic works. We quickly sent them our documents for review, and they agreed to help. After a few more months corresponding with the IRS, we flew to Washington for a meeting with the IRS attorneys, addressed their concerns and hammered out the final details.

On Dec. 21, 2005, almost two years after the start of operations, we were granted nonprofit 501(c)(3) status retroactively to our date of inception. The principal of the law firm generously wrote off his fee, and the benefactor's family foundation paid the fees of the other two attorneys – all because they believed in our practice's mission.

I would encourage other practices that are interested in following this model to apply to the IRS for nonprofit status. Any physician who wishes to apply can cite this article as support that such a model exists. We would also be happy to provide any similar organization our IRS determination letter or other information related to our application process.

Practicing rewarding medicine

One of the greatest joys of St. Luke's Family Practice is taking care of people who have no other viable medical care option. Though at first we were intimidated treating those with uncontrolled diabetes and severe mental disorders as outpatients, with time and experience we became more comfortable doing so through close follow-up. Some of our most important and rewarding new referrals have come from local emergency departments and hospital discharge planners requesting that we provide outpatient follow-up for uninsured patients.

Perhaps I became soft after 14 years of

HOW WE DID THE MATH

The following equations demonstrate how we calculated the number of benefactors we would need to enroll in our new practice and the average amount we would need to charge them to meet our revenue goal of \$600,000 per year.

Number of available visits per year:

48 weeks/year x 4 days/week x 7 hours/day x 2 patients/hour x 2 doctors = 5,376 weekday visits/year (This number was rounded to 6,000 visits to account for weekend, holiday and after-hours calls.)

Number of benefactors we could accommodate per year:

3,000 benefactor visits/year ÷ 5 visits/benefactor = 600 benefactors (The remaining 3,000 visits would be used by uninsured patients.)

Average amount we needed to charge per benefactor:

\$600,000 ÷ 600 benefactors = \$1,000/benefactor

We then estimated the age demographic of our benefactors and developed our payment schedule:

Children < 19 years	\$500/year
College students < 23	\$500/year
Young adults < 35	\$900/year
Adults 35 to 60	\$1,200/year
Seniors > 60	\$1,500/year

middle- and upper-middle-class practice, but one of the things I have really appreciated about caring for the uninsured is seeing more significant pathology. When someone doesn't seek a doctor's care for 10 or 20 years and then suddenly feels an urgent need, the problem is usually significant. Over the past four years, we have made more than a dozen diagnoses of life-threatening diseases at treatable and curable stages among our uninsured recipients.

Through our experiences, we have also learned about other community resources we can work with to help patients get the care they need, such as medications, immunizations and cancer screening. A few colleagues in subspecialties provide phone consultations liberally and occasionally see our uninsured patients for a small fee or no charge. When a patient's medical needs become so acute as to require emergency or inpatient services, they are frequently covered by the emergency Medicaid benefits. (For more details about our practice, see "Answers to Frequently Asked Questions About St. Luke's Family Practice," page 16.)

The payoff

Throughout our practice's creation and

■ The practice obtained nonprofit status from the IRS.

■ Uninsured patients can receive outpatient care, various lab tests and even some medications free of charge.

ANSWERS TO FREQUENTLY ASKED QUESTIONS ABOUT ST. LUKE'S FAMILY PRACTICE

Q. Why have you focused on outpatient care for the uninsured?

A. Primary care cognitive services are not the biggest health care expense for patients; however, getting patients into the primary care doctor's office is often the first and most important step to better health care. Providing free care to the uninsured offers basic health care services to those who might not otherwise go to the doctor due to financial concerns.

Q. What procedures and services do you provide?

A. The lab tests we provide include urinalysis, microscopy, blood glucose, A1C, urine pregnancy and hematocrit. The diagnostic procedures we perform include ECG, spirometry, pulse oximetry, audiometry and PPD for tuberculosis. We also provide influenza and tetanus-diphtheria vaccinations, and corticosteroid, ceftriaxone, antihistamine and promethazine injections. Casting and splinting, as well as office "lump and bump" surgery, are also performed in-house. We pay for all the supplies and charge nothing for the service.

Q. What about payment for other labs and diagnostic studies?

A. Because we see patients more frequently and spend more time on the history and physical exam, we can sometimes order fewer lab tests. We send patients to the county facility to pay cash for labs (e.g., \$15 for complete blood count, \$30 for a comprehensive metabolic panel, \$38 for a lipid profile). For radiographs, our patients get a 50-percent discount at a local radiology office for cash payment at the time of service. Most plain radiographs are \$30 to \$100. An upper GI runs about \$120. Pelvic and abdominal sonograms run about \$100 to \$120. Most CTs are about \$300 without contrast.

Q. How do patients get prescription medications?

A. Our practice strives for an evidence-based medicine approach that usually requires fewer and less expensive medications. We try to be price-sensitive when prescribing. A local pharmacy donates bulk medications (doxycycline, atenolol, metformin, hydrochlorothiazide and glyburide) that we divide into appropriate units and dispense free of charge. For medications with difficult substitutions, we provide limited pharmaceutical samples (e.g., thiazolidinediones, angiotensin receptor blockers, some antidepressants, atypical antipsychotics, nasal steroids). We also direct patients to a local pharmacy that offers selected prescription medications for \$4. Additionally, we use patient assistance programs through the Partnership for Prescription Assistance (<http://www.helpingpatients.org>).

Q. Do you provide inpatient care?

A. We provide care at all sites for our benefactors – office, home, hospital, or rehab or skilled nursing facility as needed. We do not offer that same level of care for our recipients. It would take too much time away from outpatient care, which is what we feel we do best.

Q. How do you make sure recipients really don't qualify for other programs?

A. The county has a network of eligibility workers who work to sign up as many people as possible for Medicaid. Sometimes patients take advantage of our practice, but we concentrate our efforts where they can do the most good.


Q. Do the recipients pay anything?

A. The medical assistant asks recipients if they would like to make a donation at the end of their visit. If they ask us to suggest a donation amount and are from a working family, we suggest one hour's wage. On average, we collect about \$12 per visit. The donations we receive from recipients are almost enough to pay our medical assistant's salary.

development, there have been trade-offs and challenges. Trying to practice medicine in the 21st century on a very limited budget can be difficult. But like anything else, our confidence and skills grow with practice. We no longer have to review insurance contracts, attend IPA meetings or scrutinize insurance aging reports.

One of the best parts of our practice model is that everyone who comes to St. Luke's wants to see us and hear our opinion. Without feeling rushed, we have the time to carefully listen to complaints, ask the necessary

questions and perform thorough clinical examinations. We can fully utilize the Internet and electronic decision-making software to help us in real time. We also have time to call consultants and ask their advice as necessary.

We never could have created our practice without the initial inspiration, the support and confidence of our board of directors, our benefactors, our community and our families. After four years of success, we are glad we tried. 

Send comments to fpmedit@aafp.org.