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MDVIP is a national network of truly exceptional physicians who focus their smaller, more personalized primary care practices on wellness and prevention, enhancing their patients’ medical experience and empowering them to live healthier, more vibrant lives. How do they do that? They engage patients to become proactive in their own healthcare solution.
The Changing Healthcare Landscape and its Impact on the Practice of Medicine

Physicians in the roundtable believe we are truly at a crossroads. We are evolving down to about three ways to practice medicine.

The first way to practice medicine is when primary care physicians are forced to make compromises in the face of ongoing changes, uncertainties, and pressures from patients, payers, and governmental agencies. How long a primary care practice can endure under those circumstances, no one knows.

The second way is for physicians to become employees of big hospitals or affordable care organizations (ACOs), in which the physician is accountable not to the patient but to the organization, which in turn is accountable to payers and governmental agencies. The second way can endure under those circumstances, no one knows.

The third way was the subject of this roundtable: MDVIP. MDVIP started out with an idea...it brings doctors, the best and the brightest of the practice, together in MDVIP. As of January 2012, it has grown to 525 doctors across the United States and continues to rapidly expand, making it the first and one of the largest primary care and preventive health organizations in America. MDVIP physicians are committed to better patient care, which means time for screenings, teaching, and a focus on wellness. This kind of practice also enables a better quality of life for participating physicians—important during this uncertain time.

Objectives of MDVIP Roundtable

- Educate PCPs about an alternative model for practicing medicine
- Dispel myths about this membership practice model
- Demonstrate the benefits of more time for optimal care and developing the patient/physician partnership

MDVIP: Practicing Medicine the Way You Want

Summary of the Proceedings of the MDVIP Roundtable

Roundtable Discussion

How the revolution in medicine has impeded physicians from practicing the way they want

The panel agreed that practicing medicine has changed in ways that work against the desire to provide attentive, unrushed medical care to patients while earning a reasonable income. Meanwhile, insurance companies, quality assurance agencies, and others have insinuated themselves into the physician/patient relationship. Ultimately, physicians have had to pay so much attention to the business end of their practices that patient care can suffer.

“In general, doctors now feel much less in control,” said Dr. Malinow. “Payers want to pay the least amount of money while we struggle to keep from marginalizing our patients to some impersonal treatment algorithm.” Maximizing the number of patients while minimizing the time spent with each has been the main way physicians have tried to bolster their income. “Doctors realize they can’t make a living seeing patients anymore,” he said, noting that he personally joined several speakers’ panels for extra income, which only took more time away from patient care. “But that’s what medicine’s become,” he noted.

Dr. Scott said, “Third-party intervention pretty much controls everything right now, including what medications we prescribe. We have to pre-authorize everything.” Dr. Weiner suggested that there has been a fundamental cultural shift, where even the terminology reveals the priorities: “It’s about efficiency and volume and prior authorizations and resource allocation. The concept of a patient and a doctor and the care is really off the radar.”
Physicians have a business to run, but running a business is not why they went to medical school. Dr. Sollenne said, "I find it very disheartening that we're here talking about taking care of patients and our first discussion is always financial. Our passion is taking care of patients, but if you don't make money you can't stay in practice. For me, it became about watching two graphs. One is reimbursement. It's going down. The other is overhead. It's going up. And at some point, those two lines are going to cross, and when they do, it doesn't matter how good a doctor I am, I'm out of business or I'm stuck with somebody else running my practice, telling me how long I can spend with patients."

"All of us will readily admit," agreed Dr. Malinow, "that the best time during office hours was in an exam room with the patient because you could forget about the business concerns. I found myself on the proverbial hamster wheel, literally running from exam room to exam room to be sure I wouldn't run behind, and to be sure that our office wasn't a sinking ship financially. The time I was able to spend individually with patients dropped. He tried extending his office hours, but that only impacted his personal life.

The dominance of business matters, said Dr. Weiner, is "an inherent conflict with what you really need to do, which is be thoughtful and analytical and listen and be deliberative in your decision making." These matters also adversely affect patients, their perception of their care, and their relationship with the physician, he said. "Think about what it must be like for a patient to be frustrated, disappointed, stressed, and rushed. It's a much more toxic and ineffective practice from the patient's perspective as well."

On top of business pressures, quality measures such as those governing ACOs put further pressure on physicians to do even more in less time and for less money. "It's not about excellence," stated Dr. Barber. "It's not about personal relationships. It's about public service, and it's about administration. And so I just felt my passion to provide patient care being slowly sucked away and a sense of increasing despair."

The decision to join MDVIP

Dr. Barber relayed an all-too-familiar story. "We were carrying thousands of patients, and it turns out you just can't take care of that many people." He noted that 600 patients are really all a physician can care for, including physicals and attentive care. MDVIP sets a limit on practice size at 600, but the average practice has about 430 patients. With this smaller practice, the focus can really be on preventive care and overall wellness. All patients receive an individualized plan for optimal health, which includes education on what they need to do to stay healthy and what risk factors they have, so they can partner with the physician to prevent disease and its complications.

The decision to join MDVIP came to Dr. Malinow after the realities of his practice caused him to let down too many patients. "I felt like I was wounded and bleeding on the battlefield," he said, "and MDVIP was that chopper that came in and swept me up and carried me to safety, and I'm forever grateful. It's changed everything about my practice. I'm a completely different person now, more relaxed. My heart rate is lower. It's restored balance in my life and I'm healthier."

He also verified Dr. Barber's comment on workload. "I work a long, hard 10- to 12-hour day, and I'm busy. But I literally have a no-waiting waiting room" in which patients often do not even have a chance to sit down between checking in and going into the exam room. He welcomed MDVIP precisely because it enabled him to offer the care he had always wanted to provide. At first, he resisted. But, he said, "More and more I felt like I was swimming upstream. I was really desponding, and I was getting to be an angry person a lot."

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Dr. Solenne worried at first whether a practice with only a few hundred patients could actually be more profitable than his much larger, conventional practice. In switching over, he would lose many patients; and if the transition to MDVIP failed, how would he rebuild his practice? Dr. Lee shared his apprehension but was reassured by MDVIP’s predictive model that indicated he would succeed.

All the panelists agreed that MDVIP enabled them to meet their financial needs even with a smaller practice. Each one had a story of financial difficulty prior to joining MDVIP, some going without pay and others noting they would be paid last (if anything was left) after the rest of their staff. With MDVIP, the smaller practice limits overhead, while membership fees and payment for services provide a healthy, continuous revenue stream. What’s more, the panelists mentioned, the money comes in even during vacation, so there are no worries when you return to the office.

Dr. Lee also was a little leery about being so constantly available to patients, that he might call him at odd hours with trivial medical issues. He was so busy in his conventional practice that odd hours were the only time patients were able to reach him, whereas now he has time to answer the vast majority of calls during the day.

For Dr. Weiner, it was the fear of doing nothing, rather than the fear of what might happen from taking action. MDVIP offered him a reasonable plan to simplify, streamline, and get back to basics in providing excellent patient care.

The patients who would not be able to come along in the new MDVIP practice were a concern for Dr. Barber. He found MDVIP very supportive and helpful. Their predictive model was reassuring and accurate. But, he said, “The one part that MDVIP can’t shield you from is those face-to-face interactions with patients you’re going to say goodbye to.” As Dr. Fowler and others noted, MDVIP will put a representative in the office to speak with patients and help ensure a smooth transition. “It just amazed me how well they knew us as physicians and what we were going through.” His patients were able to understand the hardships he faced. He said, “I never had one patient tell me I shouldn’t have done it.”

Other panelists said they were on the verge of quitting medicine altogether, which means their patients were going to lose them anyway. “Had I not made a change,” said Dr. Fowler, “I honestly don’t believe I could have practiced medicine much longer.” Dr. Barber agreed. “The fact is that at some point you realize, I’m not going to be able to take care of anybody unless I make a change.”

Some panelists were concerned with being seen as elitist, but that did not happen. Dr. Barber told the story of how one of his patients who refused to join because of the membership fee was the CEO of a Fortune 500 company, while schoolteachers and tradesmen somehow found a way to join him. “For a lot of people,” he said, “it just comes down to how much they value the relationship. And it turned out that didn’t necessarily have to do with how wealthy they were.” Dr. Weiner concurred, “I wasn’t looking to have an exclusive or elitist practice by any means, just one that was downsized and manageable. Sure enough, those who valued the relationship and recognized this care for what it was were the ones to join.” Many patients also recognized that their health would benefit from a close relationship with their doctor who now had the time to put disease prevention at the forefront.

Based in Atlanta, Dr. Fowler was concerned in particular because he is an African-American (the first in MDVIP). He said, “I heard some eyebrows were raised” among his colleagues. “But now they’re asking me how they can do it.” Dr. Scott also was worried about her reputation in a small town where she would often run into patients at the grocery store but found her community very supportive. Only one patient from Dr. Lee’s old practice complained that the new practice was elitist. After Dr. Lee met with the patient and explained his rationale for joining MDVIP, that same patient later decided to join him.

Dr. Solenne offered a different take, asserting emphatically that MDVIP actually is about being the best physician and offering patients the best care. “I want to be the very best doctor I can be, and I want people to recognize me as being a good doctor. I’m quite proud of surveys that include me in the best doctors in Texas and the best doctors in America. I busted my tail to be the best doctor I can be…I don’t think it’s something you should apologize for. I think you should go out and tell them that you’re a good doctor, and they should be proud to have a good doctor.”

Some critics of membership practice models such as MDVIP believe that these programs will contribute to the shortage of primary care physicians since member physicians limit the number of patients they take. Dr. Barber believes that this criticism is short-sighted. “I’ve spent 25 years teaching second-year medical students at USC and trying to inspire them to go into primary care, and it’s not happening. And there are a lot of great reasons for that. They look at the lifestyle, and the reimbursements and income are low, and they have this crushing debt as medical students. I think what we can do here is hold up the model to say, here is a way of primary care that actually looks like fun. That’s actually going to get them into primary care. Nobody’s holding up anything that’s going to get students to go into primary care the way things are now.”

Dr. Weiner concurred, “If everyone agrees that [the state of affairs] is unacceptable, why not advocate for an alternative? [MDVIP] restores the pride and foundation of a career track and a model of practice that has gone away, that people have lost faith in. So, therefore, it kindles interest in going into primary care, which people are losing. So this for me is really restorative at many levels.”

How MDVIP has improved patient care and physician satisfaction

All the panelists shared examples about how being an MDVIP physician improved their ability to deliver optimal patient care. Another commonality is a better home life. They are able to interact more with their families and are involved with spouses, families and are involved with spouses.
children, and grandchildren. Their flexible schedules and financial situations allow them to enjoy life in the off hours, pursuing activities and interests that most people can enjoy but primary care physicians in a conventional practice typically cannot. They find that they no longer have the anger, frustration, fatigue, preoccupation with work, and anxiety that permeated the little time they had at home, and instead feel satisfied and content with the day’s work. They have been able to attend to their own physical and mental health, as well as the health of their patients.

Summing it up, Dr. Malinow said, “I remember looking [at hundreds of family photos], and I might have been in 10 pictures. Now I am in the pictures. I’m in front of the camera; I’m behind the camera. I missed out on that; I missed out on a lot of experiences.”

Panelists find there is more time to attend to the business aspects of the practice, which are also less demanding. They have time to offer staff guidance and make sure everything is running well. There is less antagonism among staff and between staff and patients.

As dramatic as those benefits are, even more dramatic are the changes to the way they offer care to patients. Dr. Sollenne said that with a smaller practice, he knows his patients well enough without having to look up records when they call with a problem. Regarding being on call, which is 24/7 for him, he rarely gets calls late at night and when he does they are important. Calls are not disruptive and they are quickly and effectively handled.

Importantly, the kind of care required to meet quality measures comes naturally in the course of interacting with patients in an MDVIP practice. “We have many standards of care that we’re held to,” said Dr. Weiner, “by insurers, by our professional societies, on HEDIS measures, and on outcomes data.” However, in a conventional practice, physicians generally have few tools to help patients succeed. With MDVIP, he said, “It’s just a 180° shift. As opposed to, ‘What do I have time to do for you today?’, it’s ‘What do you need and how can I help you?’”

Dr. Lee shared a similar experience. In his old practice, he was on par with other physicians in the community for various quality measures, which were not very good overall. “Most recently, it’s 100 percent across-the-board for doing those measures,” he said, “and it’s not because I’m any smarter; it’s because I have time to implement those levels of care.”

With an efficient and happy office environment and the time to spend with each patient, suggested Dr. Scott, MDVIP physicians can do a lot more for their patients. “They just want to be one-on-one with us,” she said, “and they know it’ll be done right and that it won’t get lost in the shuffle.” She teaches about diet and exercise and even held a healthy eating seminar with healthy foods to sample. An unprecedented number of her patients have lost more than 25 pounds in the past year. Dr. Lee had the same kind of experience, with patients losing weight, quitting smoking, and cutting out alcohol.

Dr. Sollenne captured the experience of the panel when he said, “My four gripes have all gone away: the too hard to get a hold of, the not enough time, the running behind during the day, and the getting results back.” His patients appreciate the changes he has made. “There are fewer impediments to care.”

With fewer impediments come fewer mistakes. In fact, statistics show that a tremendous number of people die each year because of medical mistakes and the clinical error rate in hospitals. One panelist noted that even the most talented physician will make a mistake now and then. However, MDVIP gives physicians the time to pay attention, listen, think analytically, and formulate a plan, and possibly avoid mistakes they might otherwise have made.

The panel all had numerous patient stories, some very poignant, where time made a life-saving difference—a symptom that could have been missed, rechecking one measurement that was a little off and finding a life-threatening disease, or being available to contact other MDVIP physicians in other locations on behalf of a patient or family member who is having a medical emergency or being admitted to a hospital. The unique reciprocity program that MDVIP offers to patients allows patients and physicians availability to other MDVIP physicians when they travel.

By way of closing, the panel was asked what advice they would offer. Every member of the panel said he/she would encourage a prospective MDVIP physician to join. Dr. Sollenne: “The thing that I tell doctors is that they need to go back to why they became a doctor, and ask [themselves] are they doing that now. MDVIP gives you the ability to go back and recapture those passions that got you here in the first place, and you need to be unapologetic about the fact that you want to deliver better care to your patients. MDVIP lets you do what you went into medicine to do in the first place.”

Kim Scott, MD: “My husband and I were hiking up the mountain, and he looked at me and said, ‘So what’s next?’ We left Phoenix after 17½ years, we raised our family, and I missed my family. I had two boys. I worked constantly. We decided to move to Utah to have more balance. Thankfully, MDVIP came along. And now I’m actually having time for family. So maybe I’ll get to know my grandchildren.”

Louis Malinow, MD: “My patient presented with a very exotic fungal infection. He came into my office with fever, shaking chills, and a cough. He was hospitalized, and it was a very rocky year. He was near death many times. We got him through it. He sent me an email that read: ‘...our recent sojourn has both of us encountering good and bad luck, with the good a direct result of your decision to change your practice to be truly patient-centered, and my decision to accept your practice as ultimately beneficial. Had either one of us chosen a different course, I anticipate that I would not have been present to write of any outcome.’”
Dr. Lee: “I would say that even though MDVIP sounds too good to be true, it’s not. I think the support they provide has made it easier to practice medicine, and certainly restores the fun and the joy of doing it.”

Dr. Scott: “I’d say that they poll your patients and if they give you a positive response and you embrace the model, you can go forward knowing that your care is going to be much better, and your quality of life will improve as well.”

Dr. Weiner: “I’d ask, why did you go into medicine in the first place? What would it be like if you could elevate yourself again to the pride, to the professionalism, to the excellence that you really sought when you first went into medicine? Think about how life-changing that could be.”

Dr. Barber: “Did you [go into medicine] to be an administrator, did you want to oversee people who were seeing people? If you did this because you wanted to do something excellent, and you wanted to have a personal relationship, one-on-one relationships with patients, then I think you need to look at this model, because there isn’t anything else out there that’s providing you with that opportunity.”

Dr. Fowler: “I would say to them, if the opportunity presents itself, don’t let it pass you by. This is a proven model, without a doubt. It will change your life for the better with respect to how you deal with your patients. It will allow you to practice the way you really want to practice. I highly recommend that if this is offered, jump on it.”

Dr. Malinow: “My advice is, do not overthink it. If MDVIP says this is going to work for you, this is going to work for you. It’s going to rejuvenate that dormant love for medicine that we all still have lurking in there. It’s just a great feeling to go to work every day knowing that I’m going to have a manageable day, I’m going to enjoy it, my patients are going to be healthier as a result of my transition, and I’m going to be healthier as a result of my transition.”

Physicians are highly motivated individuals. They go into practice to do what is good. They are there to serve people, to improve the quality of life...but after medical school, they find they have to make enough money to keep the practice going. They find that under the old model they are running from one patient to another, not able to pay their bills and not being compensated fairly. At the same time, they could not give the kind of treatment their patients deserve and needed. That was pre-MDVIP.

After joining MDVIP, doctors can spend more time with their patients improving care and truly practicing preventive medicine. But it also changed their personal lives. MDVIP has enabled them to spend time with their families and pursue interests and activities they would not have had time or resources for previously.

With MDVIP, the doctor is the center, the base upon which everything else is built. The MDVIP model provides an opportunity to improve the quality of care. Most importantly, MDVIP gives the physician an opportunity to practice medicine the way it should be practiced, the freedom to regain a healthy work/life balance, and the security of an appropriate income.

Again, the three basic choices facing primary care physicians were reviewed:

- They can continue to practice the way they have been practicing, which is very stressful and not very rewarding financially, personally, or professionally, and try to continue to adapt and compromise to present and future changes.
- They can become employees of some larger organization, such as a hospital or ACO.
- Or they can join MDVIP. With MDVIP, the physician/patient partnership and focus on wellness are at the center.

MDVIP has transformed the lives of physicians, and the quality of care of their patients, by giving physicians the time and tools to practice preventive care and, ultimately, to provide the “best medicine” to their patients.
MDVIP: Practicing Medicine the Way You Want
Summary of the Proceedings of the MDVIP Roundtable

Roundtable Panelists

**Dr. Donald W. Barber**
Internist in Glendale, CA
Practicing medicine since 1981
Affiliated with MDVIP since 2006

**Dr. Reginald S. Fowler**
Internist in Atlanta, GA
Practicing medicine since 1981
Affiliated with MDVIP since 2008

**Dr. William D. Lee**
Family practitioner in Raleigh, NC
Practicing medicine since 1977
Affiliated with MDVIP since 2009

**Dr. Lewis R. Weiner**
Internist in Providence, RI
Practicing medicine since 1989
Affiliated with MDVIP since 2005

**Dr. Kim E. Scott**
Internist in Park City, UT
Practicing medicine since 1982
Affiliated with MDVIP since 2009

**Dr. Nicholas P. Sollenne**
Internist in Houston, TX
Practicing medicine since 1986
Affiliated with MDVIP since 2010

**Dr. Louis B. Malinow**
Internist in Baltimore, MD
Practicing medicine since 1997
Affiliated with MDVIP since 2008