Dynamic Chiropractic



# DCs as Primary Physicians with Blue Cross/Blue Shield of Illinois

## AN INTERVIEW WITH THE FOUNDERS OF ALTERNATIVE MEDICINE, INC.

Editorial Staff

Ever since the advent of managed care, the role of "gatekeeper" - the primary physician responsible for a patient's care and well-being - has almost always belonged to a medical doctor. If James Zechman and Dr. Richard Sarnat have anything to say about it, however, the primary care role traditionally reserved for MDs may soon be inhabited instead by doctors of chiropractic.

Dr. Richard Sarnat and Mr. James Zechman are the co-founders of Alternative Medicine, Inc. (AMI), an Illinois-based organization which was founded in 1997 with the hope of transforming America's health care model from one based on treating illness to one that focuses on wellness and disease prevention. Their idea is to integrate alternative medicine with mainstream allopathic medicine to produce a health care model that utilizes the best each system has to offer.

So far, their plan appears to be succeeding. Recently, AMI reached a contract with Blue Cross/Blue Shield of Illinois, the state's largest managed care plan. This means that the more than 700,000 members enrolled in the plan have the option of having one of AMI's chiropractors as their primary care physician.

Mr. Zechman is the chairman and chief executive office of AMI. He graduated with honors in music from Drake University and received his MA (also with honors) from the University of Denver. Before joining AMI, Mr. Zechman was the founder of Apwel, Inc., an international trade finance and import-export company. He also served as a managing vice president for Merrill Lynch on global derivative markets.

Dr. Sarnat, a board-certified ophthalmologist, is president of AMI. He graduated from Washington University in St. Louis with a triple major in philosophy, psychology and premedical sciences, graduating magna cum laude in his primary major of philosophy.

Given his academic excellence, Dr. Sarnat was nominated by the university to be in contention for both Rhodes and Oxford scholarships. However, he declined the offer and instead chose to pursue medicine directly. He attended Rush Medical College in Chicago and completed his residency at the prestigious Northwestern University.

According to Mr. Zechman and Dr. Sarnat, their model has achieved "significant" savings while maintaining a high level of patient care and satisfaction. DC spoke with the AMI's cofounders to learn more about their success and how chiropractic is being integrated into the AMI model.

DC: Many people feel that chiropractic gatekeepers would be more cost-effective than medical gatekeepers. What do you believe is the case, and is there enough evidence to support that theory?

RS: I was a speaker at the National Managed Health Care Congress, which was held in Los Angeles from October 18-20. We were invited by John Weeks, who is the chair of that section of alternative medicine. There are approximately 3,000 people who attend this conference, and it's considered a

major conference in the world of managed care.

(*Editor's note:* Mr. Weeks is also the publisher of *The Integrator,* a managed care newsletter.)

Our track was divided into three sections. The first lecture of the day discussed the current state of managed health care. A number of people presented and talked about different models of trying to integrate alternative medicine, including speakers from Kaiser Permanente and from Anthem in Connecticut.

The second lecture consisted of what I would call the network builders, people like George DeVries with ASHP and Lou Sportelli with Triad. That was a panel discussion, and Weeks asked them a number of very intriguing questions, such as: What have they really accomplished? Have they been able to publish any research? Have they really proven that CAM as an alternative is cost-effective in terms of cost offsets?

I think the most interesting part of that whole discussion was that the network builders admitted that in some ways they have really not proven or forwarded their agenda. None of the network builders have ever really proven that the addition of CAM created cost offsets or savings down the road. They admitted that the physicians had several "issues" with the network builders: unhappy about the discounts forced upon them, and the loss of revenue from within their offices because the network builders tend to sell supplements on the Internet. It really opened my eyes to what I would call the problem with the first generation of CAM alternatives.

I then spoke with a group of speakers in the third section, "emerging products," or what I would call "second generation products." John Weeks asked, "How do you define integration? Are any of these other projects or networks really integrated so that doctors are working together for the good of the patient throughout the whole system?" For the most part, the answer was no. Other than what we're doing, things are still somewhat disjointed, or what Mr. Weeks called "CAM grafting." The unique advantage of what we are doing is that we are "integrated" in the true sense of the word. This means that from the primary chiropractic physician on up, it's really a team effort in which there's an ongoing dialogue of the patient's benefits and coordination among all of the MD/specialists; the hospitals, if necessary; home health care, etc.

What's even more important is that because our project is within an HMO, the HMO exists as a closed loop. We can track every visit every expenditure for lab diagnostics, every hospital admission and length of stay. The real focus of our company is in publishing the data of preventive medicine. What happens when you front-load the system and perhaps increase your expenditures up front by utilizing more true preventions, such as frequent visits to the primary care chiropractic physician? If that happens, what does the data show?

We've been up and running for almost 10 months, and if we analyze the data over that time, we've really seen significant savings overall in a health care system. By significant, I mean we are probably going to approach 50% savings - not 5%, 50% savings overall - of hospital utilizations, pharmaceutical costs and diagnostic and laboratory costs. Granted it's preliminary, and granted it's a small number of members tracked over the course of a year, but it's still a very significant finding. We're certainly looking forward to analyzing that data year by year as the membership grows, and membership is growing very significantly.

JZ: I think the most important fact about Dr. Sarnat's statement is we believe we have created the next generation of fully integrated CAM and allopathic medicine. For years, we've called it health care. That's really been a misnomer. It's really been sickness care. When you get sick, you go to see your allopath. What we have done is create a wellness and health care program through our

credentialed chiropractic physicians in which health is really in front of sickness.

DC: So instead of going to see your physician when you get sick, you'll go see your physician to stay well.

JZ: Correct. It's truly health care for the first time, not sickness care. This is even being recognized by employer groups. To give you an example, one very large employer group that has asked us to help market and educate their employees on our program of wellness. The company knows that we will save them significant dollars in their health care costs, because they're self-funded, and that it will keep their employees in better spirits and on the job, which is also a significant benefit to them. When we start talking about this in their HMO setting, they said they'd also like us to build a highly-credentialed, highly-qualified chiropractic delivery system for their PPO members. That's the first time we have been asked by a large employer group to formulate a PPO product. They then asked us to work with them on developing the same type of program for workers' compensation. So as a company, we've gone from working with managed care organizations on an HMO product to branching out to employer groups who are self-funded to help them across their various benefit programs, be it HMO, PPO, point-of-service or workers' comp. That's an exciting new development for us.

In another area, a very large insurer in Illinois has asked us to work with them to analyze the feasibility of creating a very high quality chiropractic PPO that is not focused on reduced fee schedules, but on raising the bar of quality providers in their network. This is significant because they are finally coming to the realization that wellness programs and keeping people healthy, even if they end up spending more on alternative medicine on the front end, will achieve significant savings in all their other costs (pharmaceuticals, hospitalizations, referrals to specialists, procedural tests and the like). It's a wonderful recognition of what our company has done in a very short time in the Chicago marketplace.

Dr. Sarnat and I also have a letter of intent with a very prominent group in Florida to work with us on network development and introductions to managed care organizations. Dr. Sarnat and I are going to Colorado next week for meetings with MCOs in Colorado. We have a similar letter of intent with those people. We will be traveling to New Mexico sometime this month and are also working with a very prominent chiropractic network there. We've been contacted by Texas, and we've also been contacted by an organization that would like to work with us in the Northeast. A lot has happened since we last spoke, and it's very exciting

RS: What we do is start with peer review. We're scanning the chiropractic communities. We're really identifying the proper strategic partners in each state. We're going through the steps necessary to duplicate what we've done in Chicago on all levels (HMO, PPO, employer groups, etc.) and try and make these programs available on a much more widespread basis.

JZ: Just to emphasize what Dr. Sarnat said earlier: we are always focused on the patient and keeping them healthy. Everything else falls into place as long as that's first. That contrasts us very dramatically from anybody else in the marketplace right now that is selling network access at reduced fee for service. When that happens, more and more gets done, and there isn't the cost savings. We've talked to a number of insurers about that. That's why we feel our delivery model is being received quite well in the marketplace, and we will establish ourselves as the next generation of how health care is going to be delivered on a very large scale in this country.

DC: You do seem to have caught the attention of a number of insurers and employers. A recent article in the *Chicago Tribune* spoke about AMI and its contract with HMO Illinois. What kind of reaction has that article generated?

RS: We met with the corporate level executives at Blue Cross a week ago. They told us they had received 700 phone calls since the release of that article one week earlier. Most of the phone calls were very positive. They'd even heard from some of their competitors, who were upset because it was such a positive article. Only a very small number of people had anything negative to say about the article, and the people who did were the medical societies that were threatened and somewhat taken aback by the fact that we are now using primary care chiropractors in a gatekeeper model.

DC: How is AMI's membership doing so far?

RS: We purposely decided to walk before we could run. I would say that 99.9% of the people who can enroll in our product were unaware of our existence until recently.

JZ: We recently started a radio marketing campaign in Chicago. We're on four different radio stations with upwards of 100 spots a week, and we'll be doing that through the open enrollment period. We've had some outstanding responses to that, and we are just starting to get the word out that our model exists. We're confident that once that part of the equation is put into motion it will gain momentum rather dramatically.

DC: Regarding your system, with chiropractors as primary care physicians, are they classified as gatekeepers in this system?

JZ: Yes.

DC: And with the model of DCs in the gatekeeper role, how are patients responding to that option?

RS: We have a number of patients already on record with testimonials talking about the dramatic improvement in their health care and their wellness; that they feel better; and that problems that have existed for a very long time and are now receiving satisfactory attention.
The patients love the product. If you look at our statistics for disenrollment (a patient leaving our IPA) they are very low. If you look at written complaints against our IPA, those statistics are nonexistent. Part of NCQA and managed care is that patient complaints, denials for referrals, disenrollment are tracked, and patient satisfaction surveys are taken. Every time we've been rated by Blue Cross/Blue Shield, we've consistently scored at the highest level. I think patients are very, very happy that they have not only political freedom to choose the type of health care that they deem appropriate, but that when they do access this plan, they're very happy with what they receive.

DC: On the other side, what about the specialists and MD providers? What's been their response to this idea?

RS: We deal with a subset of MD providers from within the Chicago area. We have almost 3,000 MD/specialist providers under contract in our integrated network. Certainly, the people under contract with us are very happy to take care of patients. They view their role as a patient's advocate and a health care professional, and their interest is in furthering the patient's health. As for the people we work with on a daily basis, I'd say the relationship has been very good. I can think of only one somewhat negative experience, and it's really not worth mentioning; we do not utilize that specialist MD provider anymore.

Within the medical arena, clearly some people are taken aback by our product. Is it jealousy? Is it an economic turf battle? Is it pseudoscientific outrage that DCs are in a primary care spot? The whole purpose of what we're doing is not to be anecdotal. The purpose of what we're doing is to publish and analyze the benefits of this type of model. We're only scientists engaging in the process of scientific inquiry. I don't have all the answers. If I knew what the results of this test would be,

we wouldn't have to do it. But at this date, we don't yet know: Is homeopathy going to be a better interventional system than herbal medicine? Is herbal medicine going to be better than acupuncture? Is it better to see a patient once a month, or once every two weeks?

JZ: But now we have the forum to collect the data and analyze it where that forum didn't exist before, and that's really the significance of our company.

RS: Exactly. So when anyone from the MD side of the world raises a finger about what we're doing, what we're doing is what we're supposed to be doing. We're supposed to be conducting scientific inquiry for the benefit of the country; for the benefit of the patient; and for the benefit of the health care system as a whole. Fortunately for us, the people at Blue Cross have that vision and courage and intellectual curiosity, and they are very interested in answering these questions.

I believe that chiropractic will prove at least equal to, if not better than, any entry point to the health care system. Time will tell, though, and that's really the interest of the project.

DC: Do you find that the chiropractors currently employed as primary care physicians are qualified to act as gatekeepers?

JZ: The answer is a definitive yes.

RS: Absolutely. We use benchmarks within managed care - how many hospitalizations per thousand people, the rate of pharmaceutical usage, asthma protocols, diabetic protocols, percentages of c-sections, rates of rehospitalization within two weeks, etc. When we first started, there was a leap of faith on our part and on the part of Blue Cross/HMO Illinois. The worst case scenario was raised. Would the chiropractic physicians be missing the proper diagnosis? Would patients show up in advanced stages of disease that should have been recognized earlier and treated differently?

Today, I think none of these worst-case scenarios have occurred; in fact, it's just the opposite. I think all of the best-case scenarios have occurred by seeing people on a regular basis. On average, our network sees the patient roughly once every two weeks. By seeing patients roughly once every two weeks, we've scientifically shown that overall, the patient's health is going to improve by all the benchmark criteria of managed care.

DC: Do you see any limits to what chiropractors can do as primary care physicians, or is that more dependent on geography and scope of practice?

JZ: There are roughly 40 states that recognize and license chiropractors as primary care physicians. The training that they receive, specifically at National College of Chiropractic in Lombard, Illinois, is focused on primary care, so we are seeing their capabilities and qualifications absolutely up to meeting the task at hand.

RS: In that sense, we've been lucky in Illinois. You might say this is the perfect place to run a test program. If you were to survey all the chiropractic colleges in the country, my guess is that National would be rated as the number- one college for the philosophy and training of chiropractic as a primary care physician. There are a couple other colleges that are right up there, and then there are colleges on the other end of the spectrum that do not believe in primary care at all. It will be very interesting to see over the course of the decade or so what kind of influence our research has on the furthering or training of future chiropractic physicians.

DC: Where do you see AMI two years from now, five years from now and 10 years from now?

JZ: I think that as we prove our program and the ability to transfer our programs to other states, it

will become very obvious that the demands for our programs and products will exceed our current structure, which is a good thing. We will look to raise the capital necessary to expand very rapidly throughout the United States. That can happen in 12-18 months.

That would be the near term. The middle term would be executing that game plan. The longer term would be the impact of long-term outcome studies on our type of delivery model, and expecting to have a major impact not just here but potentially elsewhere in the world. The U.S. medical system elsewhere in the world has long been looked at from a technology standpoint as the finest in the world. What we would like to do is say we've created not just a great technologically-based delivery system, but that we've created the best integrative model for delivering health care to large segments of populations on a very cost-effective basis. Quality, cost, keeping people healthy, and integrating CAM or alternative medicine with the allopathic side of the world is where we believe our long-term mission will take us.

DC: Thank you, gentlemen.

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