

# A Culture of Collaboration at an Integrative Health Center

BY DANIEL REDWOOD, DC

David Fogel, MD, is the cofounder (with his wife, Ilana Bar-Levav, MD), of the Casey Health Institute (CHI) in Gaithersburg, Maryland, a nonprofit integrative primary care practice that includes Internal Medicine, Family Practice, Chiropractic, Acupuncture, Massage Therapy, Yoga Therapy, Naturopathic Medicine and more. He is board certified in Internal Medicine with additional specialty training in mind/body focused individual and group psychotherapy.

As an internist, he served in the National Health Service Corps and on the staff at Johns Hopkins University School of Medicine, providing primary care to medically underserved inner city Baltimore residents. He has held positions as Medical Director of Employee Health at NASA Headquarters and as Medical Director of Integrative Medicine Associates in Washington, DC. Dr. Fogel holds a B.A. from Hampshire College and is a graduate of the George Washington University School of Medicine. He completed his residency at Washington Hospital Center.

In this interview, Dr. Fogel describes his journey from conventional to integrative medicine, the unique circumstances surrounding CHI's founding, the collaborative relationships that comprise its core, and the ways he hopes it can serve as a model for new methods of healthcare delivery that are both effective and cost-effective.

*Tell us how you first branched out from the conventional approaches you were taught in medical school.*

I was first exposed to the concept of *chi* as a teenager. It's kind of the classic story—I was beaten up, and as a result I got into the martial arts. There, I learned this incredible concept, that there was energy running through your body. That you can channel it, that it can be used for healing. So that opened me up at a young age to exploring other things. Then, I went to a kind of hippie college, Hampshire College, which opened me up to non-conventional alternatives of all kinds. This included mind-body approaches. I concentrated in humanistic psychology.

I went on to medical school. This was the era when Nixon went to China, and suddenly there were acupuncturists in the DC area. I said to myself, I need to go to an acupuncturist just to experience what it is. The Traditional Acupuncture Institute in Columbia, Maryland, was just opening up (now Maryland University of Integrative



## David Fogel, MD

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Health). I kept reading and exploring these sorts of things throughout medical school. Then, in the 1990s, when David Eisenberg published his landmark article in the *New England Journal of Medicine*, about how many people were using complementary and alternative approaches, that gave a lot of people permission to start experimenting with different models, in a more mainstream or public way.

*The people were already voting with their feet, so to speak. In Eisenberg's 1993*

*publication, it was 33% of American adults who had used some form of complementary and alternative medicine (CAM) in the past year. Five years later, his second study found that it was 42%. Something big was clearly happening. What I'm hearing you saying is that for the first time, the publicity generated by these findings encouraged more of those with an alternative bent who were "inside the tent," inside the medical tent, to start enlarging their view of the possible, and to act upon that. And that was so very important.*

Within a couple of years, major medical journals were showcasing CAM. Then NIH got involved. This all set the stage and gave me permission to do what I did a few years later, which was to open an integrative medicine center right down on Washington Circle, six blocks from the White House. This was part of a nonprofit that my parents had started, a psychotherapy and Human Sexuality Institute called the Fogel Foundation.

I opened up a branch of that called Integrative Medicine Associates. That's where I first got a taste of practitioners of different kinds sitting in the room, talking to each other about how best to synergistically use their different approaches. It was really exciting. We would have weekly case conferences and everybody came out of them charged up. The only problem was that the business model tanked.

*That was not unique to your clinic. That happened to many CAM and integrative clinics.*

I knew a number of the other players in the area that were struggling with different models. The doctors who came out of these efforts in the Seventies, Eighties and Nineties, really had to become "hard-boiled," because they had been bucking the system for a while. Your skin gets kind of thick. So we gave our best effort for a couple of years with Integrative Medicine Associates until it was clear that the model was not supportable. But I learned an enormous amount about what didn't work as well as what did work.

*That's how growth happens. When we try things that don't work, we have to refine our goals and our means.*

We closed our doors around 2000 and I really felt horrible about it. I felt like a failure. I mean, this integrative model was going to save medicine! I started out in internal medicine, but I left it when the insurance companies and hospitals began dictating to doctors how to practice medicine. They wouldn't let me sit and talk to people. At that point, I took a three-year fellowship in mind-body psychotherapy, with a strong emphasis on group therapy. I really buy into the power of collaborative group work. My passion is for collaboration and finding how people work together.

*There's a synergy that comes in groups, whether it's group psychotherapy or group delivery of integrative healthcare.*

Yes, collaboration. But for the next ten years, my wife and I built a very

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solid psychotherapy practice and I had no intention of doing anything else. We skirted the insurance issues by doing self-pay and having the patients file on their own, so nobody was telling us how to practice.

*But life is full of surprises.*

Yes. Then, through a very strange set of circumstances, which had nothing to do with medicine or integrative medicine, I met Mrs. Casey through a physician friend. She was interested in the backstory of a sculpture I had done. In our conversations, after meeting a couple of times, I mentioned that I had started an integrative medicine center in the Nineties. The next day, she asked my friend to take me out and share with me that she had had this vision to create an Integrative Center for a while, which she was looking for somebody to steward. She wanted to know if I would be interested. She then took me out and showed me a 72,000 square foot building where she had her office, and that she was willing to fund some piece of this, depending on what it was, if things worked out.

*And the "this" that you're referring to is a newly revised version of an integrative health center.*

She had been using integrative medicine for years and had been going to Virginia to get her care. And since she was very connected to Gaithersburg and Montgomery County, she wanted there to be a center here. She's deeply connected to this community.

*So this is the proverbial appearance of the angel.*

Exactly. This was apparently on my path but I didn't know it. And I did not immediately accept it, because it was huge. It meant I would have to change my life and, by extension, my wife's life (since we were co-partners in practice together).

*How did your vision unfold for what ultimately became the Casey Health Institute (CHI)?*

I knew what didn't work from my previous center. I told Mrs. Casey that I would want to do a study of what cen-

ters had survived over the last ten years, and how they did it. She was willing to fund this study so I put together a team of which my wife, Dr. Ilana Bar-Levav, was a part, along with five other people in integrative medicine and healthcare. We traveled around the country to many different centers. Do you know about the Bravewell Collaborative?

*Yes. During the first decade of the 21<sup>st</sup> century, it was a major funding source for integrative medicine centers, many of which were affiliated with medical schools.*

Fortuitously, one of the people on our team had a connection to Christie Mack, who along with Penny George, started the Bravewell Collaborative. I called Christie and she said, "Wonderful project! I'm going to open the doors to all the Bravewell connections for you. You can visit all the centers and talk to people." This was fantastic. We went all over the country visiting Bravewell and non-Bravewell centers as well. We talked to their business and practice management people, and, of course, their docs. And we put together, over the course of six months, a proposal that took the best pieces from all these places. We presented it to Mrs. Casey, and she said, "Okay, let's do it."

So that's where the vision came from. Partly from my past experience

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and partly from these travels.

*One of the things that you did in forming CHI, the Casey Health Institute, was to incorporate it as a nonprofit. In the healthcare field, most private practices (both conventional and complementary/alternative) are profit-making businesses. What led you to go the nonprofit route?*

It's very simple. The only way that Mrs. Casey could donate the money from her private foundation was if we became a public nonprofit.

*So this is the triumph of pragmatism.*

But it turns out that I would do it the same way again even if I didn't have to. Being a public nonprofit fits well with our mission and vision, and it also ties in with being organized around a staff model. At Integrative Medicine Associates back in the 1990s, we had an independent contractor model, which many practices have for CAM practitioners. It's great to sit together and have meetings to collaborate, but the people at the table are not getting paid for that time. And you know what?

People are trying to make a living. So I thought, in order to truly have collaborative team care, we needed the staff model, where people weren't worrying about not getting paid for these meetings.

With a staff model, it also means they won't worry about things like, "If I refer to the chiropractor, maybe that patient won't have enough money to pay for both that and me, and then I lose my bread and butter." These are important issues to consider, if we're trying to put the patient at the center of things.

*So basically having a staff model means that all the practitioners are on salary, not paid based on how many patients they see or what exact services they provide.*

Exactly. And that they're not worried about losing patients or referrals [if they bring in another practitioner to the care team]—they're doing what's best for the patient. It also creates a stakeholder model. It really does make a difference to people on staff if they know that any profits go back into the organization and not into a shareholder's



er's pocket. So each staff member—their time and energy and creativity—contributes to the organization's sustainability. Sustainability is a really important part of our culture, because if we're not sustainable, it's not going to be good for patients in the long run anyway. So being a nonprofit is part of the culture we're trying to create.

*Casey Health Institute is also a Patient-Centered Medical Home, or PCMH. Please explain what that means and why it matters.*

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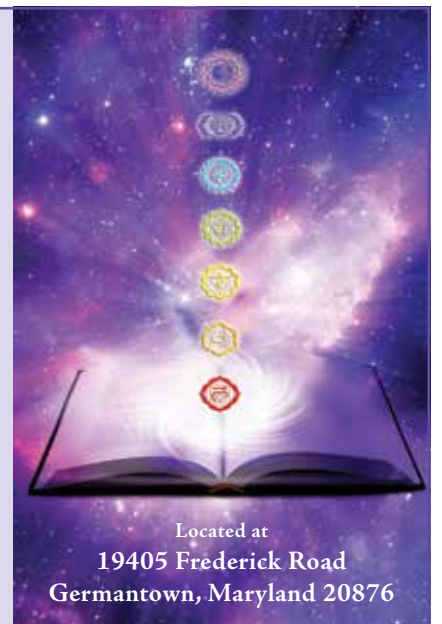


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## PATHWAYS INTERVIEW

*In a traditional medical practice, it's a linear, top-down model where the doctor is the "king" and tells everybody else what to do. This way, it's much more circular and flat in structure, and really puts the patient at the center.*

Yes, and this is a really important point. When we were traveling around looking at different models, I was also exploring what was going on in the health care policy world. I had never heard of a Patient-Centered Medical Home and it took me about six months to understand what it was. That's partly because people have different definitions, or they certainly did three years ago. A Patient-Centered Medical Home is a way of structuring and organizing a healthcare team, of which the doc is the lead but where everybody is working collaboratively at their highest level.

In a traditional medical practice, it's a linear, top-down model where the doctor is the "king" and tells everybody else what to do. This way, it's much more circular and flat in structure, and really puts the patient at the center. The doctor is trusting the other team members to be a much more integral part of total care. Do you know much about it?

*Yes. The Patient-Centered Medical Home is a model, which aims to coordinate care among different practitioners, and different types of practitioners, to the maximum possible extent. The team is supreme.*

The team is supreme, over and above any one individual.

*Which is, for the most part, something new under the sun.*

Yes, although the pediatricians were touting this for decades, as far back as the Sixties. And then the family practitioners got on board. They've been pushing it in the policy world. The really interesting thing, to me, was that nobody in the integrative medicine world, and the CAM world, was thinking about marrying an integrative medicine model with the Patient-Centered Medical Home.

*I was a consultant to a foundation-sponsored project involving both medical doctors and chiropractors, which addressed those very issues. This was around the time that the Affordable Care Act had just passed, around 2011. And you're right, except in the rarest of circumstances, it had not been put into practice in the CAM or integrative healthcare areas. A key factor that helped to drive it more to the forefront*

*was that in its section on Patient-Centered Medical Homes, the Affordable Care Act specifically stated that PCMHs may include "integrative healthcare practitioners," a new term coined by the Act but not defined, as well as licensed complementary and alternative medicine practitioners. So while the Casey Health Institute may not be the sole example of a Patient-Centered Medical Home focused on integrative medicine and CAM, I think it's the first I've come across.*

There are a few now. At the time we were doing our planning, there was one other place in the Denver area, called Clinix. They were started by a chiropractor and were really helpful to us in formulating our model. An interesting thing about Patient-Centered Medical Homes is that we found that (and this may be an overgeneralization) almost nobody that was creating a PCMH really embraced its concept. They were mostly looking to find ways to get more reimbursement. There are financial incentives to become a PCMH and so they did it. But they really were just jumping through the hoops to get incentives rather than incorporating the mission and the vision of it.

*They were following the letter of the law rather than its spirit.*

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Almost all driven by getting reimbursed. They would do the minimum. To me, the PCMH concept was so powerful and fit so seamlessly into having a staff model with other integrative practitioners, that we would figure out how to make everybody part of this collaborative, high-functioning team.

The culture of allopathic medicine, when I was trained in the late Seventies and early Eighties, and it's still this way in many respects, is really an unhealthy culture. It's hierarchical, it's often emotionally abusive, and it does not promote health in its practitioners. There's fear in it. On rounds, as a medical student and as an intern, we were worried about what they call "getting pimped." What kind of term is that for healthcare?

What does that refer to? I'm not sure I understand.

It means that you're going to be grilled in public by whoever's running the rounds, and embarrassed if you don't come up with information that is pertinent.

*Education through humiliation.*

Exactly. Along with sleep deprivation and much more. So the culture that we wanted to create in this collaborative Patient-Centered Medical Home was very important. There's one other aspect to it that I want to mention. I was taught that you tell the patient what to do, and if they don't do it, it's their fault, they're "noncompliant," and they're "bad" patients.

Well, it turns out it's exactly the opposite. You have to reach out to the patient who's being noncompliant. You have to engage them, you have to pull them in—you have to connect with them. And that's the whole thing about care coordination and the Patient-Centered Medical Home. Many of the people who were setting up PCMHs were not embracing this in spirit. Yes, we have to be sustainable financially but not at the expense of our purpose.

With the Patient-Centered Medical Home, my understanding is that one aspect of it is to shift reimbursement models to financially reward effectiveness, to

*reward positive health outcomes, instead of all the incentives being geared toward maximizing the quantity and the cost of treatment.*

In CHI's offices, we have a diagram made up of two 4' x 8' whiteboards from Home Depot. I nailed them to the wall and drew a graphic of our business model. One of the big "arms" of that starts with fee-for-service, because that's where most of the system currently is, but from there it goes right to population health. The PCMH population health model is one where we are *not* reimbursed for how much we do for a sick person. We need to be reimbursed for keeping people healthy. We need to track it and prove it and show the outcomes. And to show our practitioners their outcomes and prove that this model delivers better care, that it also saves money, and that it's a healthier way for everyone to be involved in delivering healthcare.

*That is a most worthy goal. PCMHs, the way they can be set up under the Affordable Care Act, can just involve better integrating care among conventional practitioners such as primary care MDs, nurse practitioners, gastroenterologists, rheumatologists and radiologists, for example. Or a PCMH can include various conventional practitioners, as well as CAM practitioners like chiropractors, acupuncturists,*



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## PATHWAYS INTERVIEW



Casey's grant. Without that we would never have been able to do this. It allowed us not to be worried initially about productivity right out of the gate. However, after a little more than a year, we are right on track with our business model and pro formas to be sustainable by 2017.

As to how we integrate the work of our practitioners within this culture of collaboration, one of the things we've done is to create a central team room, where a lot of informal collaboration occurs. Some collaboration can also happen through the electronic medical record, as well as through structures like "huddles" in the morning. Before we start our day, all the practitioners meet and go through every patient scheduled that day, and say, "Okay, what's going to be best for this patient?" Maybe we should recommend that the next time they come in, that we back-to-back that with a chiropractic visit, for example. We're really trying to coordinate this so that sometimes a patient will see two, and sometimes three, different practitioners in the same visit. These are things that are built into our model but how they actually get put into practice is still something we're working out. As we get busier, it gets more challenging as to how to keep the collaboration and communication going.

*In many instances, CAM and integrative clinics primarily serve those in the middle class and above. Is that the case with the Casey Health Institute, or do you have a broader community outreach?*

It is built in from the ground floor. First of all, we're a public nonprofit, and part of our reason for being is to serve the community. We made a very conscious choice (and we could have done it differently) to take insurance, and we accept almost all insurance, including Medicare and Medicaid.

*That opens up your potential outreach significantly.*

We also have a charity care policy for people who don't have health insurance. We're experimenting. It started out that it also includes our CAM services. That's a tricky business, because for many of these things, CAM isn't reimbursed by any insurance. Acupuncture is now starting to be reimbursed more, and certainly chiropractic is. But a Reiki treatment? In our charity care policy, if you qualify, you can get your CAM treatments as part of your treatment plan, just as we do for people not on charity care.

We're really trying to be connected and to have community outreach, in

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*naturopaths and massage therapists. Casey Health Institute includes these CAM professionals enthusiastically, along with yoga teachers and others. How is this working, having this range of CAM practitioners? And how is it serving your patients?*

Really well. I'm not sure how much of it is the Patient-Centered Medical Home and how much is the culture of collaboration. They're intertwined, and we're trying to define that and operationalize it, which is a challenge. We've created the culture.

We've clearly had the benefit of Mrs.

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a variety of ways. One of our family physicians, Dr. Kisha Davis, grew up in Gaithersburg and she is very connected to the community. We have a lot of outreach in different stages of development. It's central to us.

Setting up the reimbursement part the way we did was very important to us. We did not want to have a concierge model. We did not want to set up any barriers. And we believe that we're going to prove this is a better way to practice, medically and financially.

*What you are describing feels like a new kind of model. As such, it has the potential to show that something different is possible. Is there anything we haven't spoken about yet that you want to tell our readers?*

I would add that this is about the business model as well as the health model. The way that the fee-for-service reimbursement is going at the moment, we can't be completely sustainable just doing that. We sat down with healthcare business consultants

for months, going over and creating a very detailed business plan. I learned a lot. Here I am, an internist-psychiatrist, and I'm doing things I never imagined I would be doing. The business model incorporates something important, which is to have income streams that support the mission and the vision, aside from integrative primary care.

*What might those be?*

We have a wellness center, which is an entity in and of itself, but connected. This is a direct line for our primary care patients. It's based on the four pillars of lifestyle. We have a very strong commitment to yoga and yoga therapy, where we're partnered with Unity Woods, one of the oldest Iyengar yoga studios in the Washington area. It's very structurally oriented and alignment based. Then there's the exercise component, which is different than yoga. There's meditation, with a strong component of mindfulness. And we have a strong nutrition component. This is above and beyond the nutrition

counseling by our practitioners. We're planning a nutritional cooking school. So this all part of a center that we're developing, that people can come to for any of these things, and that we can refer our patients to. It's all about lifestyle, changing the model from sickness to health.

We also have a research arm that will be applying for grants. And we are pursuing a leasing policy for the remaining two thirds of the building to bring in "like minded" specialty practices. We want to offer a one stop health experience which includes medical and complementary specialties that attend to a broad range of health needs beyond integrative primary care and wellness.

#### For further information:

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*Daniel Redwood, DC, the interviewer, is a professor at Cleveland Chiropractic College – Kansas City, and editor-in-chief of Health Insights Today.*

See Daniel's ad on page 90.

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