Direct Primary Care: Implications for the Health Care Workforce

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ACCESS
HEALTHCARE
DIRECT

Why the need for Direct Primary Care?

- **Will practices be able to remain independent**
- **Uncertainty about viability of solo practice**
- Increasing overhead costs
- MACRA uncertainty-MIPS penalties
- **Primary Care workforce**
- Continual escalations in administrative hoops
- Burnout-insurance makes MDs “box checking gophers”

This is what patients have become accustomed to

Direct Primary Care puts the focus back on the patient

There is no time spent on “how many boxes do I have to check or how many ROS to get a 99214?”

Physician Trends and Attitudes

- Survey of physicians nationwide by Physicians Practice Magazine of over 1000 independent physicians nationwide
- **53% considering or already in Direct Primary Care**
- 35% considering or already working in Concierge Model
- Only 20% in process or have achieved PCMH recognition

- 4.4% plan on entering ACO
- 3.9% plan to become PCMH
- 4% plan to become hospital employed

History of the DPC Model

- ***Access Healthcare*** *conceived in 1999-incorporated in April 2001 and opens first all DPC clinic 2002* (we now have facilitated clinics in 33+ states-Hawaii included) **It all started right here in NC!**
- **Founded the AAFP DPC Toolkit, DPC Workshops, DPC Summit, helped shape DPC policy and legislation**

DPC-Direct Primary Care

- Pro
  - Significantly lower out of pocket costs for most
  - Focused on the Patient/Physician relationship rather than payer
  - Quality improved due to more time (the original value- based instead of volume-based care)
  - Complete price transparency
  - Lowers overhead/helps practices financially
  - **Improved access for underinsured and poor**
  - No barriers to innovation due to “what you can’t code for”
- Con
  - Major transition/disruptive
  - Recruiting patient panel (copay culture)

Adapted from Forrest, B.R. **Physician’s Practice** Pearl 12/7/11
New Primary Care Models Can Change the Way You Practice Medicine

Concierge and DPC-Similar but *Completely Different*

- Both improve quality of care for patients
- Both improve physician experience/pay
- Concierge has much smaller panel
- DPC improves access for low income/uninsured
- **Workforce improved instead of compromised with DPC**

Adapted from Forrest, B.R. **Physician's Practice** Pearl 12/7/11 New Primary Care Models Can Change the Way You Practice Medicine

Key Differences Between Concierge and DPC?

- DPC generally affordable for the average person (think used Honda vs. Ferrari)
- DPC can be successful in rural and poor communities
- DPC can lower out of pocket costs vs. increase
- DPC panel size is optimal vs. too small
- DPC practices by definition NEVER file insurance

Adapted from Forrest, B.R. **Physician's Practice** Pearl 12/7/11 New Primary Care Models Can Change the Way You Practice Medicine

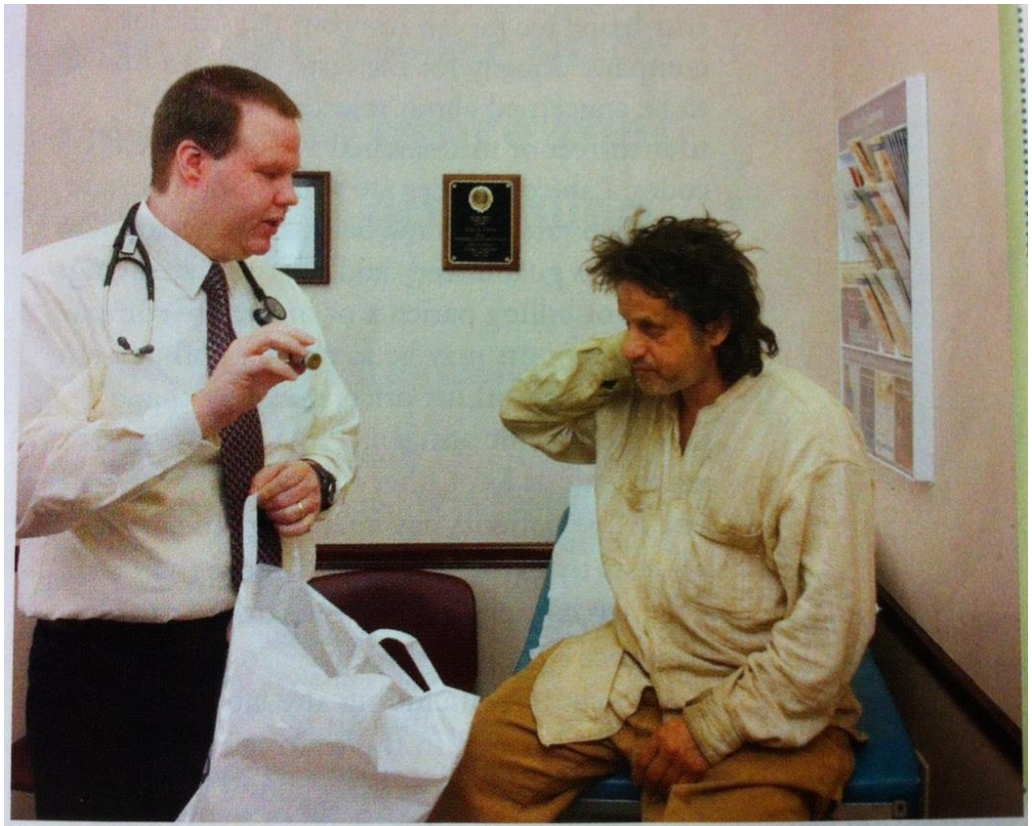
Affordable Care

Medical Home Member - **no extra charge for common labs, EKGs, U/As, etc.**

Patients who come in rarely only for acute complaints are not forced to be “members” and can have services from an “a la carte” menu posted in waiting room- typically 80% off most services

- This makes out of pocket costs average **less than a the least expensive individual cell phone plan per year or one carton of cigarettes per month** (even the chronically ill multisystem patient-including labs, in office procedures, the entire basket of services in our office)

Vision Realized-My Favorite Moment

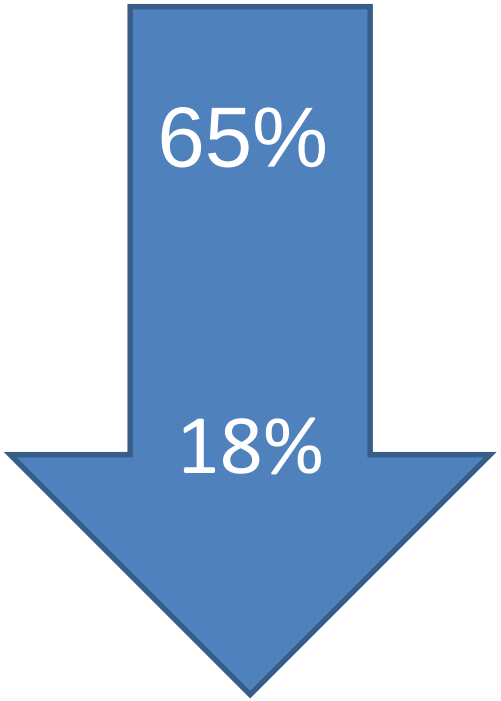


Dr. Forrest conducts a visit with a patient who has no insurance. Uninsured patients constitute about 35 percent of Access Healthcare's patient base.

Adapted from Forrest, B.R. Family Practice Management 6/07
"Breaking Even on 4 Patients Per Day"

Genius of the GYM

Overhead Dramatically Reduced



Primary Care Math

Traditional	Our Model
$1.00	$1.00
x.65 collected (avg in US)	x.99
.65	.99
-60% overhead (avg in US)	- 18%
.26 left	.83 left

Kick the Payer out of the Exam Room

Make the Physician-Patient Relationship a 2 Party affair

Summary of DPC Model for AH

- Lower patient charges-80% less (improves access for underinsured)
- Higher collections (99% for 16+ years) with overhead 15-22%
- More time with patients/less patient volume(even with **similar** panel)
- Not bound to insurance contracts - **no insurance filed**
- Less stress/Lower risk exposure/Decreases medical mistakes [1]
- Allows better familiarity and firmer patient relationships thus decreasing risk [1,2]
- Allows time to coordinate all aspects of patient's medical care **to truly be the patient's medical home**

1-O'Hare, Dennis C. et al. FPM.2/2004 Vol 11. No.2" The Outcomes of Open Access Scheduling."

2-Linzer, Mark et al. Advances in Patient Safety Vol 1."Organizational Climate, Stress, and Error in Primary Care: The MEMO Study."

The DPC Quadruple AIM

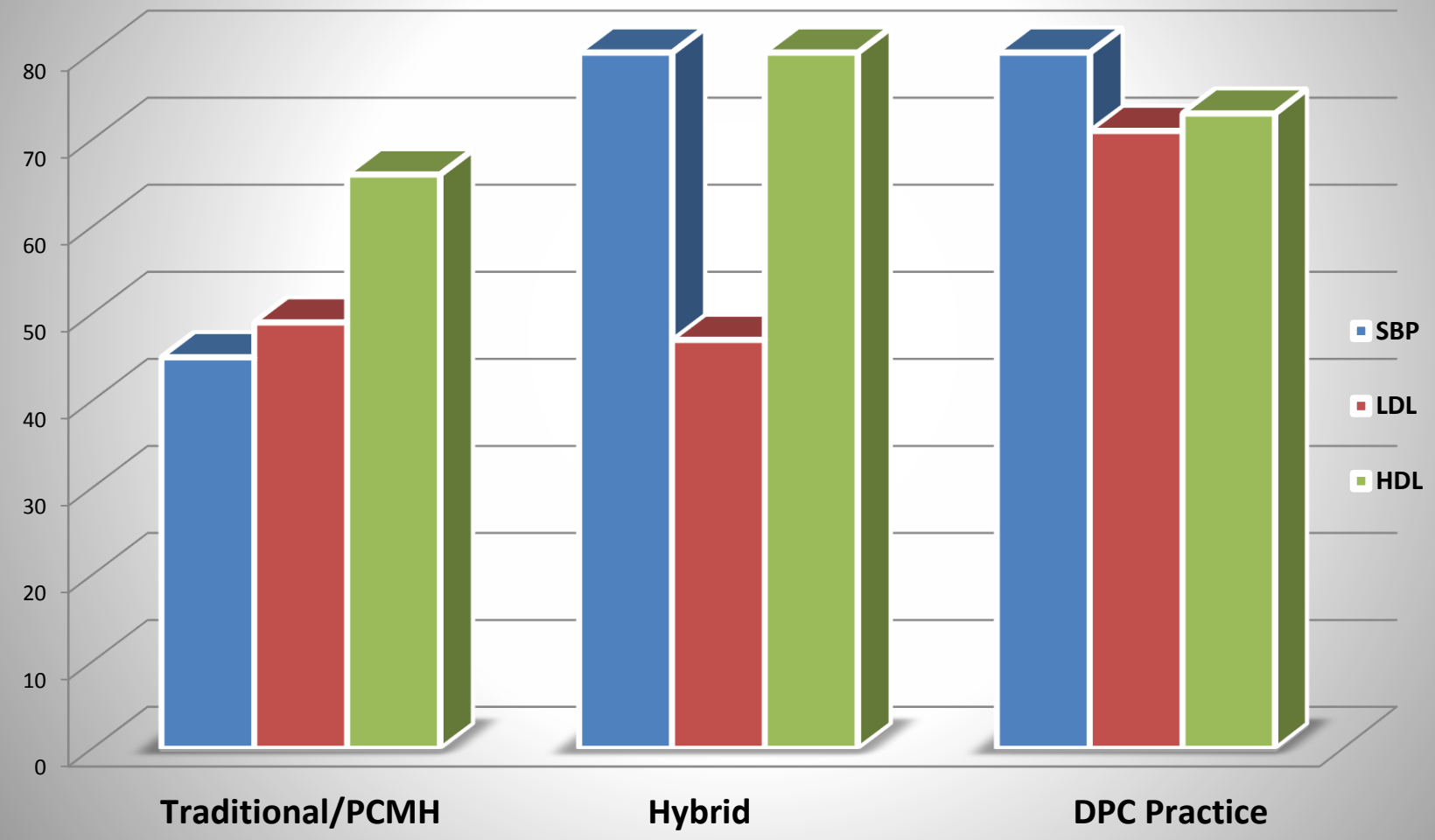
Increased

- Quality
- Access

Improved

- Cost
- Experience
  Patient & Physician

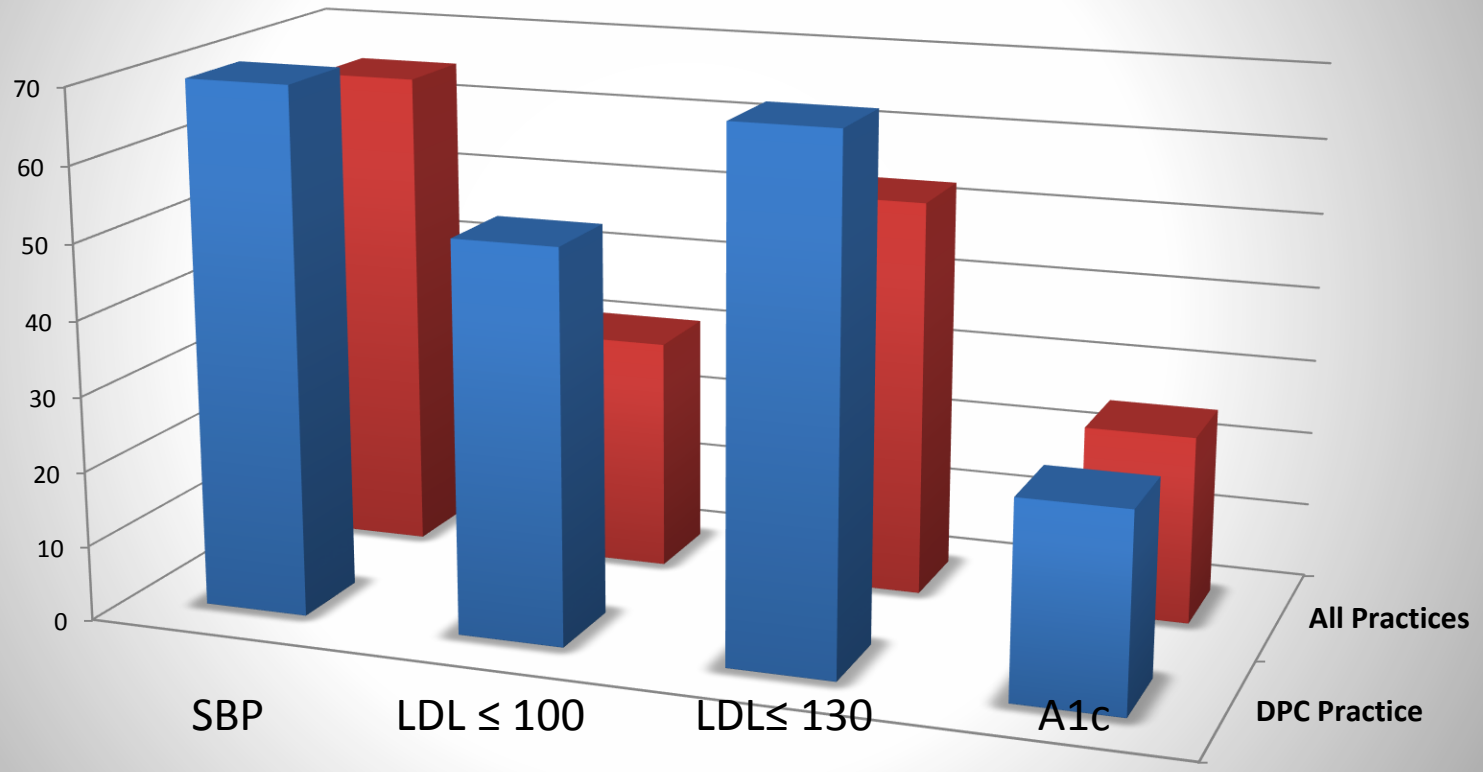
Goal Attainment Comparison



COSEHC DATA 2014
www.cosehc.org

Percent Improvement Comparison

Patients attaining target goals who were not at control at baseline



COSEHC DATA 2014
www.cosehc.org

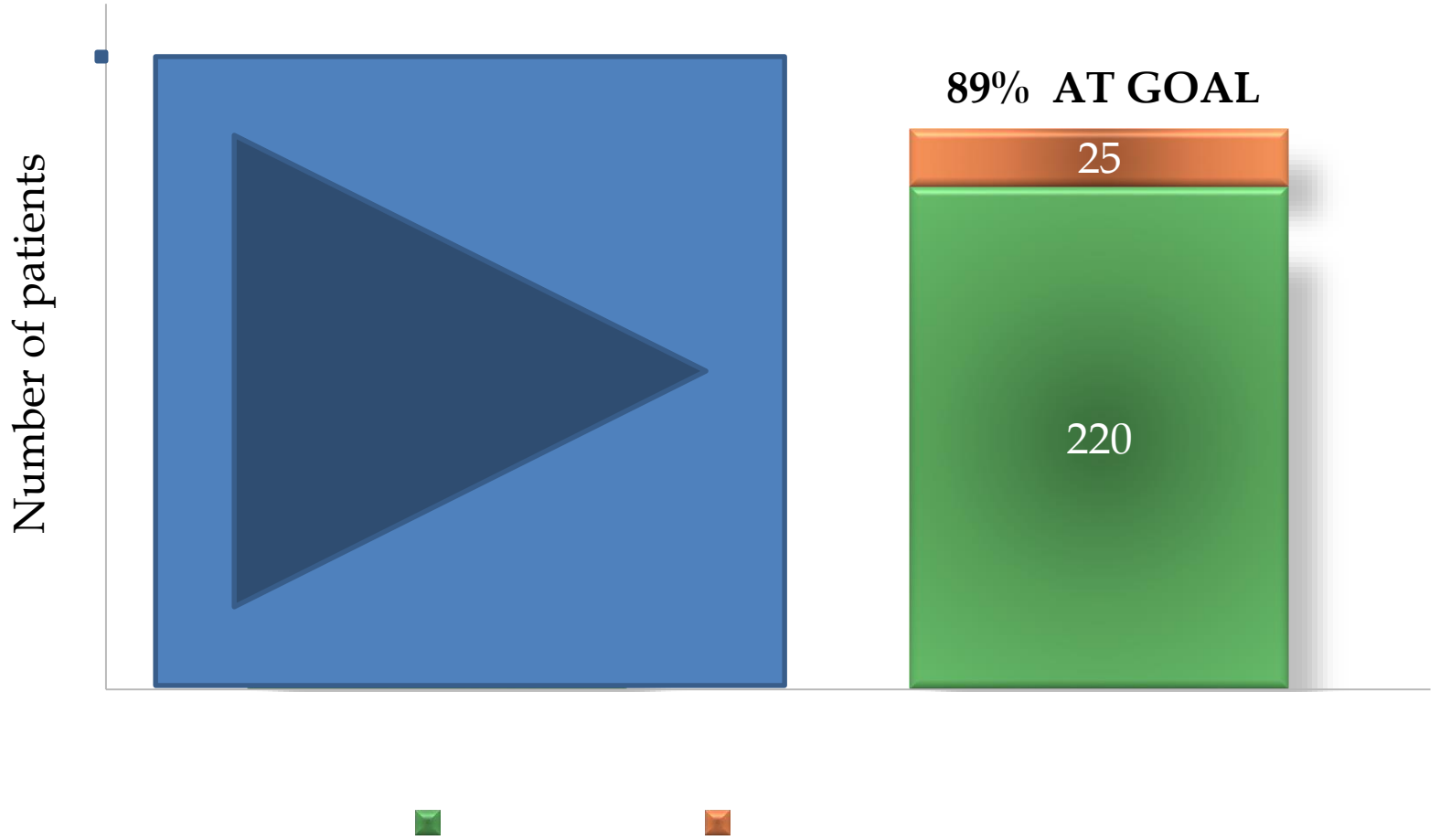
Management of Chronic Disease in a DPC Model

- *Only 50% of patients nationally with high BP who are seeing a doctor and are being treated for high BP have their BP under control[1]*
- *80% of patients at goal in a review of 3 DPC practices[2]*

[1] *NHANES 2007-2010 data*

[2] *Access Healthcare Direct patient data 2011-2013*

Access Healthcare Direct
Diastolic Blood Pressure

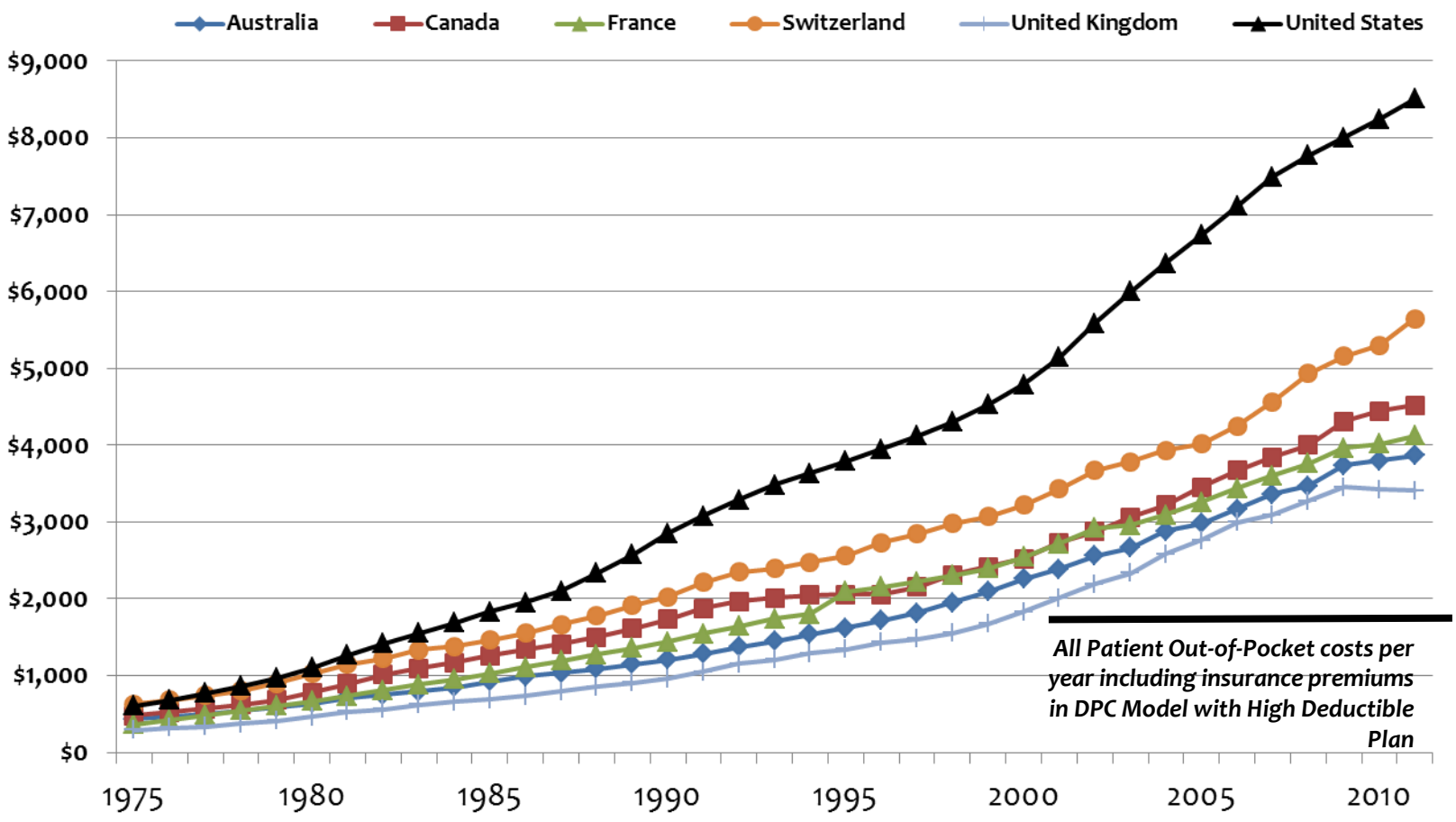


JNC 7 Goal Attainment: < 90 mm Hg; < 80 mm Hg diabetic

NC STATE UNIVERSITY
POOLE COLLEGE OF MANAGEMENT

ACCESS HEALTHCARE, PA

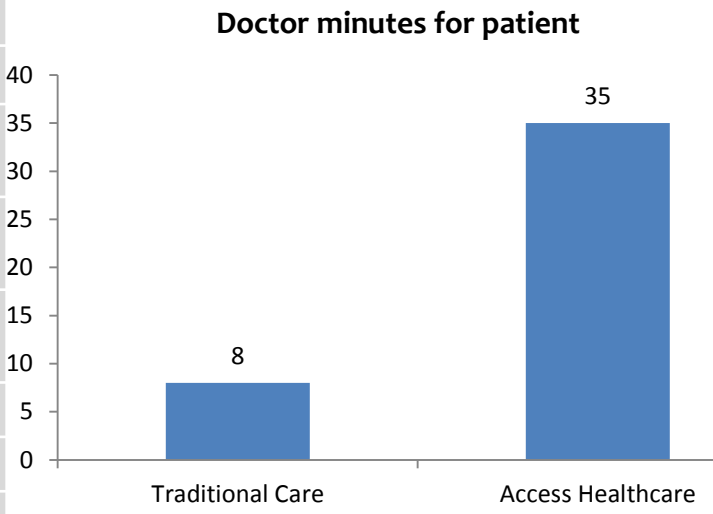
US vs. World vs. Access Healthcare Direct Practices



http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm
The Organization for Economic Co-operation and Development (OECD)

Patient Experience Compared:

Observation	Traditional	DPCMH
Patients per day	30	12
Doctor minutes available	15	45
Doctor minutes for non-patient-facing work	7.5	10
Doctor min. average for patient interface	8	35
Typical Per Patient Insurance out of pocket costs for premiums	$2500 Employee Plan[1]	$ 33% less [2]
Typical Visits per Year	2.5	4
Total Doctor time	20	140
Hospitalizations per 1000 pt/yr	**11**	4



- In the DPC model, patients get more minutes, and are charged less leading to more favorable outcomes.

[1] Various leading plans were reviewed including BCBS and UHC, this figure represents the approximate employee-based out-of-pocket from those plans, per person covered.

[2] Review of a 2013 BCBS plan with high deductible and catastrophic health coverage

Interesting Tid Bits

- Primary-care physicians with rising overhead, more paperwork, and packed waiting rooms are propelling ever-greater numbers to shed insurance and charge a retainer- up to 33% by the end of the year according to Accenture Survey

- **In 2011 the average American medical practice spent $82,975 per doctor just dealing with insurers, according to the Commonwealth Fund**.

- **According to Business Week: Patients in this model visited emergency rooms 65 percent less than similar patients. Thirty-five percent fewer of them needed to be hospitalized. They required 66 percent fewer specialist visits**.

Key Problems the Model Solves:

- Financial **viability of independent practices** (overhead can be <20%)
- Physician **burnout-** med students often say it seems like we are on vacation
- **Work force** recruitment-med students see hope in this model-being able to make as much as other specialists helps
- GME bottleneck-private residency programs can be self funding
- **Access** to primary care for most
- Practice determines reimbursement/payment rates
- **Malpractice risk** decreased
- Non-clinical **bureaucracy/paperwork** decreased
- **Quality metrics** and value based care are built in with measured practices exhibiting top tier chronic disease management

One Medical Student's Thoughts-

Why Medical Students Should Be Excited About Direct Primary Care(excerpt from blog published on DPCMH.org, KevinMD and Primary Care Progress)-By Brian Lanier

Direct primary care makes me incredibly optimistic about the future. I will avoid the hamster wheel and provide the kind of care I envisioned, while building deep, rich connections with my patients. I will be offering a level of care previously only available to the rich that almost anyone can afford. I will be taking meaningful steps towards true, primary-care driven and patient-centered health reform, and I won't have to wait for the "system" to figure it out. I will be able to provide the majority of care my patients require instead of having time only for refills and referrals. In short, I will be part of the solution, both for my patients and for the system as a whole.

Brian Lanier is a fourth-year medical student at the University of North Carolina and a future family physician. Follow him on Twitter at @lanierbrian.

AAFP Response: DPC

"The ***AAFP supports*** the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system mode, including ***the DPC practice setting***," says the policy. It notes that ***the model is structured to "emphasize and prioritize" the physician/patient relationship to improve health outcomes and lower costs and is consistent with the AAFP's advocacy of both the patient-centered medical home and a blended payment model***.

According Glen Stream, M.D., M.B.I., of Spokane, Wash., "There is more than one way to build a patient-centered medical home (PCMH)." He noted that the number of AAFP members developing DPC practices was increasing.

"***The model eliminates the insurance middleman and provides revenue directly to the practice to innovate in both customer service and quality of care*** for the patients they serve," said Stream.

Significance of Direct Primary Care in 2018

-Employers-low cost option for employers, ACA has a section discussing that this qualifies as insurance with HBE qualified plan as approved by HHS-section 1301 A 3

-Legislation pending HR 365 Primary Care Enhancement Act

-22+ states have added DPC state legislation

-Medscape article reports explosive growth of this model and in conjunction with Concierge practices represents currently 12% of primary care- expected to be 30-40% of market by end of the year

-Summits, Workshops, Bootcamps, National Conferences focused on DPC

-Insurers-products launching now to integrate into HBE eligible plans-including Medicaid and Medicare Advantage

-Large Companies like **Disney**, Expedia.com, Freelancers Union, Whole Foods, Grove Park Inn, Huntington Bank, McDonalds, and Taco Bell/Long John Silver's already looking to or currently contracting with DPC practices.

Medicaid and DPC looks promising

-In Washington State, Coordinated Care has partnered with 5 DPC practices to provide primary care for Medicaid Patients-getting $50+ per member per month

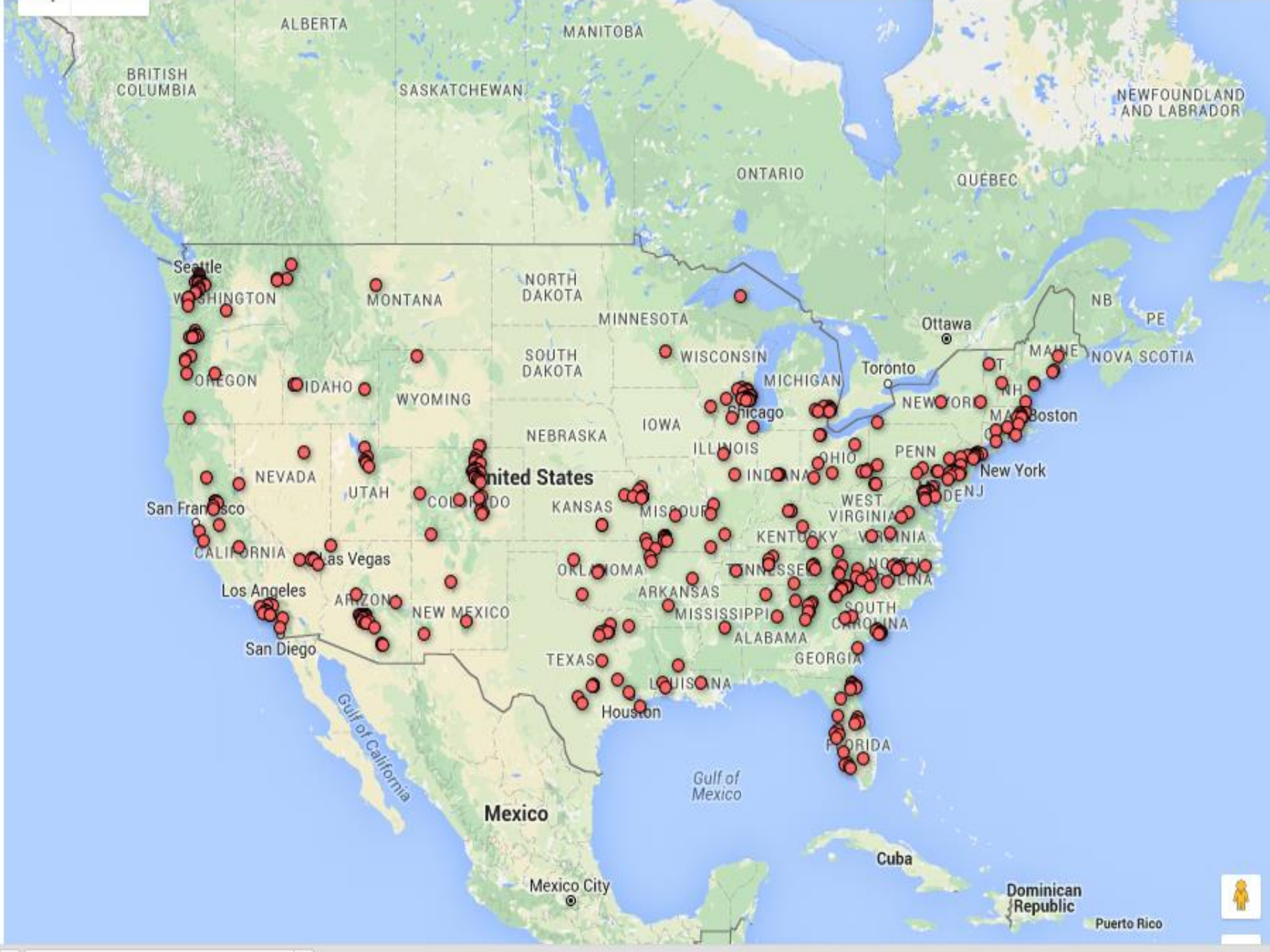
-With the initial 40,000+ enrollees: ER visits are down 60%, hospitalization and re-admission down 65%, and overall costs for this Medicaid population is 20% less for 2013 than the non-DPC pilot practices

-Opportunity exists to do this in any state (**like NC**). It would make Medicaid a preferred payer by many family physicians-double the net revenue per patient of fee for service is possible (and payment is upfront every month-no waiting on delayed reimbursements)

Physician Income Expectations

For a family physician with patient panel capacity of 1200 and a visit volume of 16 patients **maximum** per day incomes can be similar to specialists like cardiology or GI and better than general surgery and most of the other internal medicine subspecialties

If you want to do packages for the extremely economically challenged and create a lower fee schedule or sliding scale that is reduced by another 50%(as compared to average DPC practice fee), this can still net 50% more in salary for a family physician even if their entire panel was in this demographic.(works for rural communities or low median income areas)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Dominican Republic
Puerto Rico

So What's New

- ACA Qualified Co-Op Sharing Plans*****
- Medium employers/self insured wrap around with DPC
- Medicaid/Medicare

What's New in DPC?

- Mainstreaming?
  - Numerous Health Policy Articles
  - National Payers/ACA

- Becoming THE Alternative Payment Model?
  - Under MACRA- this can become one of the APMs
  - Could result in claims absent monthly payment

TCPI

IMPACT-COSEHC PTN-a CMS Grant Funded Initiative to Transform Practices to **Direct Primary Care** as a Value Based Alternative Payment Model

The Opportunity

- Burwell Announced $843 million TCPI Grant Initiative October 3 years ago
- Only 29 Practice Transformation Networks were to be awarded nationally out of thousands of applications
- Our network of DPC practices, Access Healthcare Direct has practices in 33 states with a heavy concentration in the Southeast
- The Consortium on SouthEastern Hypertension Control (COSEHC) is a not for profit based at Wake Forest University whose main mission has been Quality Improvement in the area of Cardiovascular Disease
- As part of the Fund Development Committee for COSEHC we encouraged them to apply to be a PTN under that grant- **a real longshot**

Surprising Success

- COSEHC Awarded $15.8 million to be a practice transformation network and to facilitate project with approximately 4500 practices
- In the grant, the Access Healthcare Direct network and the Direct Primary Care Medical Home Association (DPCMH.org) were tasked with transforming up to 600 Practices to a Value Based Direct Primary Care Model
- Largest data collection effort for DPC ever with standardized free clinical outcome extraction and analysis through Symphony Performance Health
- End Game is to make DPC one of the Advanced/Alternative Payment Models under MACRA with DPC memberships paid for fully by CMS

Where to Learn More

Pofeldt, E. Medical Economics "The Rise of Direct Primary Care" 4/10/16

Bendix, J. Medical Economics "Fighting Back for Independence" 8/25/15

Lankford, K. Kiplingers "Pay Cash for your Healthcare" 2/15

Sprey, E. Physicians Practice "New Practice Models are Gaining Acceptance" 9/14

Forrest, B. Physicians Practice Pearl "New Primary Care Models Can Change the Way You Practice Medicine" 12/11

Forrest, B. Medical Economics Cover Story "Cutting Edge" 5/25/11

Mescia, T. Weekly Standard "Cash for Doctors Revisited" 4/11

Mescia, T. Weekly Standard Cover Story "Cash for Doctors" 5/23/10

Morgan, Lewis. Medical Economics Cover Story "Keeping it Simple" 1/22/10

Forrest, B. Physicians Practice. July 2008. "Cash and Carry Healthcare Still Works."

Forrest, B. Family Practice Management. June 2007. "Breaking Even on 4 Patients per Day."

Forrest, B. Physicians Practice. June 2007. "Cash and Carry Health Care."

Backer, L. Family Practice Management. February 2006. "2500 Cash Paying Patients and Growing"

Forrest, B. NC Medical Journal May 2005. Innovations in Primary Care. "The Access Healthcare Model"

Twitter **@innovadoc**

http://www.physicianspractice.com/pearls/new-primary-care-models-can-change-way-you-practice-medicine (link to first article above)
http://newsle.com/BrianForrest source of compilation of 20+ articles on the DPC model
www.accesshealthcaredirect.com website for DPC network practices. Undergoing renovation and updates
www.DPCMH.org free membership for students and residents- website for members only

DPC Resources

www.accesshealthcaredirect.com

accesshealthcaredirect@gmail.com

www.DPCMH.org DPC Medical Home Association
-free membership
-resources available from this not for profit
-Certification of practices
-free toolkit available for residents.

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