Hope for Independent Family Physicians - How a Direct Care Model Can Allow Small Practices to Thrive

Brian R. Forrest, MD

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Summary of DPC Model

- Lower patient charges-80% less (improves access for underinsured)
- Higher collections (99% for 12+ 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."

History and Overview of DPC Model

- ***Access Healthcare opens clinic 2002*** (now have facilitated clinics in 16 states)
- Qliance opens first clinic 2005 (currently 5 clinics)-evolved from Concierge
- Medlion opens first office 2009 (currently 4 clinics)-evolved from Concierge
- Access Rhode Island starts DPC hybrid statewide network 2008 (23 practices)
- AMG Medical opens first office 2011 (currently 6 clinics in Manhattan)

**Historical information based on presentations, interviews with founders, and media. There may be discrepancies and/or updates but this is a best attempt to accurately reflect history of movement.*

Access Healthcare Direct Network Practice

Practices Using our model/software including hybrid practices

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What People Said 13 Years Ago

"You're Crazy!"

"That will never work."

"You won't be able to afford to stay in practice."

THE HYPOTHESIS: 1999

If You:

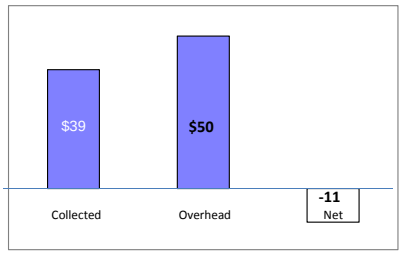
Decrease Overhead (micropractice) and
Have patients pay in full at time of service, monthly, or yearly

Then you can:

Reduce Fees,
Increase Collections,
And Focus on patient care-Improve Quality

Sample of 43 Practices in Triad Region: 2000

Average Charged = $93



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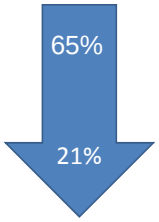
Primary Care Math

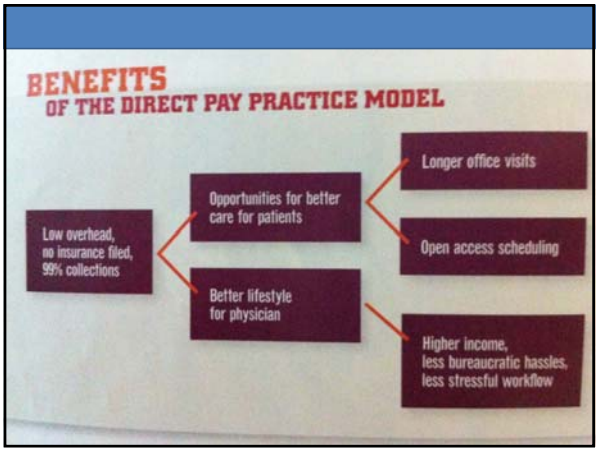
Traditional	Our Model
$1.00	$1.00
x.65 collected (avg in US)	x.99
---	---
.65	.99
-60% overhead (avg in US)	- 21%
---	---
.26 left	.78 left

Overhead Drops Dramatically



Genius of the Gym!

Kick the Payer out of the Exam Room -
Make the Physician-Patient Relationship a 2 Party affair



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5/50 Paradox

Medicaid patients ?

Insured Patients (49%) ?

Equal Access to Quality Care- Homeless and Millionaire seating

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

Results

A designated COSEHC Cardiovascular Center of Excellence ™

- As a Cardiovascular Centers of Excellence since 2009- top 5-10% for cardiovascular outcome measures and 80% lower out of pocket patient costs as audited by COSEHC, UNC School of Medicine, and NCSU MBA program
- Most patients value increased access and longer visits
- Named "Best Doctor in the Triangle" (Raleigh, Durham, Chapel Hill) by Newspaper Reader's Poll
- Currently top 10 Best of Wake County Physicians based on local magazine reader's poll

QCAT-OUR Quadruple AIM

Quality

Access

Cost

Transparency

NCSU MBA Study of the Model

3 different Direct Primary Care Physicians using Access Healthcare Model

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Direct Primary Care Medical Home Model at Access Healthcare

Ben Matthews, Chad Crafford, Charles Queen
NCSU Poole College of Management
23 August 2013

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Access Healthcare, A Direct-Pay/Care Medical Model

<u>This Presentation attempts to answer three questions:</u>

1. **Is the Direct Care model as effective for patient health?**
2. **Can costs be contained and experience optimized for the patient?**
3. **Is there an impact on Hospitalization?**

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Chronic Disease Management and Valuing Trust

Does Trust Matter?

- How much trust is built in a 35-minute visit versus an 8-minute visit?
- Research shows the cost of litigations when the patient and doctor spend more time together and have more trust is significantly lower[1,3]
- The average primary care doctor pays $11,000/yr. in malpractice premiums.
- Two physicians at Access Healthcare together pay less than $4000 per year[2].
- Also the decreased volume 30 patients vs. 10 patients, means that you are 3 times less likely to be sued just based on volume.

[1]A study of sued and non-sued obstetricians found that patients who saw obstetricians with the most frequent number of prior lawsuits were significantly more likely to report spending less than 10 minutes with their physician during each visit;
[2] Dr. Brian Forrest, Access Healthcare
3Kristin E. Schleiter, JD; Difficult Patient-Physician Relationships and the Risk of Medical Malpractice Litigation
AMA Journal of Ethics. March 2009, Volume 11, Number 3: 242-246.

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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 physicians[2]*

[1] NHANES 2007-2010 data
[2] Access Healthcare Direct patient data 2011-2013

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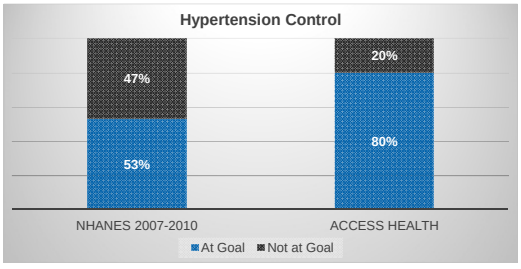
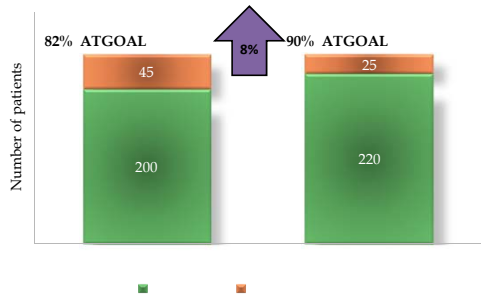
Chronic Disease Management at Access Healthcare



NHANES – CDC National Health and Nutrition Examination Survey
Centers for Disease Control and Prevention, National Center for Health Statistics
Review Date: 18 September 2013

[1] NHANES 2007-2010 data
[2] Access Healthcare COSEHC data

Access Healthcare
Diastolic Blood Pressure



JNC 7 Goal Attainment: < 90 mm Hg; < 80 mm Hg diabetic www.cosehc.org

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Traditional Healthcare System breeds Clinical Inertia

Clinical Inertia: A clinician's failure to initiate appropriate therapeutic intensification.

A Hattiesburg Clinic study comparing blood pressure control rates an their relationship to clinical inertia found that inertia was exhibited in 73% of patient visits when providers saw more than 26 patients per day.

Inertia was significantly higher for diabetic patients and for patients < 10 mmHg above goal

American Society of Hypertension, 2011

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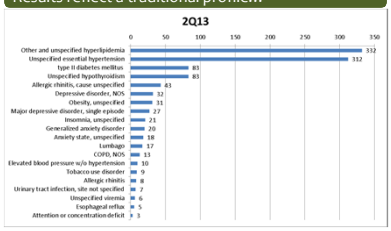
Two Doctors, One Quarter – 2Q2013
Results reflect a traditional profile…



Access Healthcare[1]:

- In a full quarter, doctors provide about 600 diagnoses.
- This equates to about 200 a month or 50 a week.
- Most patients have more than one ailment.
- Patient population is demographically and diagnosis code c/w NC averages-except higher portion of uninsured

[1]*Access Healthcare Review of patient visit data 2011-2013*

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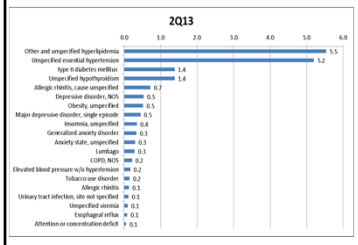
Access Healthcare …



An Average Day[1]

- 18-20 patients (2 doctors)
- 9-12 patients per doctor
- 6 treated for High Cholesterol
- 5 treated for High Blood Pressure
- 2 treated for diabetes symptoms
- 2 treated for Hypothyroidism
- 3-4 treated for various other issues.

[1]Access Healthcare Review of patient visit data 2011-2013

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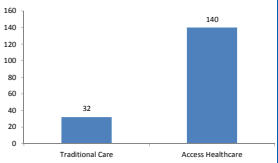
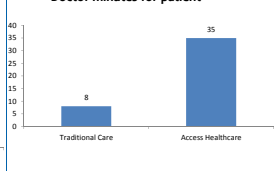
Doctor and Patient Experience Compared:





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

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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 2016 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**.
- Data from one company* estimates if every patient was seen in this model it would save $268 billion annually. In 2010**, 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**.
- In 2012 the average premium for an employer-provided insurance policy for a family of four climbed to a record high of $20,728, according to Milliman, a health-care consultancy.

*Qliance-Business Week

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Key Problems the Model Solves:

- Financial viability of independent practices (overhead can be as low as 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 money as a partialist 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
- Quality metrics and value based care are built in with measured practices exhibiting top tier chronic disease management

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One Medical Student's Thoughts-

Why Medical Students Should Be Excited About Direct Primary Care-By Brian Lanier

You've heard the story before: a young man or woman with idyllic dreams of practicing primary care goes off to medical school, only to have their dreams crushed by the realities of 7-minute visits, "production goals," and unstable reimbursement – you've heard of the Medicare sustainable growth rate, or SGR, right? Every time you turn around, there is someone talking about primary care physician burnout or complaining about practicing on a hamster wheel.

I left a career I loved as a US Marine to pursue medicine, and I didn't do it naively. I knew full well the realities of modern practice, but I took a leap of faith that I would find a way to practice medicine that would be fulfilling and allow me to be there for my family. Although I loved the idea of building meaningful relationships with patients and families, the downsides of primary care just seemed too daunting, so I thought I would go into emergency medicine.

That all changed when I read about Access Healthcare, the practice founded by Dr. Brian Forrest in Apex, NC. A friend had sent me a magazine article that featured Dr. Forrest's practice, and I was blown away. Forrest had figured out a way to provide care to the uninsured and underserved, spend enough time with his patients to build meaningful relationships, excel in quality outcomes, maintain a good quality of life, and make a decent living to boot. It all sounded too good to be true but after getting to know him and eventually doing my Family Medicine clerkship in his practice, I can say that this is truly a transformative model of care.

Direct Primary Care (DPC) is a model of delivery that hearkens back to the glory days of the family doctor. In DPC, the physician's sole focus is on the patient. Patients have easy access to their physician through open scheduling and often, email, cell phone, or Skype – methods discouraged by current reimbursement mechanisms. Visits are unrushed, and patients get the time they need, whether it's 10 minutes or an hour. The physician-patient relationship is the foundation, and instead of one-way communication, patient and doctor develop plans of care together that are targeted towards the patient's own values.

DPC works by extracting the third-party payer from the equation. Third-party involvement in primary care adds an enormous burden of cost and time – a burden that doesn't add to, but actually detracts from, the quality of care. When that burden is removed, the savings are dramatic, and the whole physician paradigm shifts from chasing reimbursement to providing the best care possible. In DPC, the patients pay the physician directly for service through an affordable subscription or transparent a-la-carte pricing. Just imagine if your car insurance was responsible for changing your oil. We'd go from a service that practically anyone can afford, to one that hardly anyone could afford, with the result being fewer people getting necessary maintenance, leading to engine damage, breakdowns, and exorbitant repair bills. Sound familiar?

The Affordable Care Act (ACA) includes a provision that allows for Direct Primary Care services to be coupled with a wrap-around insurance policy and sold on the health care exchanges. Such a product has already been developed in Washington State and is available on their exchange. There are efforts to provide care to Medicaid patients in this model as well. DPC addresses the triple aim of improved quality, lower cost, and improved patient experience in an incredible way and can be delivered to any patient population. If you care about finding a way to deliver care to the underserved, then you have to be excited about DPC.

The ACA, with its expansion of access to care, heightens already existing concerns about the dwindling primary care workforce, but many of the proposed solutions out there don't address the reasons that students shun primary care, including rushed visits, production goals, constricted scope of practice, and shrinking reimbursements. DPC addresses all of these issues in spades, and once students realize there is a viable option out there, they will be turning to primary care and family medicine in droves.

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 @blanierbrian.

AAFP Response:DPC

The AAFP recently created a document with frequently asked questions(4 page PDF) to accompany the Academy's newly created policy on direct primary care (DPC), a model in which practices charge patients a flat monthly or annual fee in exchange for access to a broad range of primary care services.

"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 to AAFP Board Chair 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 still small but 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 2013-2014

-Employers-low cost option for employers with under 50, ACA has a section discussing that this qualifies as insurance with HBE qualified plan as approved by HHS-section 1301 A 3

-Patients-higher satisfaction and better outcomes at lower out of pocket costs with complete price transparency

-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 2016

-Summit in St. Louis last October –Washington D.C. this summer, New Orleans, Miami, AZ

-Insurers-products launching now to integrate into HBE eligible plans

-Large Companies like 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.

Where to Learn More

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

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

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

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

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

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

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

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

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

Twitter **@innovadoc** (just starting to use this but giving regular DPC updates now)

http://newsle.com/BrianForrest source of compilation of 20+ articles on the DPC model
www.acchealth.com Apex practice website
www.accesshealthcaredirect.com website for DPC network practices. Undergoing renovation, re-launch in 2 weeks
www.DPCMH.org free membership for students and residents- new website launches in 2 weeks

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