

Introduction to Direct Primary Care: A Model to Help Independent Practices Thrive While Meeting the Quadruple Aim

Brian Forrest, MD



ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Every effort has been made to ensure the accuracy of the data presented here. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.



DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this activity have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.



Brian Forrest, MD

Chief Executive Officer/Founder, Access Healthcare Direct, Apex, North Carolina; Adjunct Associate Professor, Department of Family Medicine, University of North Carolina School of Medicine, Chapel Hill; Adjunct Associate Professor, Department of Family Medicine, Brody School of Medicine at East Carolina University, Greenville, North Carolina.

Dr. Forrest is a pioneer in direct primary care (DPC). In 2001, he founded Access Healthcare, the first DPC family medicine micropractice in the United States. Since then, he has helped physicians in more than 20 states transition to new models of care. He has consulted with integrated health systems and several health care industry companies about how to engage the DPC model. In addition, he teaches courses on innovative models of care and has developed a DPC residency curriculum that is being piloted by University of North Carolina (UNC) Family Medicine, Chapel Hill. Dr. Forrest founded the American Academy of Family Physicians' (AAFP)'s DPC Member Interest Group. In collaboration with the AAFP, he helped organize the first Direct Primary Care National Summit (and has served as its CME Director), helped create the AAFP Direct Primary Care Toolkit, and has designed DPC workshops. Dr. Forrest has been a featured/keynote speaker at many national conferences, has made numerous TV and radio appearances, and has been featured on the cover of publications including Medical Economics and The Weekly Standard. He has also appeared in The Wall Street Journal, Forbes, Health Affairs, Physicians Practice, and Kiplinger. His leadership positions include president of the DPCMH Association and president-elect of the American Academy of Private Physicians (AAPP). He is also on the board of directors of the Consortium for Southeastern Hypertension Control (COSEHC), which recently received a \$15.8 million grant from the Centers for Medicare & Medicaid Services (CMS) as a Practice Transformation Network for DPC practices. Dr. Forrest's Twitter feed devoted to DPC is @innovadoc and more information on his practice model can be found at www.accesshealthcaredirect.com or www.dpcmh.org. You can email questions to accesshealthcaredirect@gmail.com.



Learning Objectives

1. Identify the broad capabilities and structures that characterize the spectrum of Direct Primary Care practice models.
2. Accurately characterize the relationships between the DPC model and other reimbursement models.
3. Recognize the common conceptual concerns that primary care physicians have about the DPC model.
4. Recognize the common practical concerns that primary care physicians express when considering adopting the DPC model for their practices.



Audience Engagement System

The image shows three sequential screenshots of a mobile application interface. Step 1 is the home screen with a navigation menu at the bottom. Step 2 shows a list of CME events with a red arrow pointing to a specific event. Step 3 shows the details for the selected event, 'CME011 Adult Commonly Symptomatic Urinary My Heart', with a red arrow pointing to the event title.



Introduction to Direct Primary Care: A Model to Help Independent Practices Thrive While Meeting the Quadruple Aim



Brian Forrest, M.D.
 CEO- Access Healthcare Direct
 Founder and Owner- Access Healthcare, P.A.
 President -DPCMH Association
 President-Elect- AAPP
 AAFP- DPC MIG Founder and Liaison to
 Commission on Quality and Practice



Making our Stand as Family Physicians



OR



Why the need for Direct Primary Care?

- **Will practices be able to remain independent**
- **Uncertainty about viability of practice**
- Increasing overhead costs
- MACRA uncertainty-MIPS penalties
- RUC not working for improved reimbursement
- Primary Care workforce
- Continual escalations in administrative hoops
- **Burnout**

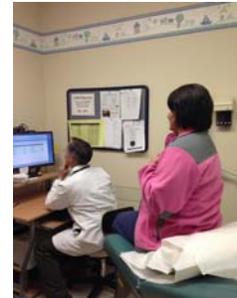


This is what patients have become accustomed to



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 1311 physicians nationwide by Physicians Practice 9/14
- **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



DPC-Direct Primary Care

- Pro
 - Significantly lower out of pocket costs for most
 - Quality improved due to more time (value- based instead of volume-based care)
 - Complete price transparency
 - Lowers overhead/helps practices financially
 - Improved access for underinsured and poor
- Con
 - Major transition/disruptive
 - Recruiting patient panel (copy 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 and Different

- Both improve quality of care for patients
- Both improve physician experience/pay
- Concierge severely shrinks panel size
- DPC improves access for low income/uninsured whereas concierge worsens
- 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

FMX

What is the Difference Between Concierge and DPC?

- DPC generally affordable for the average person (Honda vs. Ferrari)
- DPC can be successful in rural and poor communities
- DPC can lower out of pocket costs and downstream costs
- DPC panel size is optimal

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

FMX



FMX

Genius of the GYM



FMX

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



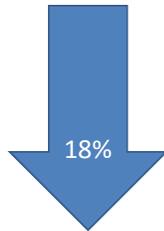
FMX

Access Healthcare: a D-PCMH Micropractice Model

- Charge low per member per month directly to patient or their employer or their insurer*
 - nominal per visit fee to cover overhead costs
 - Net profit double to triple per patient per year
- A La Carte Non-Member transparent pricing at 80% off typical rates for service
- 4 FTE equivalents in overhead costs saved per physician-mostly due to no "insurance related staffing"

FMX

Overhead Dramatically Reduced



FMX

Primary Care Math

<u>Traditional</u>	<u>Our Model</u>
\$1.00	\$1.00
x.65 collected (avg in US)	x.99
-----	-----
.65	.99
-60% overhead (avg in US)	- 18%
-----	-----
.26 left	.81 left

FMX

Affordable Care

Medical Home Member "subscription/membership model": patients charged affordable fee per month and a nominal fee per office contact- 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** (even the chronically ill multisystem patient-including labs, in office procedures, the entire basket of services in our office)

FMX

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 602. "Breaking Even on 4 Patients Per Day"

FMX

Summary of DPC Model for AH

- 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
- Allows better familiarity and firmer patient relationships thus decreasing risk
- Allows time to coordinate all aspects of patient's medical care **to truly be the patient's medical home**

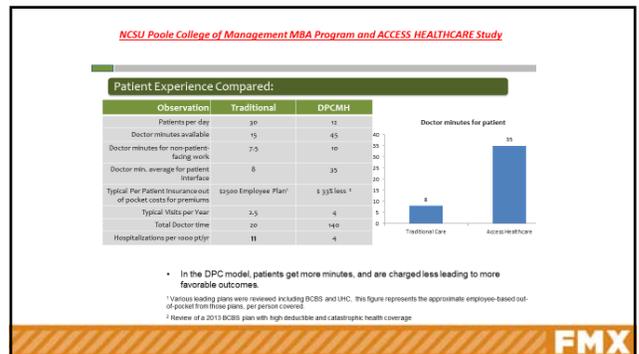
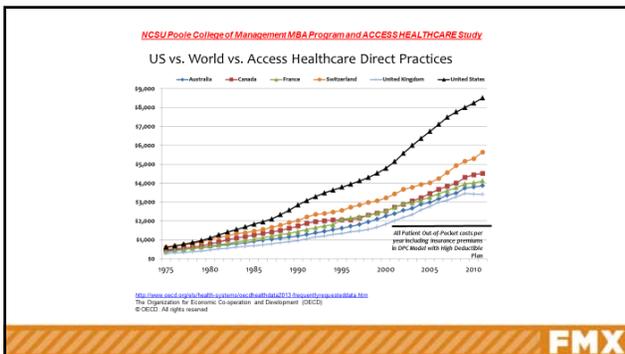
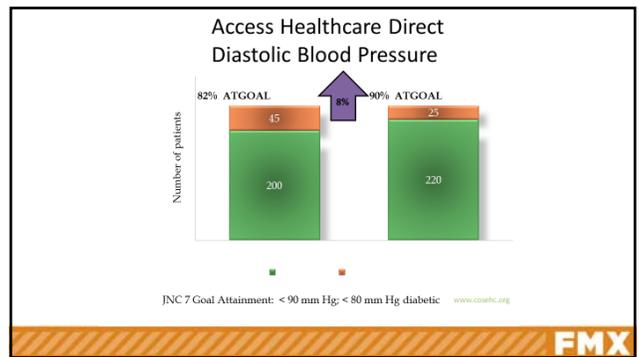
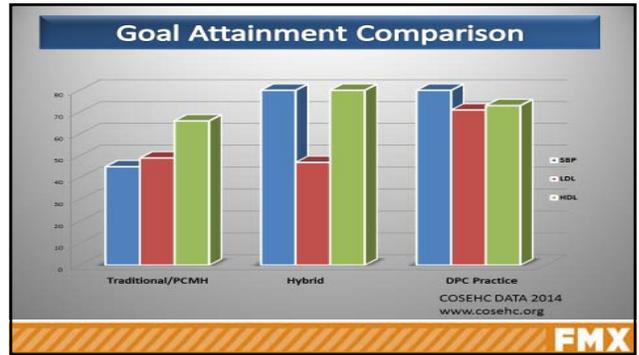
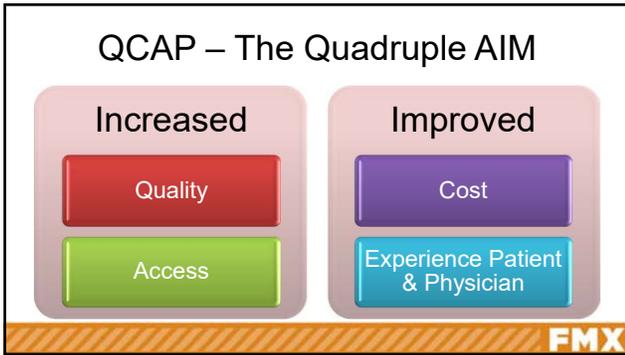
- 1-O'Hare, Dennis C. et al. *FPM*, 2/2004 Vol 11, No.2 "The Outcomes of Open Access Scheduling."
- 2-Linzer, Mark et al. *Advances in Patient Safety*, Vol 1. "Organizational Climate, Stress, and Error in Primary Care: The MEMO Study."

FMX

Significance of Direct Primary Care for Employers

- Employers-low cost option for primary care for employees with under 50 employees that are not mandated to provide coverage-also tax benefit for them
- Employers with over 50 employees-ACA has a section discussing how will qualify as insurance with HBE qualified plan as approved by HHS-this could save employers 30% or more on premiums
- Employers that are self insured are working to create wrap around products for their companies-Delta Star
- Most employers feel like they have not gotten the **value** they expect for their healthcare dollars-

FMX



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
- Quality metrics and value based care are built in with measured practices exhibiting top tier chronic disease management

FMX

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)

FMX

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 was a fourth-year medical student at the University of North Carolina when he wrote this. Now a PGY2 in Family Medicine. Follow him on Twitter at [@brianlanier](#)

FMX

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. 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 Glen Stream, M.D., M.B.I., of Spokane, Washington, "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.

FMX

Medicaid and DPC looks promising

- In Washington State, Coordinated Care has partnered with 5 DPC practices to provide primary care for Medicaid Patients
- With the initial 40,000+ enrollees: ER visits down 60%, hospitalization and re-admission down 65%, and overall costs for this Medicaid population is 30% less for 2013
- Opportunity exists to do this in any state. 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)
- In Washington State, participating physicians getting \$50+ per member per month
- This can really make practicing in rural and low income communities sustainable and recruit needed workforce into those areas

FMX



FMX

So What's New

- Legislative Update
 - SB 1989
 - Florida, Ohio, Tennessee? 20+ States
- Insurance/Payer Update
 - ACA Qualified Co-Op Sharing Plans*****
 - Medium employers/self-insured wrap around with DPC
 - Medicaid/Medicare

FMX

What's New in DPC?

- Mainstreaming?
 - Numerous Health Policy Articles
 - National Payers/ACA
- Becoming THE Advanced Payment Model?
 - Under MACRA – this can become one of the APMs
 - Could result in claims absent monthly payment

FMX

COSEHC PTN for TCPI Grant Project as it relates to DPC Practices (IMPACT)

- Recruitment goal is 600 DPC providers (PCPs, Specialists, NPs and PAs)
- Engaging with community practices across the Southeast but not restricted to just this geographical area and have been encouraged by CMS to enroll practices regardless of their location
- Practices must have software platform that can export/integrate with Symphony Performance Health for data collection (EHR/Membership Mgt)
- Practices **under Medicare (Pioneer) ACO/MSSP agreements are not eligible** to participate
- Mission is to help practices thrive in a value-based delivery environment

FMX

AES Question

Are you interested in transitioning to a DPC Model?

1. Yes
2. No
3. Maybe, need more information

FMX

AES Question

Are you already in a DPC model or in process of transitioning?

1. Yes
2. No

FMX

AES Question

Are you interested in the TCPI Grant to help transform to or optimize your practice?

1. Yes
2. No

FMX

Why Should I Consider Participating?

- Practices will be paid an incentive for participating
- Up to 20 hours of free CME Category 1
- Counts for Part 4 MOC as a QI project
- Could be entry point to CMS pilot to pay for DPC monthly fees without coding or billing
- Free software to analyze your data
- Free tools to optimize your practice
- Free education/seminars to help you be successful in DPC
- Be included in the largest uniform data gathering on the DPC practice model and possibly be included in publications

FMX

Practice Recommendation

- Consider the Direct Primary Care Model as a way for you to improve patient care and your practice viability while reducing overhead and insurance bureaucracy
- Consider the free TCPI Grant to help you make your DPC Transition

FMX

How to Participate

- ****Send an email to accesshealthcaredirect@gmail.com to request to be part of the DPC IMPACT Project**
- Go to www.accesshealthcaredirect.com : our website for DPC network practices. Participating practices will be designated on website
- Go to www.DPCMH.org, Direct Primary Care Medical Home Association - free membership and resources available from this not for profit. Will also list updates on the project.
- **Follow @innovadoc** on twitter for latest grant and DPC updates
- **Download** "Access Healthcare Direct" free app from iTunes/Google – request to participate through app

FMX

Where to Learn More

Sprey, E. *Physicians Practice* "New Practice Models are Gaining Acceptance" 9/14
Forrest, B.R. *Physicians Practice Pearl* "New Primary Care Models Can Change the Way You Practice Medicine" 12/11
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"
<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

FMX

Ready to Transition to DPC?

www.accesshealthcaredirect.com our website for DPC network practices. You can go to this site to sign up for consulting or turnkey start to finish DPC transition resources.

Send an email to accesshealthcaredirect@gmail.com to sign up for newsletter, DPC updates, and conference registration discounts

www.DPCMH.org Direct Primary Care Medical Home Association –free membership and resources available from this not for profit. Free transition toolkit available for residents.

Follow @innovadoc on twitter for latest DPC updates

Download "Access Healthcare Direct" app from iTunes/Google

FMX

Questions

FMX

Interested in More CME on this topic?
aafp.org/fmx-practice-management

FMX