Body System: Population-Based Care

Session Topic: Introduction to Direct Primary Care

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• A knowledge gap exists about available payment models outside traditional insurance-based payment environment • A knowledge gap exists about the Direct Primary Care model and its applicability in transforming how family physicians are paid for delivering high value health care services. • A knowledge gap exists about available faculty professional development opportunities.	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.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)

	Medical Knowledge		Patient Care
	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism	X	Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided

to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide examples and resources to help physician-learners identify the broad capabilities and structures that characterize the spectrum of Direct Primary Care practice models.
- Provide examples and recommendations that accurately characterize the relationships between the DPC model and other reimbursement models.
- Address the common conceptual concerns that primary care physicians have about the DPC model.
- Provide evidence and resources to help physician-learners recognize the common practical concerns that primary care physicians express when considering adopting the DPC model for their practices.

Needs Assessment

Direct primary care (DPC) is a subset model of the retainer-based practice framework for primary care practices. There is not a single DPC practice model; rather the model represents a broad array of practice arrangements that share a common set of characteristics. Perhaps the defining characteristic of DPC practices is that they offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. DPC practices are distinguished from other retainer-based care models, such as concierge care, by lower retainer fees, which cover a portion of primary care services provided in the DPC practice.

The opportunity to spend more time interacting with patients and providing ongoing follow-up services is at the heart of the patient-centered care provided in DPC practice settings[1]. The regular and recurring revenue generated by the practice retainer fees allows physicians participating in DPC practices to overcome some of the pressures associated with the traditional FFS payment system. Because DPC physicians are no longer generating revenue solely on the basis of how many patients they see per day, many report that they have significantly more time to spend with patients in face-to-face visits. Additionally, many DPC physicians provide a larger array of non-face-to-face services, such as tele-visits or e-visits, for their patients, to ensure primary care services can be accessed in a manner most convenient for patients and their families.

The core result of the DPC practice model is that physicians and patients have the opportunity to spend more time interacting. The consequence of spending more time with each patient, however, is that family physicians practicing in a DPC setting typically have much smaller patient panels than they would in the traditional FFS system.[2] Generally, DPC physicians have a

panel of between 600 and 800 patients. In typical FFS settings, the patient panels tend to range from between 2,000 and 2,500 per family physician. This often results in patients losing access to their personal physicians if they elect to not participate in the DPC contract or if their physicians cannot take on new DPC contract patients.

Patients who do receive personal care in the DPC practice will find their primary care services significantly altered when compared with care received in traditional practice settings (e.g, increased time spent with their family physicians). There are a number of reported outcomes of increasing visit time, including improved patient experience of care and improved clinical outcomes as patients become more engaged in managing their own health care.

To support a broader industry awareness of the developing Direct Primary Care model of retainer-based care, the Division of Practice Advancement (DPA) staff has developed a series of member facing resources and communication materials.[3] The most significant of these resources is the AAFP's Direct Primary Care policy, developed by the Commission on Quality and Practice.[4,5]

References

1. Wieczner J. Pros and Cons of Concierge Medicine. *The Wall Street Journal.* 2013. http://online.wsj.com/news/articles/SB10001424052702303471004579165470633112630 . Accessed Feb 2014.

2. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. *Journal of general internal medicine.* Jan 1999;14 Suppl 1:S34-40.

3. American Academy of Family Physicians (AAFP). AAFP Direct Primary Care Tookit. 2015; https://nf.aafp.org/Shop/practice-management-tools/dpc-toolkit. Accessed Aug, 2015.

4. Porter S. Family Physicians, Patients Embrace Direct Primary Care -- AAFP Recognizes Benefits, Creates DPC Policy. *AAFP News.* 2013. http://www.aafp.org/news/practice-professional-issues/20130514dpcmodel.html. Accessed Aug 2015.

5. American Academy of Family Physicians (AAFP). Direct Primary Care. *AAFP Policies* 2013; http://www.aafp.org/about/policies/all/direct-primary.html. Accessed Aug, 2015.

