AAFP

American Academy of Family Physicians
Innovation Labs Report

Adopting Direct Primary Care Using a DPC Membership Management System

Evaluating the HintOS

hint health

September 7, 2022

Direct Primary Care With a Membership Management System Phase 1 Lab Report

Executive Summary

Objective:

The American Academy of Family Physicians has launched a series of Innovation Labs to identify and demonstrate technologies essential to addressing existential problems plaguing family physicians and optimizing the family medicine experience. Family physician burnout is problem number one. We believe that a root cause of burnout is a fee-for-service (FFS) treadmill where physicians run to overcome all the burdens (e.g., large panels, short visits, large overhead needed to manage insurance requirements) associated with the current payment model. Direct Primary Care (DPC) is an innovation that has helped physicians step off this treadmill by taking prospective payment directly from their patients. This lab studied Hint Health's ("Hint") DPC Membership Management solution, HintOS. It is an innovation designed to help physicians adopt DPC by handling membership and prospective payment and allowing family physicians to focus on patient care.

Participants and Methods:

The lab studied 10 family physicians that had adopted DPC and HintOS. Impact was assessed with a qualitative survey used to structure an interview with each participating physician.

Results:

After adopting DPC, 100% of the physicians reported they now had "ample" time with their patients. Under DPC and using HintOS, physician visit lengths increased from an average of 14 minutes to 43 minutes, representing a threefold increase (~29 minutes) in time with their patients. In contrast, physicians reported that when previously practicing under the FFS model, their time with their patients ranged squarely between inadequate to constrained. Patient panels under DPC averaged 443 patients with a range of 150-800 as compared to around 1,500 for FFS practices. On a scale of 1-10, physicians' overall satisfaction with their practice more than doubled from 4.1 to 8.9. When asked what would make their satisfaction a 10, they said the major factor would be growing their membership to their ideal panel size (500-800 patients). Physicians reported that under an affordable DPC subscription model ($75-100 per patient per month) they were able to care for significantly more patients who were uninsured or underinsured. When asked on a scale of 1-10 whether they would recommend Hint to a colleague, physicians reported a median of 9.7. This resulted in a Net Promoter Score for this cohort of 100. When asked what they would say to a colleague about Hint they said, "Hint takes care of changing to DPC" and eliminates the burden of getting paid.

Conclusion:

By moving to DPC, 100% of physicians realized dramatic reductions in burnout and improvement in professional satisfaction. This was based on two major factors; first the significant reduction in the size of their patient panels while doubling their visit times with patients, and second the elimination of the time and burden associated with trying to get paid. The HintOS Membership Management solution

addressed the operational requirements of the DPC prospective payment model, freeing physicians to focus on their patients, which reaffirmed why they went into family medicine. A key learning was that these DPC physicians cared for many more patients who were uninsured or underinsured than they had under FFS, suggesting DPC may offer improved access and care and may be an avenue to expand needed primary care services. The impact on these family physicians suggests that DPC is a model for family physicians experiencing burnout, and a membership management system may be an essential innovation supporting the DPC model. These results demand further study in a Phase 2 Innovation Lab, which would specifically address: which providers should consider adopting DPC, what are the perceived risks associated with DPC and how can they be lowered, what paths can help family physicians more easily transition to the DPC model, and how DPC physicians can help other family physicians join them in this model.

Adopting Direct Primary Care Using a DPC Membership Management System

Overview

The American Academy of Family Physicians is dedicated to optimizing the family medicine experience for patients and their families, and family physicians and their care teams. Toward this goal, the Academy supports family physicians in achieving the Quadruple AIM; enhancing their care for individuals, improving the health of their patient population, reducing the per capita cost of their care while also finding joy in their work.

The family medicine experience is based on a deep physician-patient interaction that requires support from technology. Today's EHRs have greatly eroded the experience rather than enhanced it. The vision for the family medicine experience is that family physicians should primarily spend their time caring for their patients and that IT must work for clinicians not against them. The AAFP sees the innovative use of health information technology (HIT) as essential to optimizing the family medicine experience. Toward this end, our Innovation Laboratory is partnering with industry to drive innovation to optimize the family medicine experience using the latest proven advanced technologies: cloud, AI/ML, voice and mobile technologies.

Family physicians are facing existential threats. Physician burnout based on clerical burden is at epidemic levels for family physicians[1,2,3]. Clerical burden requires greater than 50% of the physician's time. At the same time, they must transform their practices to population-based care and alternative payment models. The associated financial risk threatens to burn down their margins and thus their practices. On top of that, artificial intelligence applied without optimizing the family medicine experience as a design requirement threatens to increase physician burden and sub-optimally impact patients and the specialty.

The AAFP Innovation Lab's goal is to study solutions that offer not merely incremental improvement, but that truly alleviate the underlying problems in family medicine. Technologies are essential when

they are deemed just that, “essential,” by physicians and actively promoted by physicians to their colleagues. Their value propositions must promise and then deliver such that the solution is effective and adoptable.

The Problem: FFS Is a Root Cause

With 47% of family physicians reporting burnout, we must look systemically at the root cause. All we have to do is ask family physicians with burnout how it feels to practice today. They often describe it as being on an “hamster wheel” always running, rushed and never caught up. Time caring for their patients and time with their families is compromised and their professional satisfaction has eroded.

A root cause is the fee-for-service reimbursement model that requires physicians to try and cover large patient panels (1500 - 2500) panels and conduct inadequate (around 15 minute) visits. They must spend approximately 40% of their time struggling to get paid about 60% of what they are owed. And it never seems to get better, it only gets harder. They are always asked to do more for less. Our hypothesis is that FFS and insurance driven primary care is a root cause of family physician burnout. We believe this hypothesis can be proven by studying the adoption by family physicians of an innovative alternative model to FFS: Direct Primary Care (DPC).

Innovation: DPC and Direct Prospective Payment Model

Under DPC, family physicians offer a prospective payment model as an alternative to fee-for-service insurance billing. Instead of taking insurance, physicians charge patients a monthly retainer that covers all or most primary care services, including clinical, laboratory and consultative services as well as care coordination and comprehensive care management. Because other secondary and primary care services are not covered by the retainer, DPC practices often suggest that patients acquire a high-deductible wraparound policy to cover emergencies. DPC is not insurance but rather a value-based care model where the patient or their employer chooses to directly pay for the ongoing membership because they are getting ongoing care they value.

We hypothesize that it is this innovation, the direct prospective payment model, that allows family physicians to step off the fee for service “hamster wheel”. Improved care is enabled by increasing access and visit lengths while decreasing patient panel size and the administrative burden of trying to get reimbursed. Most importantly it offers the time and freedom to actually fully care for their patients while attaining a sustainable practice to life balance. It restores professional satisfaction and optimizes the family medicine experience.

Innovation: DPC Membership Management

The AAFP Innovation Lab reached out to many DPC physicians and organizations to understand what innovations enabled the adoption of and success under Direct Primary Care. There were three innovations that were universally identified:

1. DPC Membership Management
2. Unified Communications
3. EHR platform that integrates with 1 & 2 and supports DPC

The Lab assessed the companies in these categories to find a partner for this first phase. Hint Health was chosen as a partner for several reasons. First, it was representative of the innovation category of membership management system. Second, it was broadly adopted across the AAFP membership who have adopted DPC. Third, it was most often integrated with an innovative EHR or innovation platform (i.e., Elation) designed for family medicine and integrated with a unified communication system (i.e., Spruce). This integrated solutions package is a market leader in DPC along with a solution from AtlasMD. The separate but integrated solutions of Hint, Elation, and Spruce allow the Lab to isolate and study each innovation's impact and adoption.

This lab is studying the innovation of a DPC membership management system as offered by Hint. This innovation streamlines DPC operations so the physician and team can adopt DPC and focus on patient care. It takes the burden out of managing membership and getting paid by automating the following:

1. Member enrollment & billing
2. Employer plan design, eligibility, and contract management
3. Affiliate practice network management

While this report is on the adoption of the DPC prospective payment model and the membership management system from Hint, there are separate labs underway on the EHR Innovation Platform and the Unified Communications System.

Methods

The AAFP retrospectively studied the adoption and impact of both the DPC prospective payment model and the DPC membership management system from Hint that supports it. Ten lab participants were recruited from existing Hint practices and physician adopters.

Qualitative Physician Survey

One-hour interviews were conducted with each lab participant. The interview was structured based on a qualitative survey of their experiences before and after the adoption of DPC and of the DPC Membership Management system from Hint (Appendix A).

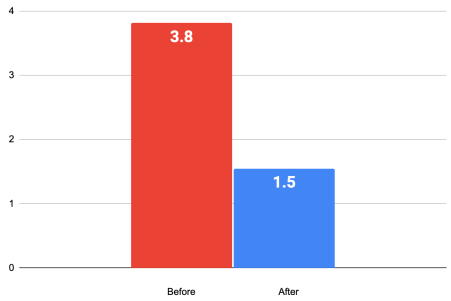
Results

Below are quantitative results and interview findings for 10 clinicians before and after adopting DPC and Hint. Results are discussed below as anecdotal evidence of these clinicians' experiences focused on the impact on their satisfaction, burden, and burnout.

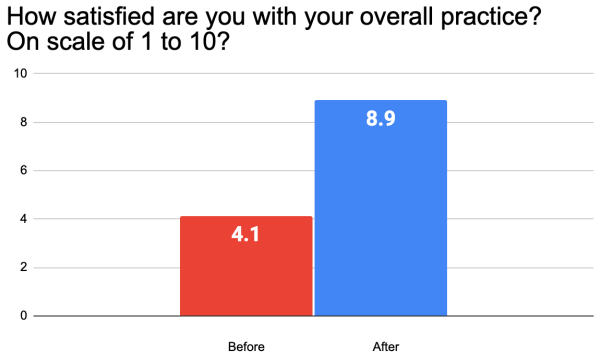
Burnout & Burden

Which of the items below describes you best:

1. I enjoy my work. I have no symptoms of burnout.
2. I am under stress, but I don't feel burned out.
3. I am definitely burning out.
4. I think about work frustrations a lot. It won't go away.
5. I feel completely burned out. I may need to seek help.

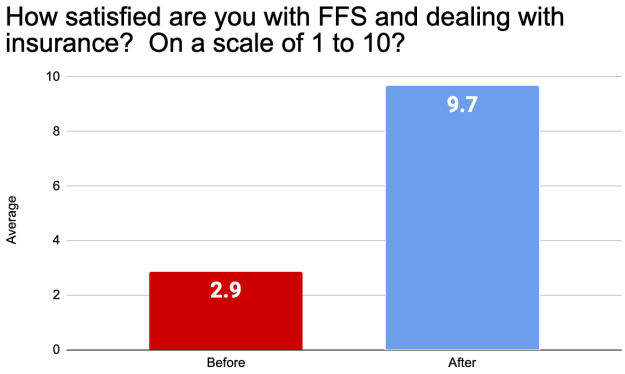


Practice Satisfaction

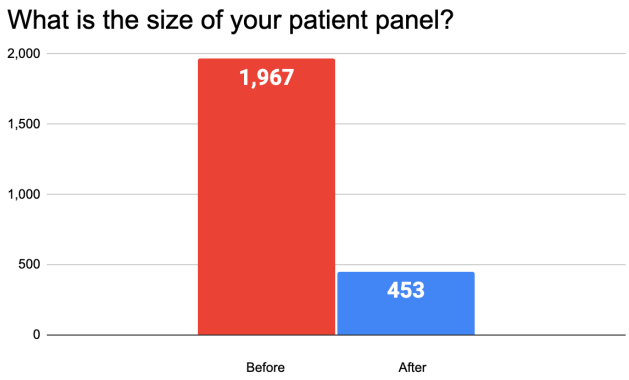


There was a dramatic increase in their satisfaction, with the average score more than doubling from 4.1 to 8.9 on a scale of 1 to 10. Their reported dissatisfaction in their FFS practices reflected their motivation to adopt the DPC model. When asked what would make satisfaction with their current practice a 10, they often reported they still wanted to grow their patient panels or their service offerings. A few reported that feeling "outside of the system," while refreshing, was at times frustrating when trying to get information and assist their patients.

Similarly, and at the heart of their dissatisfaction, they expressed strong dissatisfaction with the burdens associated with practicing under FFS. They reported low satisfaction under the FFS model, an average of 2.9 on a scale of 1 to 10. This is when several reported feeling they were on a "hamster wheel," never able to catch-up or get paid adequately. After adopting DPC, they reported a 9.7 rating of satisfaction stating that they no longer worried or even had to work specifically on just getting paid after providing care. They said that Hint took away any of the administrative burden that could be associated with the prospective payment membership model, as it managed the payments and reminders without them having to insert themselves in the payment process. They said that they really only needed to go into HintOS to see "how well it was going."



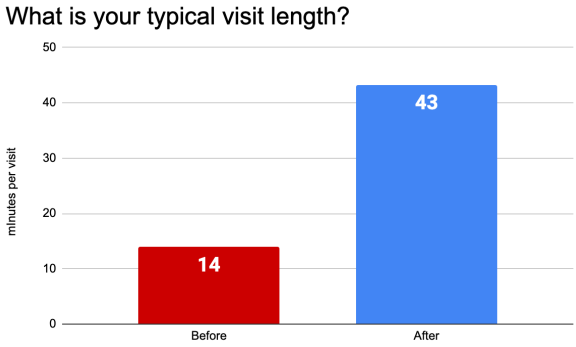
Patient Panel Size

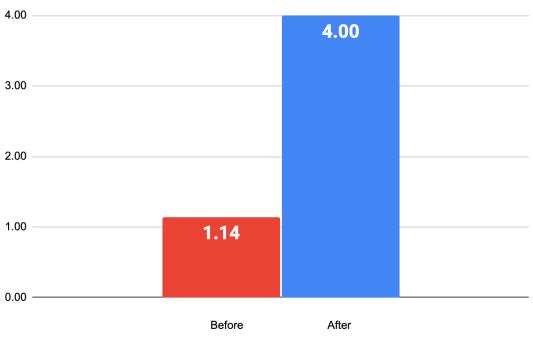


Regarding patient panel size under FFS, our participants had only 3 definitive data points (1400, 1500, and 3000 patients) with an average just under 2000 patients. Estimates of typical primary care patient panels under FFS range from 1500-2500 patients. With an *n* of 10, the participants reported their DPC patient panels ranged from 150-800 with an average of 453. Most reported ideal panel sizes of 500-800 patients. Some wanted to keep their panel size on the smaller end to maintain a good work life balance.

Patient Visit Lengths & Time with Patients

Participants reported a 3-fold increase in typical visit lengths going from an average of just under 15 minutes to about an average of 45 minutes. They reported that they felt an ideal FFS visit length should be 30 minutes. Typically under DPC, they would schedule patients for 30 - 45 min for routine visits and 60+ min for new patients. They reported that they set these visit lengths as they were ideal to take care of their patients. Their schedule often allowed for the extension of these visits as needed.





How would you rate your time with your patients?

1. Inadequate
2. Constrained
3. Adequate
4. Ample

In a follow-up to the question about visit length, participants described their time with their patients going from between “inadequate” or “constrained” under FFS to unanimously reporting that under DPC their time with their patients was “ample.” Nobody reported that it was merely “adequate.”

Uninsured and Underinsured Patients

Participants reported that they were providing more care to the uninsured and underinsured than when they were under FFS. Six out of 10 quantified that a median of 35% of their patients were either

uninsured or underinsured with a range of 30-75%. One participant explained, “Probably 55-60% are [employees of] small business owners that can’t afford insurance or are folks that can’t afford insurance and are living paycheck to paycheck. I also have patients that walk in and say, “yeah doc I have a job that offers insurance, but I can’t afford it.” Several participants offer scholarships that are free or at a reduced rate for their uninsured patients.

Net Promoter Score (NPS)

When asked “How likely is it that you would recommend Hint to a friend or colleague, on a scale of 1 to 10?” Seven of the ten respondents answered 10 while the remaining 3 answered 9.

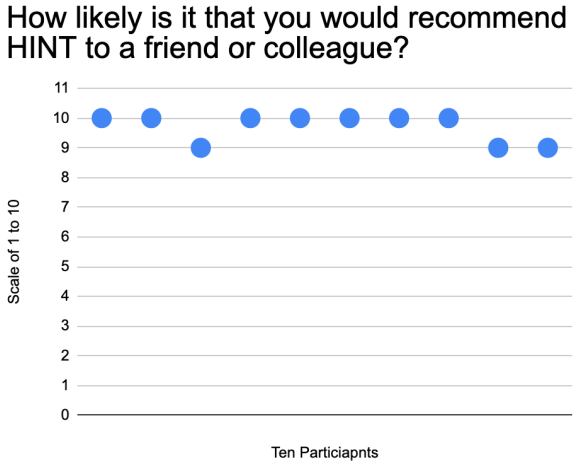
Promoters (9 -10) = 100%

Passives (7-8) = 0%

Detractors (1-6) = 0%

NPS = Promoters - Detractors = 100 - 0 = 100

The result is that all are promoters and the NPS score is a 100. The Net Promoter Score is calculated by subtracting the percentage of detractors from the percentage of promoters. (The percentage of passives is not used in the formula.)



Discussion

DPC Works

This lab provides ten proof points that DPC works to eliminate burnout, improves professional satisfaction and the family medicine experience. The results and conclusions are loud and clear. The DPC prospective payment model allows physicians to lower the size of their patient panels and their overhead both in time and money. This allows them to spend all the time they want and need with their patients and on their care. DPC offers a compelling alternative to the predominant fee-for-service practice, particularly for family physicians who are experiencing burnout. DPC is an example of the likely essential innovation of prospective, value-based care.

The Burning Questions

With family physician burnout at 47%, these burning questions remain:

- Why don’t more family physicians adopt DPC?
- What can be done to help more family physicians adopt DPC?

Why don’t more family physicians adopt DPC?

Although DPC has been around for well over a decade, the AAFP DPC Survey shows 6% of family physicians have adopted DPC. The adoption as measured in the AAFP Annual Survey has grown in a modest linear fashion from 2014 at < 1% per year. Our assumption is that adoption is still mainly found in early adopters and that it has not “crossed the chasm” to the early majority – it has not yet gone

mainstream. Our hypothesis is that the stalled adoption is the combination of perceived risks and low awareness of proven well-paved adoption paths. Here are the questions that need to be addressed:

- What is slowing the early majority from adopting DPC?
- How do we diffuse DPC from early adopters to the mainstream early majority?
- How do FP's who are burning out learn about and adopt DPC?
- How do FP's who are in training learn about and adopt DPC?
- How can FP's lower their cashflow risk when moving to DPC?
- How can FP's lower their membership growth risk when moving to DPC?

Perceived Risk
The participants often describe their decisions to move into DPC practices as a jump or a leap based on the benefit of practicing on their own terms outweighing the risks of trying something new. The main perceived risk was financial. They feared moving into unknown territory with initially less cash flow and not knowing the duration it would take to get their membership to a practice-sustaining level. Participants were uncertain how many of their existing patients would come over to a membership model and feared they might lose too many of them to develop a financially sustainable DPC practice. Yet they moved to a DPC model despite these obstacles either because of sheer desperation and/or guidance from colleagues who had successfully made the change to DPC.

Hybrid DPC/FFS Practice: Mitigation and Migration
If physicians are hesitant to "make the leap" and shift completely off of FFS and insurance, is there a way they can keep FFS patients while they develop their DPC membership? Does this help mitigate their risk? Does this help them either migrate to a full DPC practice or to a balanced sustainable hybrid practice? Can this be done at a physician level, or must it be done at a practice level where a physician is practicing either FFS or DPC?

DPC and VBC: Personalized and Population Health
These DPC doctors believe that they are providing better quality care. How can (or must) they prove their quality and lower cost of care? Can (or should) DPC practices develop scalable population health value-based revenue opportunities with employers, private payers or Medicaid and Medicare? Can they participate in pay for performance and risk-based contracting? Are there new payment models that are compelling to self-insured employers who have already embraced DPC?

<u>What can be done to help more family physicians adopt DPC?</u>
The first step in helping physicians is to identify those family physicians who stand to benefit most substantially from adopting the DPC model and where they practice. We believe these family physicians fall into 4 general groups:

- Family physicians experiencing FFS burnout (Maslach Burnout Inventory > Level 3)
- Family physicians with some FFS burnout and considering retirement

- Employed FFS physicians wanting independence
- Residents and medical students looking for deep relationships with their patients

Join vs Start a DPC Practice
The second step is to engage these family physicians and educate them on the most proven and well paved paths to DPC. We believe early majority adoption may be supported more by opportunities initially to join DPC organizations or networks rather than to start or convert a practice. We hypothesize that these are the existing potential paths to DPC practice listed in order of perceived risk from (lower to higher risk):

1. Join corporate DPC as an employee
2. Join a DPC network as an affiliate
3. Convert your practice to DPC
4. Start your own new DPC practice

How can these paths be optimized to lower risks and open up more opportunities for mainstream adoption by the early majority? The lab intends to study mainstream family physicians who have been successful on each of these paths, developing case studies and best practices.

Caring for the Uninsured and Underinsured
The anecdotal finding that these DPC practices offer significantly more care to the uninsured and the underinsured is very intriguing. DPCs may offer more care to where it is needed most. FFS practices have such small margins, large panels, and set fee schedules that there is little room to fit in the uninsured or underinsured. But DPC allows the physician the flexibility to adjust their care to meet their community's needs. Is the membership retainer model more affordable and effective in caring for these patients, particularly those with chronic diseases? Could employers (at scale) offer an affordable monthly membership for basic primary care bundled with a high deductible plan? Could DPC provide the uninsured better primary care and preventive services much more affordably than their current options: urgent care, ER or even FQHCs?

Conclusion

Family physicians who are experiencing burnout that won't go away should consider shifting from FFS to a prospective, value-based model like DPC. Direct Primary Care allows these family physicians to eliminate burnout. The lab provides 10 proof points that DPC allowed physicians to step completely off of the insurance driven fee-for-service "hamster wheel." It allowed them to attain practice and professional satisfaction by practicing on their terms and meeting the needs of their patients, reaffirming why they went into family medicine.

The lab identified an essential and potentially essential innovation. The essential innovation is the prospective value-based payment model that shifted the physicians to a care model that is based on a

direct business relationship with their patients, where the patient or potentially their employer determines value. The second potentially essential innovation is the DPC member management system that supports the physician in easily running this new direct care model. These innovations allow the DPC physician to run a financially successful practice that also provides the time needed to effectively take care of their patients.

By moving to DPC, 100% of physicians realized dramatic reductions in burnout and improvement in professional satisfaction. This was based on two major factors. Firstly, the significant reduction in the size of their patient panels while doubling their visit times with patients, and secondly the elimination of the time and burden associated with trying to get paid for care provided. The HintOS Membership Management solution addressed the operational requirements of the DPC prospective payment model, freeing the physicians to focus on their patients, which reaffirmed why they went into family medicine.

A key learning was that these DPC physicians cared for many more patients who were uninsured or underinsured than they had under FFS, suggesting DPC may offer improved access to care and may be an avenue to expand needed primary care services. The impact on these family physicians suggests that DPC may be an ideal model for family physicians experiencing burnout, and that HintOS Membership Management may be an essential innovation supporting the DPC model. These results demand further study in a Phase 2 Innovation Lab, which will specifically address: which providers should consider adopting DPC, what are the perceived risks associated with DPC and how can they be lowered, what paths can help family physicians more easily transition to the DPC model, and how DPC physicians can help other family physicians join them in this model.

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