

BREAKING EVEN ON 4 Visits PER DAY

Spurning health plan contracts enabled this practice to dramatically reduce overhead and fees while improving access for the uninsured.

Seven years ago, I began exploring ways I could practice medicine without the hassles and pressures of managed care. I also wanted to find a way to reduce fees significantly for uninsured and underinsured patients. For more than a year, I read about practice innovations and observed other practices. I used

what I learned to develop a model that, so far at least, seems to achieve my goals. Here's how it works:

- We charge our patients a flat rate for office visits. Currently, the fee is \$45.
- We do not file insurance; our patients pay at the time of their visit.

- We do not sign contracts with insurance companies.

I call this the "Access Healthcare" model, after my practice's name. The model is based on the idea that by significantly reducing overhead and improving collections to nearly 100 percent, you can charge much lower fees, improve access for patients who might not otherwise be able to afford care, avoid excessive patient volume and still have a profitable practice. We've been practicing this way for more than five years, and we are thriving.

This article delves deeper into our model and illustrates how it could work for other family physicians.

The basics

I opened my practice in Apex, N.C., in April 2002, with just a medical assistant and myself. I recently added a nurse practitioner, who sees most of our walk-in patients with minor acute care needs. She also helps manage patients with chronic conditions like hypertension, hyperlipidemia and diabetes.

The Apex area includes suburban and rural areas and a population of well-insured



After growing frustrated with the patient volume and time requirements of managed care, Dr. Brian Forrest started his own practice with a unique model of care. Its flat-rate fee and longer office visits have proven popular with patients.

People are willing to spend money on something they value, and they value time with the doctor.

and uninsured, self-employed and under-employed individuals. This mix is reflected in our practice. About half of our patients have traditional insurance that covers some of the cost of office visits, prescriptions and other services. Fifteen percent have catastrophic or hospital-only coverage. The other 35 percent have no insurance.

There are about 85,000 uninsured people in our county. Many of them do not seek medical care unless they are acutely ill. They are not Medicaid eligible and therefore have limited access to care. Many of these patients are hard-working tradespeople who either cannot afford health care premiums or have a pre-existing condition like diabetes that precludes them from having insurance. This fast-growing group of patients can pay for health care services but not at the inflated rates that most practices would have to charge them, so many fall through the cracks. Our \$45 office visits are appealing to them.

Overhead. Our overhead has been consistent at 25 percent of total revenue. That compares favorably to the typical practice's overhead of 40 percent to 60 percent of total revenue.¹ Our overhead figure does not include the employment costs associated with our nurse practitioner. These are paid out of the revenue she generates by seeing patients that I would normally not have the time to see. She is paid based on productivity, which allows her the potential of higher than normal income while seeing at least 30 percent fewer patients than at her previous practice.

Revenue. Our charges average \$82 per patient visit. This includes the \$45 office visit fee and an average lab and supply charge of

\$37. We require our patients to pay their full balance at the time of service. As a result, our collection rate stands at better than 99.5 percent, and we have shed many of the costs associated with trying to collect unpaid balances.

The net practice profit (my income) is \$62 per patient I see. We break even by seeing four patients per day, which yields \$328. When you multiply that by 245 clinic days per year, it adds up to about \$80,000, which is a bit more than our annual overhead. I provide about 3,500 to 4,000 patient visits per year, and our nurse practitioner provides about 2,500. A more detailed breakdown of our practice finances is available on page 22.

The details

The benefits of our model go beyond our solid financial footing. Access Healthcare is also a place that both patients and providers appreciate being a part of. Patients benefit from lower costs, lower fees and better access. Providers' time is freed up by not having to worry about billing. And both patients and providers enjoy our ability to offer longer patient visits.

Longer visits. My real joy is spending time with patients and trying to help them improve their health. In many practices, the high volume of patients that must be seen reduces the time clinicians can spend with each patient. Our model increases the time available for each patient encounter. I spend about 30 minutes with a patient during our average visit. This is the main reason that most patients give for returning to our practice. People are willing to spend money on something they value, and they value time with the doctor. This is truly a mutually beneficial arrangement.

Lower costs. Low overhead is crucial to our practice's viability. With one staff person and two providers, our ratio of 0.5 staff per provider is considerably lower than the national average of 3.9 staff members per FTE provider.² We each perform a wide range of duties. Our medical assistant is responsible for

■ The Access Healthcare medical practice in Apex, N.C., charges a flat fee for office visits.

■ The average patient at Access Healthcare spends \$82 per visit – \$45 for the visit and \$37 for lab and supply charges.

■ Patients must pay the practice at the time of their visit.

About the Author

Dr. Forrest is founder and medical director of Access Healthcare in Apex, N.C., and an adjunct assistant professor in the Department of Family Medicine at the University of North Carolina, Chapel Hill. Author disclosure: nothing to disclose.

scheduling, check-in and checkout, managing the phones, handling referrals, chaperoning exams, and setting up basic tests like urinalysis and strep tests. When she is in an exam room with me, a sensor on the front door lets us know that someone has arrived, and she carries a cordless phone in her pocket that has access to all of our phone lines. I have responsibilities that are not typical of physicians in other practices, such as blood draws, injections, returning patients' phone calls and notifying them of lab results. Not only does this approach reduce staffing costs, but it also contributes to high patient satisfaction because patients are not handed off to others.

Operational costs have also been reduced. No billing software is necessary because there is no insurance to file. Due to lower patient volume, minimal inventory is required so we need less space. Utility costs are kept low by turning off lights in areas that aren't being used and by operating the thermostat on a timer. An easy-listening radio station runs over a wireless intercom for background music, which saves hundreds of dollars per year over Muzak-type services. We even provide our own janitorial services. Many practices in our area pay \$10,000 to \$15,000 per year for these services. We split janitorial duties among employees. (I carry out my own trash.)

We installed a four-line phone system that uses wireless technology, so we don't need a traditional system with hard-wired lines. This saved about \$7,000 in initial set-up costs and has required no maintenance. This system also has an advanced digital answering system that can triage calls and page the provider on call, so there is no need for an operator or an answering service.

We have also reduced overhead by finding medical equipment and furniture from lesser-used sources, such as hospital surplus. The chairs in our waiting room, which are similar to those found in most waiting rooms, actually came from a large hospital's critical-care-unit waiting room. They cost us \$2 each rather than \$199 for a similar chair from a medical supplier. Our exam tables, which were about \$1,500 originally, cost \$100 each from the same hospital surplus. Similar discounts can be found for medical supplies, such as CLIA-waived point-of-service kits like strep tests.



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

Another way we have reduced overhead is by keeping building costs to a minimum. The space I originally needed to practice medicine was about 1,200 square feet. However, I purchased 2,200 square feet of space in an office complex and rented out the extra 1,000 square feet. When I needed more space, I expanded into the rental space and bought an additional 2,200 square feet next door, which is now rented by a cardiologist and a podiatrist. That rental income pays for my space and theirs, and actually nets about \$300 per month. I also have the convenience of sharing a connecting exam room with the cardiologist that I can use when needed. (It's an interior room with two doors: one into our practice and one into his.)

Lower fees. After analyzing the cost and charge ratios from the practices that I had observed, I initially set our office visit fee at \$40. I raised it to \$45 after our first year. Whether a patient is in the office for five minutes or 50 minutes, the basic charge is the same. I put a code on most receipts so that people with insurance can get reimbursed if they want to file it themselves. The law of averages works here because if the practice gets \$45 for both a 90-minute visit and a 20-minute visit, this will equate to the mean charge for a code 99213, the average level of service for a visit at a traditional practice. ➤

■ The practice does not contract with insurance companies.

■ The practice's care team consists of one physician, one nurse practitioner and one medical assistant.

■ The physician sees about 16 patients per day and spends about 30 minutes with each one.

Our practice charges patients an additional cost-based fee for lab tests but pays the lab company directly for the tests. We don't have to be concerned about rejected claims due to incorrect or mismatched ICD-9 and CPT codes. Lab companies are willing to negotiate lower lab rates with me because their payment from us is guaranteed, and they realize savings from not billing patients or insurance companies. Discounts may be as much as 50 percent to 90 percent off list price, meaning that a prostate-specific antigen (PSA) test has cost me as little as \$4. Other tests have cost even less. Most patients pay an average of \$25 for lab tests that would have cost more than \$100 if the lab company billed the patient or the insurance company directly.

■ The practice's relatively low overhead is a big reason it can break even after seeing four patients per day.

Our charges, including any lab work, are itemized on a sign in the waiting room. The transparency of our pricing allows patients to anticipate what they will owe and helps uninsured patients to plan ahead so they'll be prepared to pay at the time of service.

■ The practice itemizes its charges, including any lab work, on a sign in the waiting room.

When we opened the practice, we anticipated that about 90 percent of our patients would be uninsured. However, as people heard about our ease of scheduling and longer

■ The practice's founder expected most of its patients to be uninsured, but the majority turned out to be people who submit their own insurance for reimbursement.

office visits, patients who could submit their own insurance and be reimbursed began to fill the practice. These patients now represent the majority (about 65 percent) of the practice.

In many cases, their out-of-pocket costs aren't much higher, if at all, when they see us instead of a health plan provider. Our \$45 office visit costs less than some urgent care and office visit co-pays. Some insured patients see us and don't bother with submitting a claim to their health plan; those who do typically receive reimbursement less any out-of-network co-pay and co-insurance amounts.

Better access. Our practice uses modified open-access scheduling, which we find beneficial for several reasons. It cuts lost productivity and lost revenue from patients who don't keep their appointments. It also increases the practice's revenue by attracting patients who might otherwise go to urgent care or to the emergency department for non-emergent care. Patients appreciate being able to see their primary care provider on a same-day basis, especially when going to an urgent care or emergency department can be much more costly for them. Our accessibility increases patient satisfaction and loyalty. Many patients who need brief encoun-

KEEPING OVERHEAD LOW

The average patient at Access Healthcare spends \$82 per visit – \$45 for the visit and \$37 for lab and supply charges. If the practice sees four patients per day (\$328) during its 245 clinic days per year, it takes in \$80,360 for the year. As a result, four patient visits a day cover its annual overhead (detailed below) of \$78,400.

It is important to note that Dr. Forrest owns the building in which he practices and rents a portion of the space to two other providers. The rental income covers the mortgage payment for the entire space and nets \$300 a month in additional revenue, which offsets the overhead expenses listed below.

The employment costs associated with Access Healthcare's nurse practitioner are not included in the breakdown below. She is paid based on productivity, and her associated costs are paid out of the revenue she generates by seeing patients that the doctor would normally not have time to see.

Annual overhead	
Medical assistant salary/benefits/expenses (36 hours/week)	\$31,500
Charges for tests performed by outside lab	22,500
Malpractice insurance/practice contents insurance	10,500
Medical supplies (splints, dressings, suture sets, injectables, etc.)	9,500
Utilities (phone, electric, water, trash pickup, sharps disposal, etc.)	5,250
Profit from rental income	(3,600)
Miscellaneous (office supplies, credit card processing, Internet, etc.)	2,750
	\$78,400

For our uninsured patients, the lower price we offer compared to an office that accepts insurance is appealing.

ters such as flu shots and blood draws appreciate seeing the physician and having minimal wait times for these services.

My schedule is filled with eight to 10 patients a day for appointments, and the rest of the slots are for same-day call-in or walk-in patients, who may also fill the slots of patients who didn't keep their appointments. This arrangement allows me to treat about 16 patients per day. Our nurse practitioner usually sees another 10 patients per day. Our lighter-than-average patient load contributes to a less hectic office, which makes it easier to maintain privacy, cuts risk exposure for medical mistakes and malpractice, and allows time for adequate documentation during the workday rather than at the end.

We also do house calls, which we find to be a joyful way to practice medicine. We charge \$150 for what is typically a one- to two-hour visit. House calls are much appreciated by homebound patients who are unable to get other physicians to come out to their house.

Scope of practice. We do not follow patients in the hospital for two reasons. First, the four major hospitals in our county all have hospitalists who do an excellent job of managing inpatients and discharging them back to us for follow-up. Second, inpatient work can be time-consuming and makes being on call much more difficult. However, if I did do inpatient care, I would still use a flat rate—probably \$45 per “round.” If the average census was four patients and I could round on them in an hour, then that would equal \$180 per hour, which is reasonable with no associated overhead.

We do most standard skin procedures like cryosurgery, biopsy and laceration repair. We do not do colposcopy or sigmoidoscopy. We do electrocardiograms (ECGs), peak flow monitoring, audiometry and spirometry. For all of these procedures, we charge a flat rate that is usually much less than what a typical office would charge. For instance,

we have charged \$20 for audiometry and \$75 for ECGs.

No Medicare billing. Our practice has never taken Medicare. As an “opted-out” practice, we can treat Medicare patients as long as they sign a contract with us stating that no charges incurred at Access Healthcare can be billed by the practice or by the patient to Medicare. On the other hand, outside services such as consults, durable medical equipment and hospitalizations recommended by an opted-out physician like myself may be billed to Medicare.

The outcomes

If patient demand is an indication of satisfaction, then patients are very satisfied with our model of care. Our practice averaged 15 new patients per week without advertising until I stopped accepting new patients about 18 months ago. However, our nurse practitioner is still accepting new patients, and so we continue to grow by about 10 patients per week.

For our insured patients, the value of increased access and longer visits outweighs the inconvenience of filing their own insurance claims. For our uninsured patients, the lower price we offer compared to an office that accepts insurance is appealing. And, for what it's worth, a local newspaper recently named me “best doctor” in the Triangle (Raleigh, Durham and Chapel Hill), based on reader polls.³

More than 95 percent of our patients (about 3,500 individuals) have retained Access Healthcare as their primary care provider during the past five years. Out of that group, there have been about 45 *reported* hospitalizations. We consider that a low number, given that many of our patients have multisystem diseases and 15 percent of our patients are older than 65. Because of the time spent with patients, we can ensure continuity and

■ The practice charges patients \$150 for house calls.

■ Dr. Forrest does not follow patients in the hospital but would likely use a flat rate of \$45 per “round” if he did.

■ The practice does most standard skin procedures but does not do colposcopy or sigmoidoscopy.

Our charges, including any lab work, are itemized on a sign in the waiting room.

adherence to current treatment guidelines. For example, in a recent chart audit of my practice by a medical student doing a fourth-year elective, it was discovered that our patients' average A1C was less than 7 percent. Their average LDL is under 100. Many of these patients arrived at our practice with numbers at least 50 percent higher than these.

Drawbacks

As with any model of health care, ours has some potential drawbacks. One is working with insured patients who need out-of-network referrals. This can be a hassle when services require prior approval from an in-network primary care provider. For some patients, the co-pay may be higher for an out-of-network provider or the coverage may be less, and this is the biggest reason for patient attrition, though attrition has been very low.

A second challenge is trying to absorb staff turnover or illness with a small staff. We have addressed this by having many well-trained volunteers available to step in when needed. These volunteers are usually pre-med students from local universities who want to gain experience in a clinical setting. Typically we have two to three students per semester volunteering who can stand in if needed.

■ The practice is "opted out" of Medicare.

■ The practice averaged 15 new patients per week without advertising until Dr. Forrest stopped accepting new patients about 18 months ago.

■ One drawback to the Access Healthcare model is the hassles involved when working with insured patients who need out-of-network referrals.

The future

Access Healthcare has been fiscally sound from day one. All start-up costs were covered with savings that I accumulated for nine months (working locum tenens and urgent care shifts) before opening the practice.

After talking to colleagues around the country about expanding our model to other practices, we made it official on April 15 when we opened a SEED practice (Symbiotic Expansion Entity Development) in Chapel Hill. I act as a consultant for this practice, setting up and supporting my business model and negotiating their lab and supply costs. In exchange, I receive a small percentage of their gross revenue. I am in negotiations with several physicians to open more of these practices in the Southeast in the near future.

Low overhead, cash-only, open-access practices are viable and can actually surpass the profitability and lifestyle offered by traditional practices. They can also save the health care system money and could be one of the solutions to skyrocketing medical costs and climbing insurance premiums. Patients benefit, too, from shorter waits and longer visits with the doctor. I hope that other physicians will adopt innovative practice models to improve their satisfaction, bottom line and, most of all, patient care in the coming years. **FPM**

SUGGESTED READING

For more information on some of the concepts covered in this article, see the following:

"2,500 Cash-Paying Patients and Growing." Backer LA. *FPM*. February 2006:64.

"Access Healthcare: A Model to Provide Improved Access to High-Quality and Affordable Healthcare." Forrest BR. *North Carolina Medical Journal*. May/June 2005:208-211.

"How Many Staff Members Do You Need?" Reeves CS. *FPM*. September 2002:45-49.

"Four Steps for Improving Efficiency and Cash Flow." Guira PA. *FPM*. October 1999:14-15.

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1. Arnow FM. Acceptable overhead. *Fam Pract Manag*. November/December 2002:78.
2. *Cost Survey for Single-Specialty Practices: 2006 Report Based on 2005 Data*. Englewood, Colo: Medical Group Management Association; 2006.
3. Reader survey 2006: goods & services. *Independent Weekly*. Available at: <http://www.indyweek.com/gyrobase/Content?oid=oid%3A33238>. Accessed April 25, 2007.