Direct Primary Care

An old fresh approach to Primary Care
Trends and thoughts as of Sept 2014

• 53% are considering Direct Primary Care
• 35% are considering Concierge Medicine
• 4.4% entering Accountable Care Organization (ACO)
• 3.9% plan on becoming Patient Centered Medical Home (PCMH)
• 4% plan to become a hospital employee
What keeps a Family Practice physician up at night?

- Medicare and RAC audits
- Concern and confusion about the ACO implications
- Can I stay independent?
- Viability of practice
- ICD-10 cost and paperwork
- Medicare and medicaid payments
- And on and on!
Traditional Practice

- Low collections - average in US is 65%
- Overhead average for primary care about 60%
- 2 DNKA per day is a loss of about $25000 per year
- For $100 charged in traditional model you get about $26

- DPC model about $81
Why change?

- Low quality outcomes despite increasing cost of care
- Declining workforce in Primary Care
- Declining pay per patient seen
- Increasing Overhead in practices
- Increasing paperwork and bureaucracy related to government and insurance changes
- ETC........
ACA

- Theoretically incentivizes primary care?
- Models such as ACO and PCMH are supposed to help?
- More people are insured but many have higher and higher deductibles
- Section 1301 A3 of the ACA endorses Direct Primary Care Medical Home (D-PCMH) as a qualified plan!
What is being tried in the market

- ACO’s shared savings (while it lasts)
- PCMH- blended payment + E/M and CC fees
- Macro practice- very high volume team based care
- Clinically integrated networks (getting big)
More things being tried

• Micro practice
• Direct Primary Care
• Concierge
• House call/ Skilled Facility only
• Corporate onsite
ACO’s

- **Pro**  Financial incentives aligned for costs
- **Value based vs. Volume based care**

- **Con**  decreased shared savings like the “Limbo Bar”
- **Quality measures not consistently defined**
- **Can penalize appropriate care**
Micro practice

• Pro  Overhead vastly reduced allows more time with the patient

• Works very well in rural and low income areas

• Con  Less reserve if staff gets ill or turnover

• Physician must be willing to assume more roles
CIPN- getting big

- Clinically Integrated Physician Network
- Pro  Better negotiating power
- Smoother care transitions
- Economy of scale
- facilitates ACO
- Con  Can leave out the solo doctor that wishes to be independent
- May not work well in less populated areas
House call/ Nursing Home only

- Pro  no office overhead
- lowers patient volume
- can improve income in some cases
- helps non-ambulatory patients with access

- Con  Worsen workforce shortage / small panel size
Corporate clinic

- **Pro** helps prevent work absences
- **Convenient for patients**
- Encourages employer to be engaged in wellness
- **Lowers overhead  no need to file claims**
- **Con** Possible loss of confidentiality
- **Restricted Provider choice**
PCMH

- Pro  Modernizes practices
- Encourages systems based improvement
- Optimizes Care Coordination

- Con  Transitions costly with increased overhead
- Needs payment reform not financially viable. (reimbursement to overhead ratio not improved)
Concierge

- **Pro**  More time with patients
-  Better Quality
-  Improved outcomes in some cases
-  Better access (for panel) due to lower volume
- **Con**  Worsen workforce shortages/ small panel
-  Not accessible to most patients due to cost
DPC

• Direct Primary Care
• Pro  Significantly lower out of pocket cost for most
• Quality improved due to more time with patient
• Value based instead of volume based

• Pro  Major transition/ disruptive
• Recruiting patient panel ( copay culture,
• addiction to insurance)
Concierge and DPC - Similar but different

- Both improve quality of care for the patient, while also improving the physician’s experience and pay
- Concierge shrinks the panel size severely
- DPC improves access for the low income and the uninsured whereas Concierge worsens
- Workforce is improved instead of compromised with DPC
Differences

• DPC is generally affordable for the average person (GMC vs. Ferrari)
• DPC can be successful in rural and lower income areas
• DPC can lower out of pocket costs and downstream costs
• DPC panel size is optimal
What your colleagues will say

ARE YOU @#%^&(*&! CRAZY!!!!!!!

IT WILL NEVER WORK

YOU WON’T BE ABLE TO AFFORD TO STAY IN PRACTICE

WE/I, WILL RUN YOU OUT OF PRACTICE
DPC MATH

- Traditional $1.00
- $1.00 x .65
- $1.00 x .99
- ______________ x ____________
- $ .65 $ .99
- $ .65 - 60%
- $ .99 - 18%
- ______________ x ____________
- $ .26 $ .81
Overhead

• was 60%

• Now 18%
Summary of the DPC Model

- Lower patient charges improved access for the underinsured or uninsured
- Higher collection rate 99% and lower overhead anywhere from 15-22% in most DPC’s
- More time with the patient, less volume even with similar panel size
- No insurance contracts, insurance is not filed
Summary of DPC Model (cont.)

- LOWER STRESS/ lower risks and exposure, Decreased medical mistakes
- Allows better familiarity and stronger patient to doctor relationship and decreases risk
- Allows time to coordinate ALL aspects of patient’s care, thus you truly become the patient’s MEDICAL HOME
Affordable Care

- Medical Home Member pt is charged an affordable fee per month and a nominal fee per visit, most labs are included.

- Patients that rarely come in and only for acute complaints are NOT forced to become members and pay as you go from an al carte menu that is in the waiting room.
DPC

- Just the patient and doctor in the exam room.
- No insurance company present
- No government agency present
Income Expectations

- FP with a patient panel of 1200 and a visit volume of 16 patients per day maximum, income can be similar to most internal medicine subspecialties and often better than General Surgery.

- If you are located in an area that is economically depressed and you create a fee schedule that is reduced by another 50%. This will often allow you an income of 50% greater than the average FP.
Questions?
Where to learn more

Forrest, B.R. Physician 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. “Cash for Doctors” 5/23/10

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


Forrest B.R Family Practice Management June 2007 “Breaking even on 4 patients per Day.”


