Annual Leadership Forum Plenary

What's All the Buzz About Direct Primary Care?

May 06, 2014 08:45 pm Sheri Porter (mailto:aafpnews@aafp.org) Kansas City, Mo. – How does a plenary speaker keep his family physician audience totally engaged and yearning for more discussion late on a Friday afternoon -- especially after a 75-minute presentation that includes a slide show packed with statistics?

The answer is simple. Enthrall that audience with details about direct primary care (DPC), a practice model that is sweeping the nation and re-energizing physicians and their patients.

Brian Forrest, M.D., tells attendees at his presentation on direct primary care that the model initially appealed to him, in part, because he wanted to spend more time with patients.

Presented as part of the AAFP's 2014 Annual Leadership Forum (ALF) held here May 1-3, last Friday's session, titled "Hope for Independent Family Physicians -- How a Direct Care Model Can Allow Small Practices to Thrive," did just that.

Plenary speaker and family physician Brian Forrest, M.D., opened his DPC practice, Access Healthcare, (http://www.accesshealthcaredirect.com) 12 years ago, in Apex, N.C., to a chorus of negative comments from well-meaning colleagues. They insisted that Forrest was crazy and jeopardizing his business.

Fast forward to 2014, and it's clear those naysayers were wrong. Access Healthcare not only thrived, it now facilitates a network of clinics in 16 states.

STORY HIGHLIGHTS

- FP Brian Forrest, M.D., opened Access Healthcare, a direct primary care practice, in Apex, N.C., in 2002.
- The direct primary care (http://www.aafp.org/practice-management/payment/dpc.html) (DPC) model offers accessible and affordable health care to patients in all socioeconomic groups.
- Physicians in a DPC practice typically operate with low overhead because they don't take insurance, charge patients a monthly fee for unfettered access, and reduce their patient volume even as income increases.

Defining Direct Primary Care

So what's all the buzz about DPC? In his opening statement, Forrest clarified that he wasn't giving a presentation on concierge medicine, a model of care associated with high-cost membership practices that often target wealthy Americans and cater to business executives with deep pockets.

Instead, direct primary care offers accessible and affordable health care services to patients in all socioeconomic groups by charging reasonable fees that are paid directly by patients or their employers.

Importantly, insurance companies are not a part of this picture. "In 13 years, I've never taken a single dollar from an insurance company," Forrest told his audience.

Keep in mind, it's the absence of insurance hassles -- and the necessary army of staff members needed to deal with those daily eruptions -- that help practices achieve huge decreases in their overhead expenses. That's what enables physicians in DPC practices to keep their patient panel sizes reasonable and their prices affordable.

Physicians in traditional practice models envy Forrest's daily patient volume. "I see about 12 patients a day; 16 is the max," he said. Furthermore, DPC allows him to offer "high-quality, equal-access care for everyone."

Forrest recounted for his audience what he called "the most powerful and rewarding moment" he'd ever experienced in his practice.

"I looked out the (inner office) glass window one day, and sitting in the waiting room was this guy (a photo of a disheveled patient appeared on the screen at the front of the room), and sitting next to him was a multimillionaire.

"In an instant, I realized I had fulfilled my dream," said Forrest.

To those critics who argue that Forrest is cutting out patients without insurance, he pointed out that uninsured patients make up about 35 percent of his Access Healthcare patient base. He said his fastest-growing patient segment -- currently at about 22 percent -- is Medicare patients.

In a nutshell, the DPC model offers physicians and their patients a multitude of benefits, including

- substantial patient savings,
- improved practice collections rates,
- decreased practice overhead,
- reduced patient volume,
- more time with patients,
- zero insurance filing,
- less stress and
- fewer medical errors that mean less risk exposure for the physician.

Family physicians who heard Brian Forrest, M.D., speak about the direct primary care model approach him afterward with more questions.

As for Forrest, he said DPC has allowed him to earn a better income with "fewer bureaucratic hassles and a less stressful work day."

He put a new spin on the familiar adage that physicians who aren't at the policy discussion table would instead be on the menu. "We're sick of standing at the edge of the table waiting for crumbs to fall off ," said Forrest.

The DPC movement is not about the kind of slow, steady incremental change that policymakers favor, change that takes years to make a difference for physicians and their patients who need good affordable health care today, he said. The direct primary care model is decidedly different.

"This is radical, in-your-face, 'we-fixed it' change," said Forrest.

AAFP Gets in the DPC Game

So, what's the AAFP's take on the DPC model?

Well, in 2013, the Academy issued its first-ever DPC policy statement (http://www.aafp.org/about/policies/all/direct-primary.html) . And currently, the Academy is scheduling a series of regional workshops aimed at giving family physicians all the information they need to know before they make decisions about transitioning to the DPC model of care. Interested physicians should mark their calendars for

- November 2014 in Phoenix,
- January 2015 in Wilmington, Del., and
- February 2015 in Atlanta.

More information about these events will be available soon.

Forrest noted that the invitation he received to speak at the AAFP's 2014 ALF -- an invitation that included two additional sessions on Saturday morning -- illustrated that direct primary care is a hot topic.

"I'm here today, so the AAFP at least thinks this is worth talking about," said Forrest. "This is good for family docs. You need to go back and tell doctors in your state that there is hope," he added.

Related *AAFP News* Coverage

Family Physicians, Patients, Embrace Direct Primary Care (http://www.aafp.org/news/practice-professional-issues/20130514dpcmodel.html)

AAFP Recognizes Benefits, Creates DPC Policy (http://www.aafp.org/news/practice-professional-issues/20130514dpcmodel.html) (5/14/2013)

More From AAFP

FAQ on Direct Primary Care (http://www.aafp.org/practice-management/payment/dpc/faq.html)

REGISTER NOW FOR DIRECT PRIMARY CARE SUMMIT 2014

Attend the Direct Primary Care Summit 2014 (http://www.fmec.net/dpc.htm) on June 20-21 at the Sheraton Pentagon City Hotel in Arlington, Va., and learn more about this unique practice model.

Spend some time with physicians already successfully engaged in direct primary care (DPC), colleagues who are interested in adopting the DPC model, and national leaders and stakeholders interested in learning how DPC works for physicians and for patients. The AAFP is one of a number of sponsoring organizations.

Registration for the summit is now open (http://events.r20.constantcontact.com/register/oeidk=a07e8x25x8gadc2ba93&llr=roclcdfab), and AAFP members can save $45 on registration by using the AAFP discount code **AAFPDPC2014**. Students and residents are welcome, and their registration fees already are deeply discounted.

17 Comments

Add a Comment

MARK FOWLER

5/8/2014 11:03 AM

This may or may not be the wave of the future, but is worth a look. As a physician now in my Mid -50's I find I spend too much time on paperwork., fighting denials, fighting with balky EHR systems, and listening to "motivational managers" who have no idea what they are talking about.

I got into this to practice medicine and take care of people, not push paper, or play with computers. And, I find it disheartening to see my colleagues go hat in hand to beg Congress (and make a donation to their campaign coffers) for a decent reimbursement. I find there is very little the government can do as well as independent free American can do on their own.

Its time we sharply limited government involvement in our most noble of callings. Its time we returned to our calling, honored our oath and invited the government out the door to let us do what we were trained to do. After all, doctors provided care to the population long before the government sought to solve the problem.

SANFORD BROWN

5/8/2014 11:07 AM

The AAFP can't seem to get it right when it comes to endorsing practice models for the independent practitioner. A few years ago they touted the "micro practice" wherein physicians rent backspaces from other doctors and function as primary care provider and office manager at the same time. Does anyone do that anymore? Now they're sponsoring a concierge-light model, in which doctors don't bill insurance companies but are paid directly by their patients and are allowed to take retainer fees.

Now I've been in solo practice for almost 40 years and I've always billed insurance companies because, as Willie Sutton famously said, "That's where the money is." I have never had any hassles. Furthermore, patients expect you to bill their insurances because that's what they're paying premiums for. In a sense, they're paying twice for the same service. Hardly fair.

It saddens me that the AAFP is actually giving workshops on how to implement this model instead of showing doctors how to bill insurances and reduce practice overhead so that independent practitioners can thrive. Now that would be something to get buzzed about.

ANTHONY UBERTI

5/8/2014 1:31 PM

Sounds interesting but what happens when you need to check labs, Xrays? If the patients don't have insurance or you don't participate in the insurances how do you get these tests approved? There are very few people that can afford to pay out of pocket.

OLEG REZNIK

5/8/2014 3:00 PM

Interesting model, even if imperfect, it is good that we are exploring options outside of the insurance driven "meaningful use" and "PCMH" that were well intended but often end up driving the meaning, patient centeredness, as well as patient and physician satisfaction out of medical practices.

MICHAEL WULFERS

5/8/2014 7:20 PM

I'm a family physician with 30 years of experience who just recently, April 1, transitioned to a direct care practice model.

I would like to respond to Dr. Brown's comments.

Even though I see patients without insurance, I encourage my patients to have a high deductible, catastrophic plan. It is even better if they combine this with a health savings account. My monthly fee can be paid out of the health savings account.

Other patients adjust their insurance by switching from a high-priced "Cadillac" plan to a base option which still offers good catastrophic coverage. Most of these patients actually save money because what they save from their lower premium more than pays for the monthly fee to my practice.

Additionally, my practice offers labs through Quest Laboratories at wholesale prices (for example, a lipid profile costs $4.75), and we dispense generic medicines at cost. When you eliminate the middleman, you can decrease costs substantially.

Let me know if you have any other questions.

KIN SNYDER, MD

5/9/2014 8:20 AM

Good article on an alternative to the current direction AAFP is pushing. If the region will support the DPC model it is much more efficient than the PCMH or collaborative care model that depends on meagre insurance payments and denials. In fact, the DPC model is the traditional method of primary care anywhere. KISS applies in medicine just like in any other endeavour. The complexity in the current system is what has removed the enjoyment from practicing medicine and destroyed the traditional doctor/patient relationship.

SANFORD BROWN

5/9/2014 11:38 AM

I'm curious as to what you charge monthly for your fee? Do you then not charge your patients for office visits?

The problem going from a Cadillac plan to a catastrophic one isn't just the high deductible; it's that none of the ancillary out-patient services are covered, so that unless you can also offer patients low cost radiology procedures and PT and OT and referrals to specialists, they're really not likely to come out ahead.

GARRY STEWART

5/9/2014 2:09 PM

Please note that the 2009 IRS Chairman's Mark mandates that Tax Exempt (they almost all are) Hospitals cannot charge indigent patient's (usually 200% of federal poverty level) greater than Medicare rates or the average of three third party rates (Medicare plus 10%). With this in mind it truly changes the affordability of health care. No one seems to push this fact but it should be the economic back bone that drives the cost of health care. Most people would be delighted to be charged Medicare rates for out of pocket health care.

MICHAEL WULFERS

5/9/2014 6:27 PM

I charge anywhere from $40-$79 per month depending on age. With one adult membership, each child 18 years age and younger is $10 per month.

This fee covers everything I do it in the office. It also covers minor laboratory procedures such as rapid strep test, urinalysis, KOH preps, glucose, EKG, etc.

It also covers hospitalization. So, for example, if a patient is admitted to the hospital and I see them for five days for pneumonia, there is no extra charge.

I don't know about the insurance in your area, but most of our insurance policies base plans still cover testing. It is just that there is a higher deductible, and higher office co-pays. Obviously, under my system there is no co-pay anyway.

If you would like more details about my particular type of direct care practice, please go to my website at www.independentmd.net.

MICHAEL WULFERS

5/9/2014 6:35 PM

I would also like to add that, in my opinion, the reason that healthcare costs are so catastrophically expensive in the United States is that we do not have true insurance. Health care "insurance" is actually just a prepaid medical care plan. There's no incentive for either the patient to seek out lower-cost care, or for the provider to provide lower-cost care. The patient wants to "get their money's worth" and, under the present system, I don't blame them.

If automobile insurance was designed like health insurance, and we paid for oil changes, routine maintenance, and gasoline out of our "insurance", driving an automobile would be as expensive as healthcare. We need to introduce market forces into medicine. Then the cost of care truly will come down. The truly indigent can be provided for by charity care, or by greatly shrunken government programs.

DENISE PUNGER

5/11/2014 5:17 AM

The daily volume sounds good. How many patients weekly, average?

R NICEWANDER

5/11/2014 12:47 PM

I can not see where much "charity work" could be possible under a DCP, plus it seems to me that such a practice must enroll a large percent healthy patients, AND offer patients lower fees for meeting certain health parameters, mainly weight and non-smoking.

Hospital visits take time and energy, I cannot imagine anyone not charging extra, unless the practice is next door, or a courtesy visit.

MICHAEL WULFERS

5/11/2014 7:25 PM

I have only been doing direct care for six weeks. I suspect that my average patient load per day will be about 10 or 12 when I reach my goal of 500-600 enrolled. I'm now at 300. However, this does not include the multiple contacts with patients by phone, email, text messaging, FaceTime, etc.

The reason I can offer these reasonable prices and see patients in the hospital for no extra charge (I charge $50 extra for a house call) is because of the significant reduction in overhead seen when you don't have to deal with insurance companies, "meaningless use," etc.

The average family physician has anywhere from 5 to 7 staff supporting him. I will have one LPN, my wife as a manager/part-time receptionist, and myself.

SANFORD BROWN

5/12/2014 8:30 AM

I must bring down the average because I only have one support staff in my office. She is my receptionist, biller, medical assistant, procurer of preauthorizations, maker of specialist referrals, supply orderer and overall manager. Perhaps if I needed 5-7 people to do her job, I might be more interested in your model.

MICHAEL OPPENHEIM

5/15/2014 9:57 AM

1) When I hear concierge physicians praise a cash-only practice to the general public, I hear about the deep satisfaction they obtain from spending vast amounts of time delivering superb medical care to a grateful clientele. When I hear them around the lunch table with only doctors present, I only hear about the money.

BRIAN CROWNOVER

5/17/2014 10:02 AM

DPC = health care user (patient) paying health care supplier (FM doc) directly without the middleman (insurer) taking a huge, nonvalued added cut.

Besides the HSA acct idea, presenting a wrap around TRUE insurance policy is critical for DPC to gain traction. This is where our opinion leaders come in to help pull third party payers to the table to offer low cost policies that only cover "other than primary care" needs -- ED, hosp, subspec visits. We can partner with hungry lab and rads companies for heavily discounted cash prices; they bill the physician and we pass along our professional cash rates to our patients. This way pts see up front how much the lab or MRI will cost and they get a rate better than they can find anywhere else.

PERRY WILLIAMS

5/17/2014 6:39 PM

So Michael, docs should just continue spending their time doing inane government and insurance required tasks, provide borderline patient care because they're too busy with all that other junk, go home tired and burned out every night, and... make less money to boot?

This type of practice seems much less exclusive than the typical concierge practice. I say if you can do it and do it right and have happy patients and docs, go for it.

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http://www.aafp.org/news/practice-professional-issues/20140506forrestdpctalk.html

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