

From the President

Direct Primary Care Summit

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When I attended the Direct Primary Care Summit on the weekend of July 13-15, 2018, in Indianapolis, Indiana, a vendor told me that HMOs are dead. Patients now have high deductibles, high copays, and very costly insurance. They are having difficulty getting necessary care despite their high premiums.

Enter the main subject: Direct Primary Care (DPC). For a fixed monthly fee, patients and families are able to get reliable, high-quality primary care. Patients are still advised to maintain coverage with health/medical insurance.

The American Academy of Family Physicians (AAFP) sponsors this annual event, attended this year by more than 200 physicians. Palpable energy filled the lecture hall. An adjoining room was ringed by vendors who promised important services to DPC practices, including assistance in setting up a DPC practice, electronic records, and generic drug suppliers. Marley Drug will supply 16 commonly used generic drugs, each for \$70 per year.

The first speaker was Jeffry Gold, M.D., who asked: why are we here? Is it burnout, disgust, unhappiness, lack of control, or all of the above? Are you tired of coding, MACRA MIPS (Medicare Access and CHIP Reauthorization Act Merit-Based Incentive Payment System), and administrators? He blamed our problems on fee for service. After his talk, I spoke with him and suggested that it is insurance bureaucracy, not fee for service that is causing frustration. Fee for service should be simple and straightforward. He seemed to agree with that.

Brian Forrest, M.D., of Access Healthcare Direct and Emilie Scott, M.D., of Halcyon Direct Primary Care in Orange County, California, spoke about starting out in a DPC practice. They provided the kind of advice we have not heard for many years. They made a number of recommendations to consider:

(1) Develop an additional source of income if possible. (2) Try to recruit DPC patients from your existing practice if you have one. (3) Keep your overhead low, instead of taking out a huge loan. The practices that fail tend to have mahogany paneling and marble countertops. You can back a U-Haul truck up to the hospital surplus warehouse to obtain exam tables and other valuable start-up equipment. You really do not need more than two exam rooms. In purchasing equipment, the litmus test should be: will spending this money improve patient care? (4) Own your own office space. Dr. Forrest recommends buying twice as much space as you really need and renting out the other half. Owning an office creates an automatic retirement account. (5) Choose your location carefully. Dr. Forrest recommends locating near a pharmacy such as Walgreens or CVS. They have already done expensive research on where to locate. Try not to practice in isolation. If the physician next door is too busy to see a patient or is closed, the patient may be referred to your office. (6) Keep your collection rate up. A 99 percent collection rate is achievable in DPC. Beware of membership gaps, as occur when the patient does not renew on December 31 and waits to renew at the time of the next visit in March. If you allow that, then you just cut your membership fee by 25 percent. Dr. Forrest uses Twin Oaks, which specializes in gym memberships, but this system of processing monthly memberships also works for DPC. (7) Do not take the electronic medical record (EMR) into

the examination room with you. Patients have become frustrated with doctors checking boxes. It is best to step out of the room to do any electronic data entry, then come back in a few minutes and ask: "Is there anything else I can do for you?" (8) Do not add on fees for procedures such as irrigating ears, which are included in the membership fee. Dr. Forrest's practice includes house calls. (9) While flexibility is an advantage—a DPC practice should be able to change a price the same day and update policies as needed, membership fees should not be increased as long as a patient is paying them.

Dr. Forrest stated that DPC practices should exceed expectations and provide the best medical experience a patient ever had.

If a physician leaves a hospital system to open a DPC practice, a non-compete clause might not apply, in Dr. Forrest's opinion, because the physician is selling memberships, not competing to collect fees for "evaluation and management" office visits.

Marketing is crucial. A marketing campaign can be free, said Dr. Forrest. Doctors should try to get interviewed on a local radio station. The best advertising is word of mouth from satisfied patients. Paid print ads do not work. The yellow pages are obsolete. Dr. Scott used a review page through YELP to promote her DPC practice. Patients have a much more positive experience in DPC, so good patient reviews are likely. Patients need to know that claims will not be sent in to the government or insurance companies, and doctors can market the increased privacy that is inherent in DPC. One idea that was suggested is going to minor league baseball games and passing out business cards.

Julie Gunther, M.D., founder of SparkMD in Boise, Idaho, and Dr. Delicia Haynes spoke about the importance of setting boundaries. DPC can attract overutilizers, so the doctor cannot be looked upon as the patient's best friend. Failure to do so can result in resentment, anger, and burnout. Do not give the patients the idea that they can call any time. Dr. Haynes advised against texting. She described DPC as a different business model, and part of an effort to regain autonomy. Several years ago, I spoke about the importance of physician autonomy at the Wisconsin Academy of Family Physicians. I was told that today's physicians want to be part of something bigger and that autonomy is an archaic concept. It was good to hear a physician talking about autonomy in a positive way.

Patients who are mean or threatening, or who do not pay their bill should be terminated. Sending patients to collections is just not worth the hassle.

Some Democrats are opposed to Health Savings Accounts (HSAs) and to DPC, because they believe that DPC is for the wealthy and the young. In fact, DPC is intended for working people. It does not work as well in affluent areas where the people tend to have "Cadillac" insurance coverage. Concierge care is for the wealthy who want better access to a doctor; it may also bill insurance, whereas DPC does not. Worrying about how many boxes to check to get to a 99214-level visit should never happen in DPC.

The IRS has ruled that HSAs cannot be used for to pay for DPC. The Primary Care Enhancement Act (H.R. 365) sought to establish a

rightful use of HSAs to fund DPC. However, the politicians claimed that the Treasury would lose \$1.8 billion due to tax deductions, so a \$150 cap on the monthly DPC fee was proposed. Other purportedly minor changes made in the House Ways and Means Committee would have restricted services to certain CPT codes, a disappointment because one of the attractions of DPC is to avoid the evils of coding.

Primary physicians should call specialists for advice. Under DPC, physicians hopefully would have more time available for telephone consultation. Another resource is RubiconMD.com, where a physician can obtain an electronic curbside consult.

Under DPC it is permissible to charge for supplies, although the visit itself is included under the monthly fee. For example, for a laceration repair \$30 worth of supplies can be billed to the patient.

Since most hospitals now employ hospitalists, DPC doctors might not take care of patients in the hospital but might consider making social visits.

One presentation discussed a list of items that must be addressed in setting up a new DPC practice. One recommendation was to take a phlebotomy class at a tech school to brush up on blood-drawing skills. A complete DPC manual (or individual chapters), *Manual of Policies and Procedures for Direct Primary Care* by Dr. Kimberly Legg Corba, can be purchased from Green Hills Direct. The cost for the entire manual is \$610 and it can be downloaded from <https://dpcmanual.com>.

Josh Umbehr, M.D., from Wichita, Kansas, a pioneer in DPC, who has helped more than 500 doctors in 41 states to get started in DPC, answered questions. He referred to a hybrid practice, where only a part of the practice is DPC, as a “rabbit stew” in which there is some horse meat. Unfortunately, that might mean one horse to one rabbit. His website is <https://atlas.md/wichita>.

The insights that he shared include: (1) A niche practice is possible but will grow more slowly. It may be advisable to do full-scope family medicine as you build a niche practice. (2) Start on a shoestring and a stethoscope. Equipment may be purchased on E-bay. (3) It may help to join the Rotary Club and the chamber of commerce. (4) A small business loan may aid in start-up. (5) A billboard may be effective.

Dr. Josh told me that if Congress wants to make DPC more readily available, a bill would need only two sentences, stating that HSA funds could be used for DPC membership. That is all it would take to establish that HSAs can be used to fund DPC.

Philip Eskew, M.D., J.D., M.B.A., spoke about legal issues. He said that DPC is legal in every state. Twenty-nine states now have a law that provides that DPC is not insurance. Some points to remember about a DPC arrangement: (1) Enrollment fees should not be refundable. (2) Third parties should not be billed on a fee-for-service basis, as this could be considered double dipping. (3) Risk can be reduced by limiting panel size; detailing the scope of the practice; requiring an annual visit; and having individual contracts, signed by both parties, stating that DPC is not insurance. (4) Any per-visit fee should be less than the monthly fee. (5) DPC practices should avoid using language that sounds like insurance, such as the word “coverage.”

Dr. Eskew asks: is DPC just capitation all over again? The way to avoid that perception is to bring out the best in DPC.

Concerning third-party arrangements that patients may have, Dr. Eskew noted: (1) There is legal precedent that physicians may charge for doing a prior authorization (*Gary Gibson, M.D., v. Medco Health Solutions*). (2) Physicians who opt out of Medicare and do not take Medicaid are not subject to the False Claims Act. (3) Physicians who opt out of Medicare cannot participate in Tricare.

Dr. Eskew suggested that a physician might consider working

in a correctional facility while trying to get a DPC practice off the ground because there are no confounding insurance issues or legal issues.

Dr. Eskew has created a website, www.dpcfrontier.com, to provide more information about DPC.

Risheet Patel of Fishers Direct Family Care spoke about the advantages of working with small employers. DPC can offer convenience and is a good employee benefit. It may help reduce absenteeism for small employers. For the DPC practice, working with employers brings in new patients. Joining the local chamber of commerce may help in engaging local employers.

Erica Bliss, M.D., sought to integrate DPC into the health care system and spoke about Qliance. In 2006, she lined up investors and marketed to individuals and small businesses. In 2017, Qliance was unable to get a small business loan and could not make payroll. It abruptly closed its doors, leaving 12,000 people without the “the best health care they ever had.” The Affordable Care Act contributed to its difficulties by putting the focus on insurance rather than on care. She said that Qliance was the first major casualty but there will be more. “Standing up for what is right can get you in trouble—your license can be put on the line,” she stated. “Revolutions are bloody. Those with power and money do not give them up willingly.”

Dr. Bliss then opened her own solo practice. “I cannot tell you how much that saved me.”

She stated that “starting up the DPC movement has been like tunneling through rock.” She cautioned against doctors fighting amongst each other, limiting each other, and taking down the ones who are sticking their necks out. That is exactly what our opponents would love to see. Dr. Bliss says that the DPC movement has “collectively started to expose the hypocrisy and corruption of the healthcare system.”

Brian Forrest, M.D., spoke about Access Health Care Direct, which is a network of DPC practices in 33 states. He said that the Transforming Clinical Practice Initiative has awarded \$843 million to 29 practice transformation networks. Access Health was one of those to receive a grant, with a task of transforming practices to a value-based DPC model. The goal is to make DPC one of the advanced/alternative payment models under MACRA. In his view, doctors can try to isolate themselves totally, but “value-based care” is here to stay. Being the type of DPC practice that contracts with employers would not be mandatory, according to his view of the future. He did caution that we do not want “to get roped into the same old grind again.” We can overcome the “Copay Culture with value: short wait times, same day appointments, no technology interference.”

Maura McLaughlin, M.D., of Blue Ridge Family Practice has a “micropractice.” She advises doctors to choose a name (check brand availability) and create a logo. Many micropractices have one employee, and some even have the doctor doing everything and find that manageable. One might use a local or national lab that provides a centrifuge and all needed supplies. Usually the lab will bill the doctor, who then bills the patient. Some states allow a price mark up. In-house drug dispensing is a great financial benefit to patients. Dr. McLaughlin also prints up GoodRx coupons while the patient is in the office. For X-rays and scans, physicians may be able to negotiate low prices with independent imaging centers.

Dr. McLaughlin discussed opting out of Medicare and recommended going to the AAPS website, www.aapsonline.org, for information and a model affidavit. She has ended insurance company contracts and spoke about how to do that. She stated that physicians should check state patient-abandonment laws, which may require 90 days’ lead time. She suggested providing patients

with a list of nearby clinics. Dr. McLaughlin's checklist of items to be covered in setting up a DPC practice, which is really applicable to any small practice, may be accessed at: www.dpcsummit.org/dam/AAFP/documents/events/dpc/StartLeanThinkBig.pdf.

Nicholas Tomsen, M.D., of Antioch Med in Wichita, Kansas, and Vance Lassey, M.D., of Holton, Kansas, recommend reclaiming full-scope practice, overcoming the forces that have led to the demise of family doctors who act like family doctors. Family doctors do not need to be midlevels, according to Dr. Lassey. Family physicians should learn to do joint injections, lesion removals, cryosurgery, hemorrhoid excision, casting, and minor surgical procedures. One can learn how to do a needle aponeurotomy for Dupuytren's contracture by viewing a YouTube video, Dr. Tomsen said. He recommended the book *Procedures for Primary Care* by John L. Pfenninger and Grant Fowler. Home sleep studies can be done for \$175, and a used auto CPAP (continuous positive airway pressure) device can be purchased for \$20. Dr. Tomsen and Dr. Lassey recommend doing in-hospital and even obstetrical care. "You know your patient better than the hospitalist, and you can do a better job," they said.

Hearing these enthusiastic doctors talk about full-spectrum primary care made me feel that I want to do this all over again.

Jeffrey Davenport, M.D., of One Focus Medical in Oklahoma reported that he spends about one hour at the patient's first visit. He reviews the medication list trying to find ways to simplify and to save the patient money. He informs the patients about the drugs that he dispenses at low cost. He also reviews the list of specialists and tries to determine whether the patient still needs to be under their care. As for the poor, he provides free care to about 10 percent of his practice. He calls it his tithing.

W. Ryan Neuhofer, D.O., has a DPC practice in an underserved area of Wichita. To make it affordable, the monthly fee is kept low (\$37).

Paul Thomas, M.D., of Plum Health in Detroit, Michigan, talked about leveraging social media in DPC. He showed images of websites. These generally included maps showing the office location. Sample web page headings are "About us," "We are here for you," and "Health is downtown." The site explains how DPC offers comprehensive services with upfront monthly membership pricing. It provides "hassle-free care when, where, and how its clients need it." Services include personalized prevention, nutrition, and exercise counseling, chronic disease management, and care for those occasional sick days. With its convenient location, it offers immediate physician access including walk-in, same-day, and next-day appointments, and 24/7 virtual access to a clinician. The website invites visitors to follow the practice on Facebook.

Joel Bessmer, M.D. represented Strada Health Care, an organization that seeks to work with employers. For Strada, data is "sort of a big deal." He recognized that many in the room were trying to get away from submitting data, but the employers who pay the DPC fees for their employees want data. Dr. Bessmer presented data showing that DPC practices have better results for cholesterol levels, weight loss, blood pressures, blood sugar, and inpatient admissions than other practice models. Through data mining, he stated, DPC practices will allow the governor to log into a computer and find the average blood pressure for state employees. I asked myself: why would the governor need to know this? Dr. Bessmer believes that DPC is a key to restoring interest in primary care, and that if we do not act fast, primary care will be owned by CVS and Walmart.

Jay Keese, a lobbyist instrumental in starting the DPC coalition, and Staci Brown, D.O., of Paradigm Family Health gave an advocacy briefing. They stated that DPC allows for a significant reduction in

administrative expenses because 90 percent of all care costs are completely outside of third-party billing. The payment model is simple: a monthly retainer. Employer claims data shows an overall reduction in the cost of care of up to 20 percent with DPC. Hospital admissions are down 37 percent.

Dr. Brown gave the following suggestions on communicating with your legislator: (1) A personal visit is best. (2) Use your own words. (3) Always share a personal story. (4) Do not take notes while you are with the legislator but write down notes as soon as you leave. (5) Get the staffer's card, and send a thank you note in which you reference why you were there. (6) Follow up frequently; an E-mail every week is about the right frequency. Note that postal letters to Congress are delayed by testing for dangerous agents. They go to Ohio first before Washington, D.C. (7) Be persistent, and timely. Be aware of pending legislation.

Conclusions

One of the speakers declared that the old guard at the AAFP has let us down. As a family physician, I agree with that assessment. A major initiative of the AAFP has been the Patient Centered Medical Home (PCMH). The PCMH revolves around electronic medical records, which are now recognized as a major contributor to burnout. Another feature of the PCMH is placing the physician in a supervisory role over midlevel providers. But it turns out that family doctors would rather take care of patients than manage nurse practitioners. I spoke with Alan Schwartzstein, M.D., speaker of the Congress of Delegates of the AAFP, who attended the Summit to assess family doctors' interest in DPC. He told me that the AAFP is now backing away from the medical home concept.

It is encouraging to know that there is a significant faction within the AAFP that shares the concerns of AAPS about where our profession has been heading. There is renewed interest in independence and autonomy. At the end of the meeting, I felt optimistic about the future of the practice of private medicine.

To be realistic, DPC does present difficulties. Many patients may not want to pay a monthly retainer. AAPS general counsel Andrew Schlafly commented that "DPC physicians are on very tight budgets.... [DPC] is essential to freedom in medicine, and we should continue to be a leader in it. But we can also be a leader in other segments that are equally important...such as out-of-network billing with respect to insurance companies or differentiating us from the AMA on key political issues."

AAPS Executive Director Jane Orient, M.D., said that "Some AAPS members are doing fine with old-fashioned fee for service. I prefer this. DPC seems little too much like an HMO to me." She added, "It is also disturbing that some are trying to get their model approved under MACRA."

What AAPS strives to do is to add value for all types of practices and specialties. Its efforts are crucial in the fight against the total government takeover of medicine. The American Academy of Family Physicians has shown that it will not help in that battle.

Resources

Slides and videos from the Direct Primary Care Summit can be viewed at: www.dpcsummit.org.

Free information and resources are available at: www.accesshealthcaredirect.com.

Send an email to accesshealthcaredirect@gmail.com to sign up for the newsletter and DPC updates.

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