DIRECT PRIMARY CARE: A NEW MODEL FOR PATIENTS AND PHYSICIANS

By Randy Robinson, M.D., and Mason Reiner

"Dear, how much were the groceries?"

An efficient, effective healthcare system is built upon an enduring relationship between patients and their primary care physician. CMS's Comprehensive Patient Care Initiative (CPCI) rightly states that risk stratified care, access and continuity, planned care for chronic conditions and preventive care, and coordination across the medical environment are the hallmarks of good primary care. Unnecessary healthcare expense in the US because of the inefficiencies in the system lead to over $910 billion in waste due to unnecessary services, excessive administrative costs, inefficient care delivery, missed prevention opportunities, fraud and inflated pricing (Don Berwick, *JAMA*. 2012; 307(14):1513-1516.)

To illustrate differently, if you were to buy a dozen eggs, a gallon of milk, and a small basket of oranges with pricing paralleling the growth of healthcare costs of the last 60 years, you would pay $237.(IOM)

Today's rapidly evolving and unsustainable healthcare climate is pushing us to look at healthcare differently. In many ways, we are experiencing 'the perfect storm' – new regulations, and more than ever, patients eager for better health care options.

One new model that directly addresses the concerns of access, quality, and affordability is the Direct Primary Care Medical Home. This is not patient-centered, nor is it physician centered. It is relationship centered. Care is delivered and pivots around the axis of an enduring relationship between the patient and his/her primary care physician. Direct Primary Care (DPC), as a retainer-based payment model, is not inherently anti-insurance. It simply strives to reposition insurance for what it is meant to do-pay for the unpredictable and the expensive. It places medical management where it belongs, between patient and physician. This model works to correct our current dysfunctional healthcare framework, which has positioned doctors as part of the business transaction and patients merely as consumers. DPC realigns healthcare delivery incentives away from fee-for-service (do more-earn more) at one end of the spectrum and still avoiding modified capitation such as the ACO model, at the other (do less-earn more). The focus is now health-based, relationship based.

A patient told us about a recent experience she had with her primary care practice when she received a call from her doctor's office weeks after getting a cholesterol screen to inform her about her high

cholesterol. The Medical assistant said to “cut out the fat.” Mind you, the patient is a mere 5 ft. 6 inches and weighs 110 lbs. Sadly, the assistant could not differentiate between HDL and LDL, nor did she ask questions about fasting, family history, etc. If there were a well communicated, bi-directional relationship in place the outcome would have more likely been “following up in six months” and delaying statin initiation.

With physician led care management, effective coordination across the healthcare system and an overall better health care experience for patients, the dream of the patient-centered medical home becomes an affordable reality for all.

The successful DPC model is built on several key building blocks.

Location, location, location. In today’s intense working environment where 85.8% of males and 66.5% of females work more than 40 hours per week, DPC addresses the burden of traveling for care. By locating near commercial centers, and integrating email, text messaging, and telemedicine capabilities into the practice, DPC can deliver convenient, time-efficient, high-quality care – a benefit for patients as well as employers.

When a hemoglobin A-1c lab test for a patient comes back grossly elevated, scheduling a 15-20 minute conversation about proactive diabetic management is a necessity. The only difference, utilizing DPC, the physician is in his or her office and the patient is at work as well as on a break. The vast majority of effective primary care is knowledge transfer, communication, and continuity. The physical point of service is no longer necessary for billing purposes.

Land of the free. Medical practices already spend $80,000 – $85,000 per physician in administrative interactions with health plans (Casalina LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, Levinson W. What does it cost physician practices to interact with health insurance plans? Health Aff. 2009;28(4):w533-w543 (July/Aug 2009). Free from bureaucratic burdens of insurance processing, coding, and collections, DPC physicians are able to focus on building enduring relationships with the patients, the key to cost-effective, comprehensive healthcare. The reduced cost and time burden allows physicians to see fewer patients and have more time to spend on care delivery. Thus allowing physicians the ability to coordinate, communicate, and advocate for patients instead of focusing on time-consuming processes and satisfying patient volume targets.

I got your back. Care coordination is key to keeping sick patients out of the hospital, decreasing medical redundancy and errors, and improving the health of the medically intensive patient. 74% of all healthcare

spending is attributed to four disease processes-diabetes, heart disease, obesity, cancer. The time and availability to "quarterback" patient's leads to decreased spending and improved health.

An ounce of prevention is worth a pound of cure. We live in a country where 50 to 70% of healthcare costs can be attributed to people's behaviors. The personal and coordinated care provided in the DPC model puts the primary care physician where they belong, in the middle of patient care. This vantage point is critical for physicians to look at the whole patient and address important lifestyle factors that are contributing to the patient's overall wellness. Practices around the country are collecting data to demonstrate that patients being treated in this model consume less advanced diagnostics, experience less errors in care redundancy, and less overall utilization of healthcare.

When a 30-year-old patient with a sprained ankle comes in to a DPC office, rather than asking questions and checking off boxes that raise a level I to level a II visit, speaking about his diet and whether or not he wears a bicycle helmet will have far more importance.

If the physician has time to do health risk assessments, rather than relying on a standalone corporate wellness plan, and discuss behavioral or medical changes, the employer gets what they paid for – not just the wellness plan, but *wellness*.

Win win win. In the DPC Medical Home, practicing medicine doesn't look that different than it did when you were a young boy or girl thinking about going into medicine. Medical graduates have a preservation of income, payors pay less for healthcare, and patients have a far more satisfying experience. These medical homes have the quality of concierge medicine, the accessibility of retail health clinics, and the cost reductive behavior of corporate health programs. It represents a major step towards the "triple aim" of care delivery goals.

The sum is greater than the parts. The sum of these attributes will ensure that this powerful approach will continue to rise to the forefront of today and tomorrow's healthcare landscape. DPC is well positioned as a positive driver for change as we all search for better ways to deliver health to individuals, communities, and America.

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