

# DPC Transitions

## – The Good, The Bad and The Ugly

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Participate in polling questions and submit your questions to <https://aafp4.cnf.io/>



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# Learning Objectives

At the end of this educational activity, participants should be better able to:

- Explore an example of how a fee-for-service practice can transition to DPC.
- Discuss how a multi-physician transition is different from a solo practitioner transition.





Which of the following is a key component to transitioning a group practice from a traditional fee for service model to DPC?

- a) Research and Understand the DPC Model
- b) Communication with your partners
- c) Communicate with your patients
- d) Know your finances
- e) All of the above
- f) None of the above

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***Live Content Slide***

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**Poll: Which of the following is a key component to transitioning a group practice from a traditional fee for service model to DPC?**



# Family Physicians of St. Joseph

## DIRECT PRIMARY CARE



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# Pre-Transition

- Our Practice
  - 2 NP's, 1 PA, 1 Office Manager, 2 RN's, 2 LPN's, 4 MA's, 2 Billers, 5 Receptionists
  - **Total Staff = 19**
  - 7700 Patient Panel
  - 30 years of service to a county of 154,000
  - Member and Leadership Role on PHO Board
  - Working Towards PCMH Certification
  - Renting Office Space



# Why Consider Direct Primary Care?

- Increased Overhead Costs
  - Staff Salaries
  - Health Care Coverage for Employees
  - EHR Maintenance Fees
- Increased Annual Billing 2015, Decreased Annual Profit
- MACRA/MIPS Announced Winter 2016
- Symptoms of Physician Burn Out Developing
- MAINTAIN OUR INDEPENDENT PRACTICE

## Estimated Impact of MIPS by Practice Size

Practice Size	Eligible Physicians	Percentage likely to be Penalized	Percentage likely to receive Bonus
Solo	102,788	87%	12.9%
<b>2-9</b>	<b>123,695</b>	<b>69.9%</b>	<b>29.8%</b>
10-24	81,207	59.4%	40.3%
25-99	147,976	44.9%	54.5%
100 or more	305,676	18.3%	81.3%
Overall	761,342	45%	54.1%

Source: CMS 2016

# Exploring DPC

- Attended 3 different DPC Conferences 2016
- Engagement on DPC Facebook Page
- Watched YouTube videos
- Looked at multiple DPC practice websites in addition to DPCfrontier.com; Not much of a precedent for a multi-physician practice transition
- Reviewed ramifications of departing from private and government insurance
- Assessed feasibility of DPC in our community

# Transition Plan 2016-2017

- Assess Our Expenses: **We were already building a building!**
- Establish DPC Fee Structure: Assessing feasibility and profitability
- Establish Vendors
  - Labs, Radiology, Wholesale Medications
  - EHR Vendors, Telemedicine Vendors, Billing Software Integration
- Evaluate PHO and 3<sup>rd</sup> Party Contracts
- Patient Contracts
- Marketing and Branding New DPC Practice

**BUILDING  
GROUNDBREAKING:  
November, 2016!!**





# Announcement

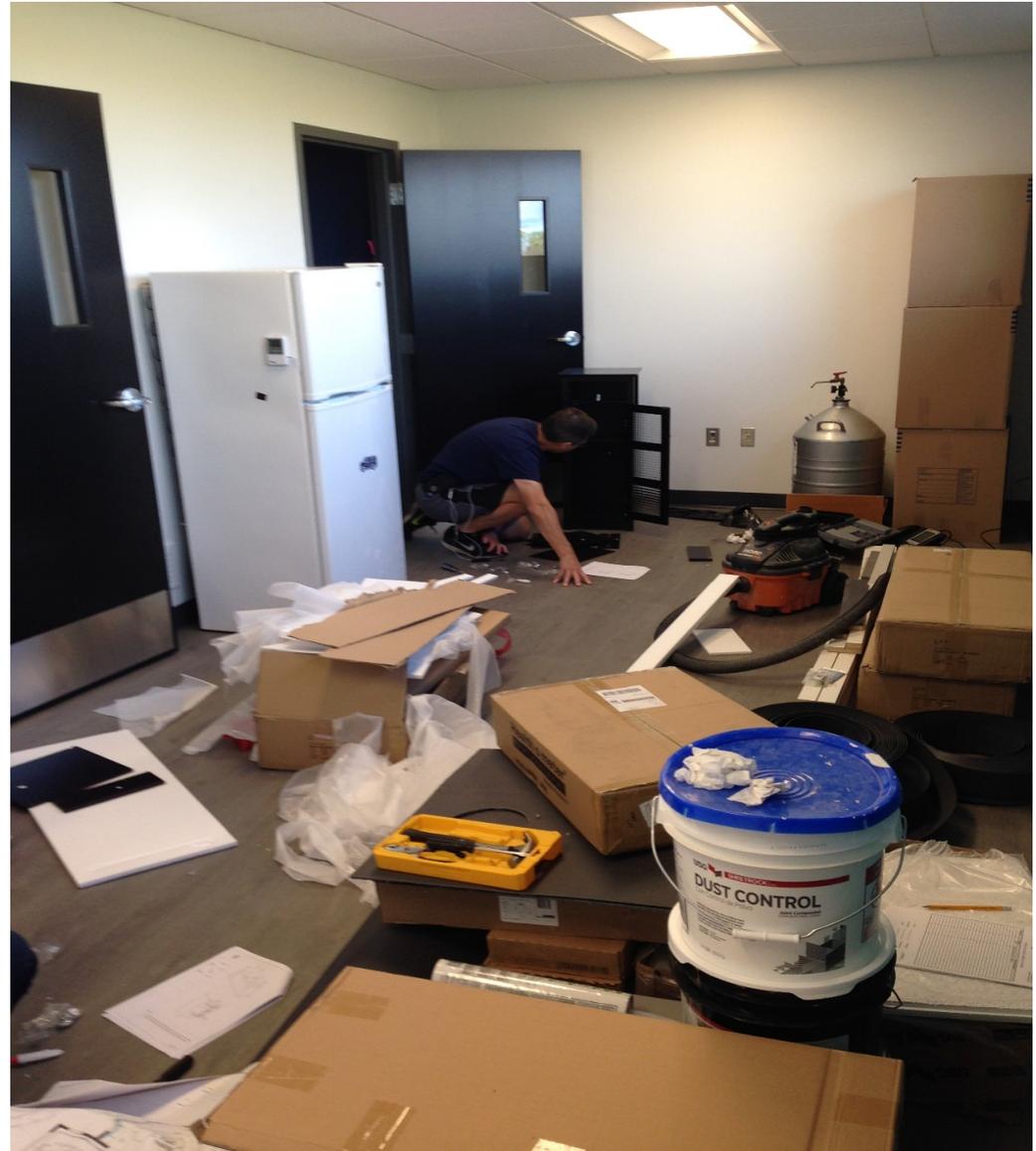
## April 2017

- 6 Month Notice for All Non-Medicare and Non-Medicaid Patients
- Continue FFS for Medicare and Medicaid Patients until 10/1/2018
- Town Hall Meetings to explain DPC for all existing and prospective patients
- Local Newspaper and TV Coverage
- Meetings with Local Subspecialists and Business Leaders





# Preparing for October 1<sup>st</sup>, 2017!





# First Day of DPC October 1, 2017

- Brand New Building
- 1 NP, 2 RN's, 2 LPN's, 2 MA's, 1 Office Manager, 4 Receptionists: **12 Staff Members**
- Hybrid Practice Model
- Practice Patient Numbers:
  - Dr Eggebrecht: 413 DPC; 495 Medicare; 35 Medicaid
  - Dr Mancini: 487 DPC; 273 Medicare; 30 Medicaid
  - Dr Meadows: 326 DPC; 324 Medicare; 40 Medicaid
  - Dr Gendernalik: 212 DPC; 353 Medicare; 7 Medicaid
  - **PRACTICE TOTAL: 1438 DPC; 1445 MEDICARE; 112 MEDICAID**



# The Ugly

- New EHR, New Telemedicine Software, New Billing System, New Building and Location
- Dispensing Medications for first time
- No Medicare or Medicaid Payments received October-December 2017
- No Physician Salaries from October-December 2017
- Physician Salary Cut > 50% for 2018

# Summer 2018

## The Bad

- Over OUR Head: DPC Summit 2018
  - Providing DPC Services while billing Medicare/Medicaid
    - Necessary Evil for us to help with cash flow
  - Very Little Small Business Engagement
    - Despite Cold Calling, Attending 3 Rotary Meetings, Chamber of Commerce Trade Fair
  - Accountant Calls With Concerns about our cash flow
  - Practice overhead at 70%!
  - Needed to Reduce Operating Costs, Held Physician Salaries, Laid off RN and Office Manager, NP left practice after not accepting re-structured contract.



# Saved by Annual Payments

- September/October 2018
- Several Medicare Patients decided to stay and pay their annual membership
- Result: large revenue influx
- Accountant calls: You Owe Taxes!
- Started to turn the corner financially





# Fall 2018 to Present

- October 1, 2018 – 100% DPC Practice
- 0 NP, 1 RN, 1 LPN, 2 MA's, 0 Manager, 0 biller, 4 receptionists : **Total Staff = 8**
- Overhead down to 50%
- Practice Patient Numbers on 11/7/2018:
  - Dr. Eggebrecht: 715
  - Dr. Mancini: 697
  - Dr. Meadows: 582
  - Dr. Gendernalik: 529
  - **PRACTICE TOTAL: 2523**

# The Good

- Maintained our Independence- Physician-Directed Patient Care, not Government and Insurance Directed Patient Care
- Better Patient Engagement, Patient-Physician Relationship
- Improved Morale
- Improved Job Satisfaction
- Improving Community Perception
- Helping People Who Had No Access to Care



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# Takeaways for a Group Transition

- You *really* need to be able to communicate with your partners – there can be no egos
- Be willing to make sacrifices and to support each other
- Know your community – will it sustain >1 DPC doctor all at once
- Have savings or a back-up source of income
- Hybrid vs straight DPC – weigh the pros and cons
- Watch your finances and cash flow yourself



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**Poll: Which of the following is a key component to transitioning a group practice from a traditional fee for service model to DPC?**

# DPC vs. FFS: A DPC Doc Who Owns a FFS Practice

Mark Machalka MD



# So why me?

- Owner of a FFS practice as well as a DPC practice
- Unique ability to literally compare
- Loyola Med School in Chicago suburbs in 2000
- St Vincent FM program in Erie, PA in 2003
- OB fellowship at Breckenridge Hosp in 2004
- Marshall Medical Associates since then until 2017
- Whole Family Direct Care to present



# FFS practice

- 2 sites
- 2-4 PA's (now 1 NP) (NP and 1 PA full time)
- 2-3 MD's (all part time now)
- 1 office manager
- 1 Nurse Care Manager
- 3.5 front staff
- 1.5 xray techs
- 2 billers
- 6 MA's
- **STILL NOT ENOUGH!**

# DPC practice

- 1 MD
- 1 PA
- 2 MA's
- 1 wonderfully helpful wife

# FFS practice and the DPC practice



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# So who knows what is MACRA?

1. Medical Access based on Computer Regulations Act
2. Medicare Access and CHIP Reauthorization Act
3. Medicaid Access, Credentialing, and Reporting Act
4. Marginal Access to Care is now Reality Act

# So now that you guessed ... FFS, VBC, and MACRA

- VBC is still FFS just harder to get reimbursed
- MACRA broken into MIPS and APM's
- Marshall Medical Assoc is in CPC plus
  - Government money .... But you don't get to keep it?
  - Several measures to meet
  - Literally have to give them a spreadsheet of what you would do with the money
  - Must have extra staff (blessed to have a physician org called IHP)
  - Can't calculate time commitment
  - Little to no patient responsibility
  - NOT just medicare pt's
  - PCMH status
  - Too many billing rules.... Have to have billers!



# Day in the life of FFS

May 9, 2016

- 16 pts (actually more seen)
- Started at 8am and finished at 6:15 ish (last pt at 4:45)
- Walk-in's in the morning
- Same Day Appointments (SDA's) (I blocked a couple so I could catch up)
- Missed most of lunch and left work late
- Used a scribe to get charts done (over \$20,000 out of my pocket for the service)
- LATE for everything



# Day in the life of DPC

May 6, 2019

- 6 pts
- Started at 9 am and done by 4:45pm (full hr lunch)
- Had openings
- 2 call ins (actually 1 texted me)
- Had charting time for ½ hr that morning
- 30 min meeting with FFS practice office manager
- Made it to coach swim practice at 5:30.... ON TIME!



# Why share with a FFS practice?

- Labs
- Vaccines
- Xray and Ultrasound (also an echo deal)
- EKG
- Handy things like a pulse ox, BP cuff, thermometer
- PFT's
- In office labs (strep, flu, u/a etc)
- Tools (from scissors to swabs to sutures) and cleaning tools
- Insurances (health, malpractice, etc)
- Rent, phones, internet, and cleaning

# Why should the FFS share with me?

- RENT!
- I don't need as much space
- Share cost of supplies like those swabs
- I am an option for their high deductible pts and no insurance pts

# Incentives to the patient

- Pt's have seen me bring back a pt and escort them out while they were still in the waiting room
- See us when walking out and can talk to me and my MA
- Since I have more time I can “socialize” and they see I am backing up my claims
- Here about the texting
- I have taken call for my staff and surprised when I help/ pick up the phone

# Questions?

Submit your  
questions to:  
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Don't forget to  
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session!

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