16 Years of Do’s and Don’ts in DPC

Brian Forrest, M.D.
Learning Objectives

• Gain an understanding of best practices in DPC
• Learn about critical mistakes that can keep you from being successful
• Become aware of key features of DPC practices that thrive
The material presented here is being made available by the DPC Summit Co-Organizers for educational purposes only. This material is not intended to represent the only, nor necessarily best, methods or processes appropriate for the practice models discussed. Rather, it is intended to present statements and opinions of the faculty that may be helpful to others in similar situations.

Any performance data from any direct primary care practices cited herein is intended for purposes of illustration only and should not be viewed as a recommendation of how to conduct your practice.

The DPC Summit Co-Organizers disclaim liability for damages or claims that might arise out of the use of the materials presented herein, whether asserted by a physician or any other person. While the DPC Summit Co-Organizers have attempted to ensure the accuracy of the data presented here, these materials may contain information and/or opinions developed by others, and their inclusion here does not necessarily imply endorsement by any of the DPC Summit Co-Organizers.

The DPC Summit Co-Organizers are not making any recommendation of how you should conduct your practice or any guarantee regarding the financial viability of DPC conversion or practice.
Faculty Disclosure

It is the policy of the DPC Summit Co-Organizers that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All faculty in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of this material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.
Do #1  100% Collections

- 99% actually-but loss of collections is a source of overhead
- Membership management software has to be automated payment
- Clearly stated policies and membership contracts
Do #2 Low Overhead

- Hospital surplus, Group Purchasing Organizations, Staffing, DPC Networks
- Litmus test—will spending this money actually help improve patient care?
- Technology and Automation—membership management software/telemedicine
## Primary Care Math

<table>
<thead>
<tr>
<th>Traditional/PCMH</th>
<th>DPC Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>x.65 collected (avg in US)</td>
<td>x.99</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>.65</td>
<td>.99</td>
</tr>
<tr>
<td>-60% overhead (avg in US)</td>
<td>- 18%</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>.26 left</td>
<td>.81 left</td>
</tr>
</tbody>
</table>
Do #3 Perfect Location

- average 1000-1200 sq feet needed
double space/rent half
- Near other medical/pharmacy
- Option to Sublet from or to specialists or other health professionals
- Population density adequate?
Do #4 Cost Effective Marketing

- Word of Mouth-“Best Medical Experience Ever” Durham Bulls?
- Advertising-earned media better but talk radio or presorted post can help
- When transitioning existing practice: letter to existing patients/symposium
- KIS: Think Dollar Store, easy for one patient to explain to someone
Do #5 Change the “Copay Culture”

- Biggest challenge is creating value proposition for patients
- Financial argument-lower costs than billing insurance-but not always
- “What you want in healthcare at a price you can afford” The liver and mustard sandwich
Do #6 Show **VALUE** to Community

**V**-alue demonstrated to your patients in costs, time, access
**A**-vailability that will exceed traditional models
**L**-isten to patient’s concerns and address them proactively
**U**-se word of mouth and media to locally create buzz about DPC
**E**-xceed expectations & make it the “best medical experience ever”
Do #7 Help Patients/Employers Save on Healthcare Costs

- Discounted specialists services
- Lower premium insurance products with higher deductibles
- Self-funded employer plans coupled with DPC
- HCSM plans and DPC membership paying integrated plans
- Wholesale pharmacy, patient assistance, and mail order-inclusive plans
Working with Employers

- Can build critical mass of patients in panel
- Easier to do with a network
- Despite emphasis in conferences less than 20%
- Ideal size over 250 employees self insured or
- Under 50 for small businesses (Subway)
- Need quality outcomes and costs data-SPH/MD-INSIGHT can help provide your “report card”
Do #8 Be Flexible and Nimble

- Always be price competitive-Even the same day!
- Re-Evaluate memberships and pricing at least annually
- Listen to patients: formal and informal feedback (Hear it once-um, Hear it twice –done)
- Fix Problems or bad policies as soon as you are aware of them
- Keep sharpening the sword- your office flow and logistics can always be improved
- Have policies in place but be willing to have some “gray areas” (late to appt, etc)
Do #9 Excellent Customer Service

- Exceed their expectations and focus on them
- Use time not spent on billing tasks to improve Patient Engagement
- Let technology improve communication and efficiency
- Teach, Teach, Teach
- Have Conversations instead of Giving Lectures
- Be super accessible and available with under 5 minutes in waiting room
Do #10

Enjoy Practicing Medicine and Love What you are Doing!
Don’t-

• Look at one version of DPC and then proceed in that direction
• Stagnate and persist with something that is not working
• Go it Alone
• Try to hybridize and file some insurances
• Transition without a well thought out plan and understanding of your community
• Give patients codes for each visit if they have insurance and want to file it
• Spend time and effort on anything but **building your panel** year 1
• Be hidden and assume patients will find you
• Forget to opt out of insurance networks and Medicare when appropriate
• See DPC patients without a written contract
• Allow patients to buy memberships before you have seen them as patients
• Have too many options like more than 3 membership levels-especially the first 2 years
More Information and Resources

www.accesshealthcaredirect.com general information on DPC for providers and patients

Send an email to accesshealthcaredirect@gmail.com to sign up for newsletter, DPC updates, and conference registration discounts

www.DPCMH.org Direct Primary Care Medical Home Association - free membership and resources available from this not for profit. Free transition toolkit available.

Follow @innovadoc on twitter- 200+ articles on DPC


Sprey, E. Physicians Practice “New Practice Models are Gaining Acceptance” 9/14

Forrest, B.R. Physicians 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. Weekly Standard Cover Story “Cash for Doctors” 5/23/10

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


Twitter @innovadoc (giving regular DPC updates now)

http://www.physicianspractice.com/pearls/new-primary-care-models-can-change-way-you-practice-medicine (link to first article above)

www.accesshealthcaredirect.com website for DPC network practices.
www.DPCMH.org free membership, resources for students and residents, DPC membership scholarships
Questions?

Contact Info:
Brian Forrest, MD
Access Healthcare – Apex, NC
919 363 0190 (office)
brianforrestmd@gmail.com
Twitter @innovadoc

Submit your questions to: aafp.cnf.io