New Practice Models Are Gaining Acceptance in Primary Care


By Erica Sprey [6]

Our Great American Physician Survey, Sponsored by Kareo, indicates greater physician acceptance of alternate practice models to help themselves and patients.

Source: Physicians Practice

Manhattan cardiologist Arthur Weisenseel has enjoyed a long and satisfying medical career; one that encompassed teaching at New York-based Mt. Sinai Hospital, running a successful cardiology practice with another physician, and stewarding his aging patients into a healthy old age. But, somewhere in the last five years to 10 years, his practice became problematic. Weisenseel says that despite working as hard as he could, he wasn't able to consistently pay both practice expenses and himself. He says of that time, "I worked awful hard to get [there]. And to go home without reimbursement was becoming demoralizing."

So, like a growing contingent of like-minded physicians, Weisenseel decided to explore other practice models. Encouraged by his patients and positive conversations with colleagues, he has now successfully converted his practice to a hybrid-concierge model, where patients can choose to pay an extra fee for concierge services or continue to reimburse him through traditional insurance plans like Medicare and third-party payers. Now he couldn't be happier: Relieved of worries about financial and regulatory burdens, he says, "I come to work with joy and confidence."

Physician pioneers

It's no longer business as usual for physicians and their practices. Tired of the incessant drum beat communicating ever more difficult-to-achieve edicts from payers and government agencies, physicians are looking for a way out of the bureaucratic morass. Many of them feel burned out; many of them tell us that something has to give. And a small but growing number of physicians like Weisenseel are changing their practice models, allowing them to completely side-step payers, institute patient-centric services, or even reduce their patient panels so they can develop genuine relationships with their patients.

This is the fifth year we've been reporting on our groundbreaking Great American Physician Survey, Sponsored by Kareo. In it, we ask physicians how they feel about their profession, their practices, their patients, and home life. We heard from 1,311 physicians across the country. Forty percent say they are employed by a hospital or other institution, and nearly as many are either a partner/co-owner of a private practice or employed in a private practice.

* Would you like to know what your peers and colleagues are saying about their work and personal lives? Visit our Great American Physician Survey to find out.

In this year's survey, the numbers tell us that the needle is continuing to move ever so slowly in the direction of new practice models like concierge medicine, direct-pay practice, and Patient-Centered Medical Homes (PCMH). Of the physicians who responded to our survey this year, 35 percent say they would consider or are already working in a concierge-style practice model, 53 percent say they would consider or are already working in a
direct-pay practice, and 20 percent are in the process of transitioning or have already achieved PCMH recognition. Historically, that shows slow but steady acceptance of alternate practice models. Florida-based consultant Christi Hudiburg sees that trend in her own consulting business, Envision Healthcare Consulting. She tells Physicians Practice, "The past 25 years have left many healthcare providers uncertain and unprepared for the future when it comes to reimbursement, technology, and quality programs. This has led them to search for security in alternate areas. With all of the requirements placed on them by CMS and the insurance companies, it is much easier to go into concierge medicine or direct pay, as there is no ‘Big Brother’ watching over you."

**Physician needs**

It's no secret that physicians are practicing under growing regulatory and administrative burdens. "Touch-time" with patients continues to evaporate; more time is spent at the keyboard, rather than communicating directly with patients. That loss of personal connection with patients pains many, if not most, physicians. In our survey, 24 percent of physicians indicate “finding more time to spend with patients," was their biggest challenge in 2014. Prior to changing his practice model, Weisenseel says that he didn't want to squeeze in more patient visits just to keep up with overhead. Now he says being a hybrid-concierge physician allows him to give his concierge patients, "a very careful yearly physical and a discussion on everything from diet to economic to psychological to even spiritual needs. It allows you to be the total physician that I’d always hoped I might be able to do for all these years."

North Carolina-based, primary-care physician Brian Forrest knew almost from the beginning that he didn't want to practice revolving-door medicine. "I always knew, even in residency, that I was going to open my own practice to try to address some of the problems that I've seen in healthcare. ... In fact, one of the practices I was working in, there was one day where we saw 63 patients ... It was literally like a circle; they came down one hall into the [exam] room and they went down another hall ... to pay."

Forrest, whose practice is aptly named Access Healthcare, has been practicing in what he calls a direct-care micropractice model for 13 years; he was a pioneer in the direct-pay movement. "In 2002, I basically didn't know anyone in the country that was doing something like [direct-pay primary care]," he says.

Even though his practice does not accept insurance or participate with Medicare or Medicaid, Forrest's practice model allows him to see patients with and without insurance. Forrest's payment model is much like a gym membership; patients who purchase a membership pay an annual or monthly fee, which entitles them to avail themselves of the practice's services, usually with minimal additional charges.

For those patients who don't purchase a membership, the fees for services are slightly greater, but still less than a traditional practice. Forrest purposely keeps his fees low, he says, so that patients who do not have insurance or have limited means can afford to see him. This something he is able to do because he operates with a much lower overhead — with no insurance to bill, he can work with a much smaller staff. As a service to patients, the practice does provide a receipt with CPT codes for those who wish to submit paperwork for reimbursement from their insurance company. Forrest says, "We love practicing this model. Never would I change to a different way of doing things."

To read more about transitioning to a direct-care practice visit bit.ly/direct-pay-start.

While our survey indicates that physicians as a group feel above-average levels of happiness and satisfaction with their careers and lifestyles, there is a slight bump in general happiness scores for direct-pay and concierge physicians. In comparison to the entire sample size of 1,311 physicians, where 26 percent rated themselves an "8" on a scale of 1-10 (where 10 is "extremely happy"), 27 percent of direct-pay physicians and 31 percent of concierge physicians rated themselves a "9."

**Financial pressures**

Aside from less time with patients, physicians tell us they are struggling to bring home the bacon, and keep their practices profitable. Logically, the more resources you devote to staffing, technology, and administrative tasks, the less time you have to see patients, which is essentially the engine that drives practice revenue. In our survey, 45 percent of respondents indicated that they "strongly agree" with the statement, "I used to enjoy being a physician much more, but today it is more stressful and less financially lucrative." And 52 percent of physicians said they could not afford to sacrifice anything — money, management decisions, partnerships, or employment benefits — to work fewer hours.

According to Cindy Dunn, who is an independent consultant with the Medical Group Management Association Health Care Consulting Group, morphing payer reimbursement methodologies are also a driver for acceptance of alternate practice models. She says, for instance, if practices cannot
internally support increased reporting burdens for quality incentive programs like Medicare's Physician Quality Reporting System, "then I think they do look to consolidate with other providers in their community, or maybe become a hospital employee, or align with a large system."

Dunn also feels that increasing pressures on physicians to comply with programs like ICD-10 and meaningful use of an EHR system may be enough to "push them to become a concierge physician." She goes on to say, "I see burned out people. I see folks who can't meet the legal and financial obligations, and are trying to keep up."

Financial considerations are germane for all practices who are considering change, even those that choose to pursue PCMH recognition through agencies like the National Committee for Quality Assurance (NCQA). Practicing family physician Michael Munger is a medical director for St. Luke's Medical Group in the greater Kansas City, Mo. area. Recently, he lead the charge in helping his group, which is comprised of 11 office locations, achieve NCQA's PCMH Level 3 recognition — the highest level of recognition — a process which took Munger's group two years to complete.

Munger acknowledges that aside from a desire to become patient centered, his group recognized the financial benefit from transitioning to a PCMH as well. "I think that many others are seeing that in the not too distant future, value-based payment platforms [and] value-based purchasing are not just going to affect hospitals or inpatients. In the entire ambulatory world it's going to move that way and primary care is going to be the prime example. I think if all practices are not moving in that direction, my belief is they need to be. I truly believe that fee-for-service medicine is extremely limited," he says.

**Payer influences**

Thirty-nine percent of respondents to our survey indicated that their biggest frustration in practicing medicine was "too much third-party interference." While that's nothing new, it may take on a new urgency as value-based reimbursement, bundled payments, and quality incentive programs progressively dominate the payment landscape.

Practice management consultant Susanne Madden founded Patient Centered Solutions, a subsidiary of consulting firm The Verden Group, in response to overwhelming client demand for information on becoming a PCMH. "It's a program that has been rolling for quite a while now ... and has only been gaining traction year over year, as time goes on," she says. "Right now, something like 15 percent to 16 percent of all primary-care practices in the country have achieved NCQA's medical home recognition."

Like Munger, Madden says the dominant reason practices are interested in becoming medical homes is changing payer market forces. She says that fee-for-service reimbursement is waning; the new focus will be on quality care and patient outcomes. "What is really being sought in the industry ... and through commercial payers is this idea that the services rendered are adequate, appropriate, evidenced-based, and produce results as opposed to just paying for encounters."

That focus is much easier to achieve when your practice is structured in a patient-centric way. Munger says that moving from episodic, physician-centered care to managing the whole patient and improving patient access will not only make patients happier, but will achieve better outcomes. Of course, one way to completely eliminate payer influences is to stop accepting any type of insurance. Dave Albenberg has been practicing primary care in this kind of concierge model for 12 years. His practice, Access Healthcare (not affiliated with Forrest's practice) is based in Charleston, S.C. Albenberg says, "I was in traditional practice ... for six years, and left that practice essentially with the mission of trying to unwind the triangulation [payer-physician-patient] by not taking insurance. That was my main mission."

His patients pay him a yearly fee: When they come in for visits, they do not pay any extra. Albenberg says it's "a cleaner, more simplified model."

**Happier patients**

A great part of the lure for physicians to pursue non-traditional practice models is to remove the intermediaries (e.g. payers) that can negatively influence the physician-patient relationship. Albenberg says that making the change to concierge was beneficial to himself, as well as his patients. He says some of the benefits are: "Working for myself, understanding my environment ... having close relationships with my patients, [and] feeling adequate."

Weisenseel points out that he is now under less pressure to limit the time he spends with his patients, after converting to a hybrid-concierge practice. "The way it really turns out, I give people what I think they need and I don't worry about the cost. I feel I owe the concierge patients an extra degree of attention. I'll find myself probing even though they don't ask; 'How are your children? Do you need any advice?'"

Even if you are philosophically opposed to concierge or direct-pay practice, there are inexpensive
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ways to make your practice more patient-centric, and increase both provider and patient satisfaction. One of the first changes Munger made to his practice on the road to achieving PCMH recognition was open-access scheduling. He's quick to point out that it is an inexpensive proposition, and one that is well-received by patients.

"... My patients would comment to me, 'Gee, I love you doc, but I wish I could see you when I needed you that day.' You take that to heart as a physician," he says, "And now [after open-access scheduling] ... that's extremely satisfying when the patient says, 'Thank you so much for seeing me today.'"

First steps
So what if you've searched your heart and decided to radically change your own practice model? How should you start? You might be surprised to hear that it is not with your accountant or attorney. Albenberg advises that the very first step is looking inward: "I think first of all, [physicians] really have to examine their own intentions. What are their goals? ... For me it was getting into a system that I understood, spending more time with patients, and [developing] more solid relationships," he says. Albenberg adds that if you are not prepared to be patient-centric and ready to emphasize customer service, concierge practice is probably not for you.

Logically, the next step is to gather information. If you are considering concierge, direct-pay practice, or becoming a PCMH consider talking to physician groups, consultants, professional organizations, or credentialing agencies affiliated with each model. If you have committed your practice to becoming a PCMH, the next step would be to choose an accrediting body, either NCQA or the Accreditation Association for Ambulatory Health Care, and educate yourself and your staff on required recognition criteria. According to Dunn, in order to successfully create a plan for your practice, you must first get your physicians to agree on which criteria they will focus on first. That might mean making sure that all your diabetes patients have a foot and eye exam yearly. Munger suggests selecting something simple, like open-access scheduling. Even if you progress no farther than that, your patients will love having increased access to your practice.

Finally, it is important to let your patients know about your transition, and answer any questions they might have. While a few might feel abandoned if, say, you make the change to a hybrid-concierge practice, generally a detailed explanation is all they'll need. Weisenseel says most of his patients were positive about the change, "The great majority of people who joined did so enthusiastically ... The patients who didn't join, I made it clear to them, 'There's no prejudice.' They weren't worried."

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In Summary
A small, but growing number of physicians are changing their practice models: allowing them to completely side-step payers, institute patient-centric services, or even reduce their patient panels. Interested? Here are first steps:

• Consider your motivations and goals
• Talk to peers and consultants
• Assess current financial status
• Communicate with patients

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