



A Collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group

Primary Care e-Letter *May 2009, Issue 20*

We are sending you a new Primary Care e-Letter based on an interview with Dr. Daphne Miller, a family physician who has developed an innovative private practice in San Francisco. There are two very different models of primary care practices of the future: the team-based model and the individual physician model. There are good arguments for each one. Both address the problem of primary care physicians by themselves being unable to provide excellent care for the average panel sizes existing in the US (about 2300 patients for a full time primary care physician). One way to solve this problem is to add other team members to the practice and have the physician focus on the sickest patients in the practice and on training and mentoring other team members. Another way to solve the problem is to substantially reduce panel size so that the physician can truly establish relationships with every patient and do an excellent job with their acute, chronic and preventive care. The interview with Dr. Miller describes the latter approach.

From the Primary Care e-Letter team: Interview with Daphne Miller MD, Family Physician in San Francisco

Can you tell us the history of your practice?

After my family medicine residency I thought I would pursue a career in academic medicine with a focus on health services research. But days after receiving my first NIH funding, I found myself in a panic. I realized that what I really wanted to do was be a community-based family physician. There was, however, one seemingly insurmountable obstacle: I could not find a place where I wanted to work. My previous jobs, at both private and community clinics, had been fairly onerous and unsatisfying. I found myself on the run from exam room to exam room, putting out fires without enough time to engage my patients or address the chronic issues that brought them to the office in the first place. What I really wanted was a job that did not exist and so I decided to design my own practice.

With this in mind, I accepted a business loan instead of an NIH grant and rented a small office space in my neighborhood. My only goal was to develop a practice that was accessible to a diverse population and that had a structure flexible enough to allow me to spend time with my patients and to build relationships over the long-term. In retrospect I plunged in rather blindly but it all seems to have worked out that was almost nine years ago.

How many patients receive care in your practice?

Avril Swan, MD and I both work 18-20 hours per week. Last year, we cared for a combined total of 1240 unique individuals. I guess you would say that our individual half-time panels are each about 620 patients. The breakdown is 70% female and 30% male; 20% under age 18 and 17% above age 50. 25%

have family income low enough to receive reduced fees on a sliding scale. In addition, 6% are Medicare and 1.5% Medi-Cal.

How many visits per day do you have, and how long are the visits?

In a full day (9 am to 5 pm) I see on average 1 to 2 new patients and 10-12 follow-up patients. Initial visits are all one hour and follow-up visits range from 15 minutes for focused urgent issues to 45 minutes for patients with complex health or psychosocial problems.

Have you succeeded in breaking the tyranny of the 15 minutes visit? If so, how did you do that?

Doctors who are tied to the 15 minute visit need to see many patients each day to keep their practices financially afloat.

We have succeeded in overcoming the financial necessity of seeing many patients each day. We have done this by doing two interrelated things: 1) maintaining a low overhead and 2) not contracting with private insurers. (see below)

Do you interact with patients by email, telephone, group visits -- alternatives to the one-on-one face-to-face visit? How is that working?

Yes to all of the above and it works very well. We have phone and email consults. We also have pain management groups and are starting a mid-life women's group. I am also thinking of starting a walking group and a pediatric well-visit group. The wonderful thing about having a small, independent practice is that you have a lot of room to experiment and try new programs.

Do you have a registry of your patients so that you can tell if patients with diabetes have gotten all their routine lab tests, and you can tell which patients are in poor control of their diabetes or hypertension or cholesterol and need extra time spent with them?

In my EMR (Springcharts) I can call patients up by diagnosis. I also have a reminder system on the chart to flag patients that need follow-up reminder calls. Soon I will be able to search the whole database by lab results (e.g. elevated HgA1c). EMRs are a huge investment for a practice and the one we could afford did not come with all the bells and whistles. We are slowly adding these components.

How are the finances of the practice organized? Do you take any insurance at all? What do patients have to pay to be in the practice?

We are only contracted with Medicare. All other patients pay out of pocket for their visit and then get reimbursed a certain percentage based on that insurance's out-of-network provider reimbursement policy. There is no upfront cost to enter the practice and the rates vary based on time spent with the patient. Initial visits usually cost about \$325 and follow-up visits range from \$65 to \$200.

If you look at the gross revenue for our practice, the cost to receive primary care in our practice averages out to \$360 per individual per year. Of course this does not include outside charges such as diagnostic tests, specialist visits or hospital charges. We do a lot in-house and try and keep referrals and testing to a minimum.

Is there a sliding scale?

Yes there is a sliding scale based on income. When physicians accept private insurance, they give a deep discount to the insurance company regardless of whether the patient in question could actually afford to pay full cost for the services. We are not contracted with an insurance company and therefore we cut out the middlemen and offer discounts directly to patients who cannot afford our rates. At the same time, we collect the full fee from patients who can afford to pay. Within any given month, about 25% of our patients are getting some form of discount.

Is the practice doing well financially?

Yes. Since we maintain a low overhead our salaries are very competitive with those of physicians who are still doing the 15 minute visits. Last year we took home, on average, 60-70% of our monthly gross. This year, with three physicians in the practice, I expect this number to be higher.

What is the LOON model of primary care? Is it different from a concierge practice? Do you think this model is the best model for all primary care practices in the US, or only for some practices? What are its advantages over more traditional practices? Does it have disadvantages?

The LOON model stands for Low Overhead Out of Network. It is a way of maximizing time with patients while minimizing administrative costs and paperwork. Because we do not contract with insurance we cut down our overhead in two major ways:

- 1) Smaller staff- Staffing is a major expense for medical practices. Our staff spends the majority of their time on direct patient care rather than getting prior authorizations, filling out forms, fighting with insurers, etc. Therefore we need fewer office employees: we have two half-time employees for three physicians. The fact that we are entirely paperless also allows our staff to dedicate more time to patients and less time to tracking labs and filing.
- 2) Lower rent- Because we do not need to be maximally efficient with our time, we do not need to stash patients in empty rooms. As a result we need less office space. Each physician only has one exam room and the three of us work nicely in little over 800 square feet.

I believe that small, low overhead neighborhood-based practices are excellent venues for providing patient-centered community-based health care. In general they allow for more time with each patient, more physician accessibility and, perhaps most importantly, more physician satisfaction. Since the cost per patient to deliver care within this model is very reasonable, and probably well below the national average, our practice could be easily funded by a single payer system. If there was national support for physicians who wished to practice in a LOON model, I would posit that many more young physicians would choose a career in primary care medicine.