PHYSICIANS PRACTICE
YOUR PRACTICE YOUR WAY

The Great American Physician Survey

The High Cost of CARE

also:
- FULL RESULTS TO THE 2016 GAP SURVEY
- WHY PHYSICIANS AREN'T FANS OF THE ACA
- THE RISE OF DPC
Time matters. The statistics are staggering! In the 2016 Great American Physician (GAP) Survey, 71 percent of physicians said that they lack adequate time for their personal life. No wonder — most doctors are working between 41 and 60 hours a week, some more than 80 hours. Over half of respondents to the GAP Survey say they have a poor work-life balance.

Consider the costs of a work-life imbalance: Fatigue, poor health, and missing out on time with family and friends. Sixty-one percent would consider going part-time if they could, and if they could do it all over again, many respondents would select a specialty that offered better work-life balance. This was more important to them than selecting a more financially lucrative specialty. Moreover, the time-squeeze is taking its toll on physician-patient interactions. Survey respondents indicated that the greatest obstacle to strengthening their relationships with their patients is insufficient time.

Physicians are feeling the work-life balance dissatisfaction more than ever. In a national study conducted in the Journal of Graduate Medical Education, almost 50 percent of physicians, regardless of specialty and work environment, show signs of “burnout” — indicative of longer-term stress — causing a decrease in self-worth, overall happiness, and energy level.

Burnout has significant implications: it not only has deleterious effects on one’s own emotional well-being, it also affects interpersonal interactions (i.e., staff, patients, and family). And study after study finds that physician stress and is directly correlated with patient satisfaction and compliance with medical advice.

Feeling a loss of control over one’s work environment is significantly related to physician burnout. Here are three other interrelated predictors:

• Conflict at home related to balancing home and work
• Number of hours worked
• Favoring work over home

With the majority of respondents in our survey indicating that they are married (or in a long-term relationship), having adequate time for their relationships is a critical factor in preventing physician burnout. So what’s a physician to do? Experiencing unfavorable
work-life balance and its concomitant negative impact is not a foregone conclusion. There are numerous strategies, some quite innovative, that can lessen physician stress. And given that the majority of physicians like their profession and would not trade it in for another, learning to manage stress and improve work-life balance is essential. Here are some tactics to implement:

- Learn to delegate and learn to say “no.”
- Leave work at work and home at home. Only check emails at specific times during the day (no more than three to four times a day).
- Give your relationship with your significant other the attention it deserves. Relationships require quality time, attention, and nurturing. Make the most of the time you have together — the leading predictor of relationship satisfaction is having a higher proportion of positive (versus negative) interactions.
- If you are in a group practice, cultivate a team approach to lessen any one physician’s burden, provide mutual support and streamline the healthcare process. Focus on improving communication among providers — this will lessen stress and improve care. Find opportunities to discuss quality of care and interesting cases.
- Consider implementing a flexible schedule in the workplace. It may seem daunting, but many physician practices and healthcare organizations are trying out various options and finding out that they work.
- Assess how much of your time is spent on activities that are not physician-specific ones so that you can make more use of nonphysician healthcare providers: Free up precious physician time by using physician assistants or nurse practitioners whenever possible. Utilize medical assistants to take notes and enter data into the EHR.
- Foster a work culture that promotes physician and staff satisfaction, health, and wellness. Talk about stress and work-life balance. Make it a priority in your practice. Healthcare providers who make self-care a priority tend to have higher patient satisfaction scores, improved safety outcomes, and experience less stress. Happier patients lessen stress in the workplace because they are more cooperative, appreciative, and compliant.
- Practice “stress resiliency” behaviors, including regular exercise, a healthy diet, adequate sleep, fun and relaxation, develop and nurture supportive relationships, volunteer (acts of giving and kindness are correlated to increased happiness) and daily mindfulness exercises.

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Assess how much of your time is spent on activities that are not physician-specific ones so that you can make more use of nonphysician healthcare providers: Free up precious physician time by using physician assistants or nurse practitioners whenever possible.
Each year *Physicians Practice* conducts a national survey of physicians across all specialties and practice models to find out what is on their minds politically, professionally, and personally. In this, our seventh survey, slightly more than 80 percent of the 1,314 respondents told us they like being a physician. Yet because of continuing economic and regulatory pressures, 72 percent found the profession more stressful and less lucrative than in previous years, and a strong majority said they are concerned about the direction that healthcare is headed.

When asked about their greatest frustrations with being a physician, third-party interference topped the list at 37 percent. Following that was the declining ability to practice independently (13 percent), government regulations (12 percent), and high stress (10 percent). Lest the picture sound too grim, 48 percent said they felt they had a good work-life balance. And on a scale of overall happiness, 62 percent fell between a nine and a seven (where 10 was extremely happy).

**survey HIGHLIGHTS:**

- When asked about the largest barrier to patient care, 40.5 percent said higher deductibles and patient cost sharing, while 20 percent said the higher cost of care.

- Forty-six percent of physicians say they are an owner/co-owner/partner of a private practice. Thirty percent say they are employed by a hospital or other institution. Twenty-nine percent of respondents said they were a solo physician; 30 percent said they worked with a group of two to five physicians.

- When it came to selecting an area of specialization, 76 percent of physicians said they chose a specialty because it was clinically stimulating. Only 2.6 percent said money was the primary consideration.

- Once an idea that was frowned on, converting to some form of cash-pay practice has gained ground. Forty-five percent of respondents said they would consider concierge practice if the circumstances were right, and 62 percent said they would consider direct primary care.

- On the Affordable Care Act, 47 percent of respondents say it has done a disservice to physicians; 45.5 percent say it’s been mostly good, but not all good; and 7.5 percent say it’s been great for all Americans.
Northeast (CT, ME, MA, NH, NJ, NY, PA, RI, VT) (22.5%)
Middle Atlantic (DC, DE, KY, MD, NC, TN, VA, WV) (10.8%)
Southeast (AL, FL, GA, MS, SC) (14.1%)
South Central (AR, LA, MO, OK, TX) (12.5%)
Plains & Rockies / North Central (CO, IA, ID, IL, IN, KS, MI, MN, MT, NE, ND, OH, SD, UT, WI, WY) (21.0%)
West (AZ, NV, NM, AK, CA, HI, OR, WA) (16.1%)
Other (3.0%)
**THE SINGLE-MOST IMPORTANT FACTOR IN THE SELECTION OF MY SPECIALTY WAS:**

- I liked it clinically stimulating (76.6%)
- I liked the hours (6.2%)
- I liked the income potential (2.7%)
- *Top Answer was “I liked the patients”*

**INCLUDING ME, MY PRACTICE/ INSTITUTION HAS:**

- More than 100 physicians (14.1%)
- 51-100 physicians (4.0%)
- 21-50 physicians (5.2%)
- 11-20 physicians (7.1%)
- 6-10 physicians (10.3%)
- 2-5 physicians (30.0%)
- No other physicians; I work solo (29.3%)

**TO WHAT EXTENT DO YOU AGREE WITH THE FOLLOWING STATEMENTS?**

- I like being a physician: 4.29
- I’m fairly happy with my selection of a specialty: 4.11
- I used to enjoy being a physician much more, but today it’s more stressful and less financially lucrative: 4.05
- I am happy with the direction healthcare is headed: 1.86

**WHETHER I CURRENTLY ENJOY BEING A PHYSICIAN OR NOT, GIVEN THE CHANCE TO GO BACK IN TIME AND PICK ANOTHER CAREER PATH, I WOULD:**

- Do everything roughly the way I did it the first time (49.1%)
- Choose a specialty that provides greater work-life balance (23.8%)
- Choose some other career in healthcare as a non-physician (16.5%)
- Choose a more financially lucrative specialty (10.6%)

**I AM:**

- Employed in a non-clinical profession (for example, as an administrator) (2.0%)
- Working in a clinical setting that is not identified above (4.0%)
- An employed physician in a private practice (10.1%)
- An owner/co-owner/partner of a private practice (46.4%)
- Retired (3.2%)
- An employed physician of a hospital or other institution (29.6%)
- *Other (please specify) (4.7%)

*Top Answer was Locum Tenens*
WHAT WOULD YOU BE WILLING TO SACRIFICE IN ORDER TO WORK LESS?

52.9% Nothing — I can’t afford to sacrifice anything.
27.3% Money
3.9% My future opportunity to become a partner
11.2% Influence over management decisions
2.7% Partnership
2.0% Benefits

WOULD YOU CONSIDER GOING PART-TIME?

Yes: 61.1%  No: 38.9%

THE MAIN REASON I WOULD PREFER TO WORK SOMEWHERE ELSE IS (please check only one):

33% To get away from the unhealthy culture of my current workplace
28.5% To get more time for my personal life
12.1% To make more money
9.1% To live in a different geographic area
8.2% To advance my career or partnership prospects
9.1% Other (please specify)
IN THE NEXT THREE YEARS, I PLAN TO: (CHECK ALL THAT APPLY)

- Continue practicing as I do now........................................................... 55.7%
- Retire................................................................................................. 16.3%
- Move to a different practice .............................................................. 8.2%
- Transition to a direct-pay practice ...................................................... 6.1%
- Merge with other private practices ................................................... 4.9%
- Close my practice ........................................................................... 4.0%
- Join an Accountable Care Organization (ACO) .................................. 4.0%
- Become a Patient-Centered Medical Home (PCMH) ......................... 3.7%
- Transition to a concierge practice ..................................................... 3.7%
- Sell my practice and become hospital employed ............................ 2.4%
- Go into solo practice ........................................................................ 2.1%
- Leave my practice to become hospital employed ............................ 2.1%
- Other (please specify) ...................................................................... 14.6%

UNDER CERTAIN CIRCUMSTANCES, WOULD YOU CONSIDER SWITCHING TO A CONCIERGE PRACTICE?

- Yes — if the circumstances were favorable (45.0%)
- No — such a practice is not right for me (42.3%)
- I’m already working in such a practice model or I’m planning to switch (5.2%)
- I think concierge practices are bad for the healthcare system (7.5%)

UNDER CERTAIN CIRCUMSTANCES, WOULD YOU CONSIDER SWITCHING TO A DIRECT-PRIMARY CARE (DIRECT PAY) PRACTICE THAT DOES NOT ACCEPT INSURANCE?

- Yes — if the circumstances were favorable (62.1%)
- No — such a practice is not right for me (42.3%)
- I’m already working in such a practice model or I’m planning to switch (5.2%)
- I think direct-pay practices are bad for the healthcare system 3.6%
I THINK THE LARGEST BARRIER TO GOOD HEALTHCARE FOR MY PATIENTS IS (please check only one):

- Higher deductibles and higher patient-cost sharing (40.5%)
- I don’t have enough time to educate patients properly (16.8%)
- Patients don’t follow my advice (6.8%)
- Patients do not schedule regular preventative checkups/physicals (3.3%)
- *Other (please specify) (12.5%)

*Top Answer was Government/Insurance Interference

WHAT ARE SOME OF THE THINGS PREVENTING YOU FROM BEING CLOSER TO YOUR PATIENTS? (Check all that apply)

- Increased competition from urgent-care and retail clinics (15.7%)
- Private insurance requirements (39.3%)
- Lack of time (73.0%)
- Government regulations (50.6%)

I AM:

- Married: 83.3%
- Unmarried, with a partner: 6.6%
- Unmarried, no partner: 10.1%

I DON’T HAVE AS MUCH TIME FOR MY PERSONAL LIFE AS I THINK I SHOULD HAVE:

- True: 70.8%
- False: 29.2%

PLEASE CHECK OFF THE APPROPRIATE ANSWER TO THESE FIVE STATEMENTS:

<table>
<thead>
<tr>
<th>TRUE</th>
<th>FALSE</th>
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<tbody>
<tr>
<td>I eat right most of the time</td>
<td>80.8%</td>
</tr>
<tr>
<td>I eat right most of the time</td>
<td>19.2%</td>
</tr>
<tr>
<td>I get routine check-ups and follow my doctor’s advice, at least most of the time</td>
<td>62.5%</td>
</tr>
<tr>
<td>I get routine check-ups and follow my doctor’s advice, at least most of the time</td>
<td>37.5%</td>
</tr>
<tr>
<td>I exercise on a regular basis</td>
<td>60.4%</td>
</tr>
<tr>
<td>I exercise on a regular basis</td>
<td>39.6%</td>
</tr>
<tr>
<td>I, as a patient, have considered alternative/complementary medical treatments</td>
<td>49.6%</td>
</tr>
<tr>
<td>I, as a patient, have considered alternative/complementary medical treatments</td>
<td>50.4%</td>
</tr>
<tr>
<td>I get adequate sleep</td>
<td>48.6%</td>
</tr>
<tr>
<td>I get adequate sleep</td>
<td>51.4%</td>
</tr>
<tr>
<td>I feel like I have a good work-life balance</td>
<td>48.1%</td>
</tr>
<tr>
<td>I feel like I have a good work-life balance</td>
<td>51.9%</td>
</tr>
<tr>
<td>I smoke cigarettes</td>
<td>3.4%</td>
</tr>
<tr>
<td>I smoke cigarettes</td>
<td>96.6%</td>
</tr>
</tbody>
</table>
**I AM A REGISTERED:**

- Democrat (26.6%)
- Republican (36.9%)
- Independent (28.4%)
- Another party (1.0%)
- I am not registered to vote (7.1%)

**IN THE NOVEMBER 2016 PRESIDENTIAL ELECTION, I AM MORE LIKELY TO:**

- Vote for the Democratic candidate (40.2%)
- Vote for the Republican candidate (45.6%)
- Not vote at all (14.1%)

**WHAT MAJOR HEALTHCARE POLICY INITIATIVE WOULD YOU LIKE TO SEE THE NEXT PRESIDENT ENACT UPON TAKING OFFICE (check all that apply):**

- Rein in prescription drug costs for patients (48.4%)
- Put stronger regulations on large insurers (45.9%)
- Repeal/replace the Affordable Care Act (44.6%)
- Address physician compensation inequity (PCP vs. specialty) (43%)
- Retain the Affordable Care Act (19.6%)
- Other (please specify) (17.6%)

**AVERAGE RATING ON A 1-10 SCALE FOR HOW HAPPY I AM (10 BEING EXTREMELY HAPPY, 1 BEING EXTREMELY UNHAPPY):**

6.94

**AVERAGE RATING ON A 1-10 SCALE FOR HOW HEALTHY I AM (10 BEING EXTREMELY HEALTHY, 1 BEING EXTREMELY UNHEALTHY):**

7.34

**WHICH STATEMENT BEST DESCRIBES YOUR PERSONAL FEELINGS ABOUT THE AFFORDABLE CARE ACT, IN TERMS OF THE EFFECT ON PATIENT ACCESS TO CARE?**

- I think it has done a disservice to Americans (47.0%)
- I think it’s mostly good, but not all good (45.5%)
- I think it’s been great for Americans (7.5%)
HOW HAS THE REFORM LAW AFFECTED YOUR PRACTICE? (Check all that apply)

- I see more patients than I used to (20.2%)
- I'm seeing more chronic-needs patients (21.5%)
- I've been dropped by certain insurers (12.7%)
- Collecting deductibles has become more challenging (39.6%)
- No effect (32.1%)
- It's boosted my business tremendously (2.8%)
- It has forced me to drop out of Medicare, Medicaid, or other programs (7.3%)

WHAT HAVE BEEN YOUR MAJOR COLLECTION ISSUES WITH PATIENTS COVERED UNDER FEDERAL OR STATE HEALTHCARE EXCHANGE PLANS?

- Difficulty collecting copays/deductibles (45.1%)
- Claims denials for patient’s non-payment of premium (23.8%)
- Request for refunds from payers for non-payment of premium (7.3%)
- Other (please specify) (23.7%)

YOUR ATTITUDE TOWARD VALUE-BASED HEALTHCARE CAN BE BEST DESCRIBED BY THE FOLLOWING:

- 54.1%: I think it’s a good idea in theory but much harder to execute in practice
- 20.4%: It’s a bad idea that will not succeed
- 15.6%: I don’t know enough to make an opinion
- 6.2%: I think it’s good for the healthcare system and good for my patients
- 3.7%: Other (please specify)
Physicians are becoming increasingly alarmed about the meteoric rise in costs to provide healthcare to their patients. Physician Practice’s 2016 Great American Physician (GAP) Survey found that one-fifth of the 1,314 physician respondents say rising deductibles and cost sharing represent the largest barrier to good healthcare for their patients.

Pediatrician Terence McAllister and his spouse Leann DiDomenico McAllister, co-owner and practice administrator for their Plymouth, Mass.-based micropractice, Performance Pediatrics, say their practice and patients have been feeling the ill effects of a state decision to reel back reimbursement rates for the poorest patients.

“For patients on state assistance, the impact is in our community. Those patients are having a hard time finding any providers at all. Because even though they once had commercial primary [insurance] with the state secondary to cover their copays, now if the state is covering their deductibles, in Massachusetts the state only pays us 68 cents on the Medicare dollar [for Medicaid patients]. It is a very low amount, lower than a number of states similar in size to Massachusetts and [with] similar politics. So a lot of docs, including us, are just not taking those patients anymore,” DiDomenico says.

Complicating the financial picture, third-party payers are moving en masse to insurance products with higher deductibles, placing greater financial burdens on both medical practices and their patients. What can physicians do to navigate this trend and help their patients better access care? We talked to the experts in the field to find out. Here’s what they said.

BARRIERS TO PATIENT CARE

Cost has assumed a key spot in discussions revolving around healthcare reform. It is top of mind for physicians as they struggle to contend with problems created by higher patient deductibles and rising drug costs. Here are three key factors that are driving up costs:

- **Payer initiatives.** Travis Broome is a healthcare economist who spent the first part of his career at CMS leading the development of Meaningful Use measures. Now he is healthcare policy lead at Aledade, Inc., a Bethesda, Md.-based firm that helps small, independent practices form Accountable Care Organizations (ACOs). He says that the motivation for establishing
Aledade was to give physicians the collective power to manage outside demands such as strict payer requirements, growing patient cost sharing, and government programs that aim to steer physicians toward value-based care.

“The ACO is an organization that can contract with Medicare — that can contract with [Blue Cross Blue Shield] — to get the claims data flowing to [physicians], to know what the payer knows. And also to create the financial model for making the investments in care coordination, care management, population health … We get someone in their practice to help [physicians] translate what they see in the population health platform [to] what they should do differently,” says Broome.

**High-deductible health plans.**

While there isn’t a single cause that has contributed to the sharp rise in healthcare costs, the advent of high-deductible health plans (HDHPs) seems to have accelerated the process and ratcheted up the problem for physicians and their patients. It puts practices in an uncomfortable position: needing to collect outstanding patient balances more aggressively, while trying to sympathize with cash-strapped patients. It is a no-win situation, often forcing the staff to take on the role of “bad guy.”

HDHPs were ostensibly created as a way to rein in runaway health costs, but they are increasingly becoming a problem for patients. Because of large annual deductibles which can range from hundreds of dollars to more than $5,000, these plans are also limiting patient access to healthcare — a fact confirmed by our survey respondents, 40 percent of whom said higher deductibles and higher patient cost-sharing were the largest barriers to good patient care in their practices.

Laurie Morgan, a partner with San Francisco-based consulting firm Capko & Morgan, says over the last decade the percentage of patients with HDHPs have exploded, citing statistics from the Kaiser Family Foundation. “In 2006 there were about 50 percent or so of employees who were on regular employer insurance (not ACA plans and not Medicaid or Medicare) facing a deductible,” says Morgan. “Moving up to 2015, that number was over 80 percent, so a huge increase in the number of people who are actually facing deductibles.” Not only has the number of people with deductibles increased, she points out, but the amount of the deductible has increased. “This is a significant jump [in the size of deductibles] and it is also getting out of the realm of the amount of money that many people have on hand to just write a check.”

**Prescription drug prices.**

In the 2016 release of the International Federation of Health Plans Comparative Price Report, which compares the global prices of healthcare and prescription medications across different countries, the United States stands out as the worst bargain, by far. For example, in the U.S., the arthritis drug Humira costs $2,669, yet in Switzerland the same drug costs only $822.

Most recently, a rising number of pharmaceutical companies have made exorbitant price increases for commonly prescribed medications. Mylan Pharmaceutical’s drug EpiPen is one such example. The drug, which is used to treat anaphylactic shock in children and adults has undergone a six-fold increase over the last eight years — from $100 for a single injector to approximately $600. This puts many parents in an unthinkably position: choosing cost over protecting their child’s life. Terence McAllister says he has witnessed his patients’ families struggle, sometimes choosing to purchase only a single pen, rather than carry backups. For his own emergency response kit, McAllister now uses epinephrine and a syringe, rather than an EpiPen. “EpiPens expire in a year,” he notes, “and it doesn’t make sense to buy a new EpiPen every year when the cost of epinephrine is a fraction, a tenth or less of what it would cost me to buy an EpiPen. “EpiPens expire in a year,” he notes, “and it doesn’t make sense to buy a new EpiPen every year when the cost of epinephrine is a fraction, a tenth or less of what it would cost me to buy an EpiPen. So those few extra seconds it would take me to draw up the epinephrine is something I have to account for.”

**THE EFFECTS OF HIGHER COSTS**

When the cost of care is too high, patients are more likely to avoid visits to their doctor or skip needed testing, like blood work to check for diabetes. According to the American Academy of Pediatrics (AAP) Periodic Survey of Fellows #91, 20 percent...
of patients with HDHPs chose not to seek preventive care for their children, and roughly 50 percent either reduced or combined follow-up visits to their doctors, and used telephone consultations in place of in-person visits. That has been Terrence McAllister’s experience. “We certainly have seen a decrease in the amount of use that people are making of acute care. We’ve noticed that people, especially those with [HDHPs] are more likely to put off routine care for chronic problems like asthma or Attention Deficit Hyperactivity Disorder, or not to seek care promptly for more acute problems,” he says.

Another result of the high cost of care is the intentional “rationing of care” by physicians who strive to order fewer tests or prescribe lower cost medications to help patients manage their healthcare costs. A survey published in the Journal of General Internal Medicine asked 1,348 physicians about their prescribing patterns for 10 interventions, focusing on the frequency of self-reported rationing. The survey found that primary-care physicians were more likely to ration care than surgical or procedural specialists. Overall, 53 percent reported that they had changed their clinical practice and refrained from ordering certain procedures or medications in order to reduce cost.

**TAKING BACK CONTROL**

While physicians may feel hamstrung by outside forces and the high cost of care, there are concrete things they can do to take back control of their practices. Here are five strategies to consider:

- **Educate patients and staff.** The burden of high healthcare costs can touch both low- and high-income patients, says Morgan. It is embarrassing to be asked for an unexpected, large sum of money regardless of social strata. Some practices feel they shouldn’t be responsible for educating patients about health insurance and their financial obligations. However, as Morgan points out, someone must do it. And since practices are essentially the endpoint in the revenue cycle and must often collect greater sums from patients, it is to their benefit to embrace both staff and patient education, so that there can be better communication on financial responsibilities.

- **Use technology to assist in patient collections.** One of the more effective strategies to assist in collections, says Morgan, is the use of technology. Using payer websites to verify patient eligibility and insurance benefits in real-time gives staff members valid information that they can share with patients, so that they may have respectful financial discussions about cost sharing. There are also a number of technology systems (patient portals and tablets) that can be used to facilitate ease of payments, and in some cases set up payment plans.

- **Review payer contracts.** While many practices let their payer contracts sit neglected in a desk drawer, this is the worst thing they can do. Many contracts contain an evergreen clause which lets them roll over at current reimbursement rates if the practice does nothing, says Morgan, meaning physicians can lose out on potential rate increases. It is better, she says, to hire outside help, if necessary, to manage payer contracts. The cost may be more than offset by negotiating more favorable terms at the end of the contract.

- **Offer patients cash discounts.** Because patients are more often faced with large deductibles that must be paid out of pocket, practices may come out better by offering cash discounts. The benefit to the practice is that they receive payment upfront in cash, and to the patient, a reduced financial responsibility. There is even a benefit to the insurance company, as payments that are accepted in cash are not applied to a patient’s annual deductible. Morgan says practices must first review their payer contracts to make sure that this would not be in violation of a payer’s “All Nations Clause,” which would require that the practice charge the same fee for its services to all parties, patient and payer alike. If the terms of the payer contract allow for a cash discount, then this option is open to the practice. Morgan says it is always wise to contact the payer for guidance, first.

- **Join a larger group.** Becoming part of an ACO, independent physician association, or other large group can help small independent practices reap economies of scale, and provide better care to their patients through care coordination. The benefits to physicians include retaining their independence, access to powerful health information technology; participating in population health initiatives; and gaining negotiating clout with payers.

“In the shared savings programs and the ACOs, not only do you do [population health] because it’s good for your patients, but so many physicians over time have essentially been trying to do the things that we are helping them to do because they are physicians, because that’s what they believe in, and not because it is a financial model,” says Broome.

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Physicians Practice wanted to find out how physicians were experiencing the effects of health reform in their own practices. So we contacted five physicians who took the survey (without knowing their answers to the questions) to get their in-depth opinions on health reform. Not a single one expressed unconditional support for the ACA. Some were previously fans of the law, but have changed their opinions over time. “A couple of years ago I would have said the ACA was [mostly better for physicians], but as we are proceeding with [major health insurers dropping out], premiums going up, and people unable to afford their deductible, I’m leaning towards maybe this wasn’t the right way to do it,” says Joseph Zebley, a Baltimore-based family physician at a concierge practice.

Perhaps this frustration comes from four years of having to deal with the negative ramifications of the law. In particular, as Zebley notes, collecting patient deductibles has become more challenging for physicians and their practices due to changes stemming from the ACA. Nearly 40 percent of survey respondents say this was their biggest challenge deriving from the reform law, the top concern. Moreover, 45 percent of physicians say collecting copays and deductibles for patients with exchange plans was their largest collection issue. This, in turn, has led to a changing, more tumultuous patient-doctor dynamic, say physicians interviewed for this article.

NEW PATIENT-DOCTOR DYNAMIC
For many physicians, this changing dynamic has created an uncomfortable environment when it comes time for patients to pay. This is the case at Stacey Blyth’s practice. Blyth, a family physician based in Greensboro, N.C., works for a multispecialty medical group, LaBauer HealthCare.

“The ACA kind of inadvertently consolidated the money and the power in the hands of the insurance companies. I’m at odds all the time with my patients trying to help them get the care they need out of their insurance company. Every time they come in, they want to come in less [after the visit] and do less because they can’t afford the deductible, the medicine, any of it. It’s horrible. I’ve practiced 15 years, I did not have this relationship with my patients five years ago,” says Blyth.

Brenda Fortunate, a retired family physician who works as a part-time faculty member for Genesys Health System in Grand Blanc, Mich., saw a similar impact on her practice before she hung up the stethoscope last...
year. “On one hand, we were able to offer preventive exams to almost anyone since that was a provision of the [ACA] and as a family doc, I believe prevention is key. On the other hand, the individuals who have high deductible plans aren’t coming to the office because all of a sudden they not only have to pay their healthcare premium, but the full cost of their office-based services as well,” she says.

“On one hand, we were able to offer preventive exams to almost anyone since that was a provision of the [ACA] and as a family doc, I believe prevention is key. On the other hand, the individuals who have high deductible plans aren’t coming to the office because all of a sudden they not only have to pay their healthcare premium, but the full cost of their office-based services as well.”

–Brenda Fortunate, family physician

The collection issues have additional ramifications beyond creating a tense environment. At his concierge practice, Zebley says that because patients pay an annual fee, the practice can forgive a lot of the high deductibles by having patients write explanatory letters explaining why they cannot pay the full amount. However, this leads to a slight reduction in overall revenue. With more than 50 percent of responding physicians indicating they can’t afford to work less, it appears that he is not the only one with revenue cycle problems.

Arvin Nanda, a family medicine physician at a three-doc practice in Dayton, Ohio, says narrow provider networks are a major repercussion arising from the law that affect his practice since they kick patients off a more cost-effective plans. “The insurance costs for patients continue to go up. Many of them can’t afford it,” he says, noting that like other physicians, he has had some tough conversations with his patients. “Many of the things that are recommended for care are not covered by insurance … even blood work is sometimes not covered.”

**MAJOR REGULATION OVERLOAD**

One potential mitigating factor in the ACA’s decreased approval is the law comes at a time where physicians have been bombarded with multiple forms of government interference, whether it’s Obamacare, Meaningful Use, ICD-10, the Physician Quality Reporting System (PQRS), or the impending release of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Indeed, the biggest frustration with being a physician in 2016, according to the GAP Survey, is third-party interference, which undoubtedly includes federal regulations.

“There is a symbolic nature to the ACA,” says Anders Gilberg, senior vice president of government affairs for the Medical Group Management Association. “When you talk to physicians about the ACA … they tend to take a lot of their experiences with the current administration, roll it into one, and associate it with the [health law]. Although there are some discrete different things in the ACA, many physicians don’t differentiate the administrative complexity [and] the regulatory burden they’ve faced. Since the [ACA] was the largest symbol of healthcare legislation in the current administration, when you ask them about it … they roll up a number of their frustrations into it.”

Robert Berenson, a physician and institute fellow at the Urban Institute, a Washington D.C.-based think tank, says there are elements of the ACA that both Republicans and Democrats would actually agree are needed, such as alternative payment models, developed under the auspices of the CMS Innovation Center. However, the health law has gotten an overall bad rap by many, he notes, because of the prominent, unpopular provisions such as coverage expansion and the individual mandate. Berenson says many of the ACA provisions actually are widely accepted, even if the law itself may be controversial.

**AMEND THE LAW**

While there is a somewhat negative tint to how many physicians view the ACA, it’s not all bad. After all, nearly half of the respon-
dentists to the GAP Survey say it’s been mostly good and 7.5 percent say it’s been great for the country. Along with the preventive-care factor, Fortunate says the ACA has been great for patients who have benefited from the Medicaid expansion. Nanda says on the positive side, the ACA allows kids under 26 to stay on their parents’ insurance plan, which is important for his practice, located near Dayton University. Another positive, he says, is it prevents patients with pre-existing conditions from getting kicked off their insurance plan.

Some physicians say the law can be amended and improved, rather than completely replaced. For Blyth, the answer to an improved ACA is clear. “If we could somehow reinstitute a public option, so that we could show what care really costs vs. what [private insurance companies] are choosing to charge to make record profits, then there could be something here we could salvage,” she says.

Nanda doesn’t like the idea of a total repeal. “Billions have already been spent on the ACA, to do a total repeal I think puts us back at ground zero and we’ve wasted all that money,” he says. “It doesn’t need to be repealed, it needs to be modified greatly.”

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— Arvin Nanda, family physician

REPEAL THE LAW

Others, however, are less certain it can be improved and think a total wipe out is necessary. Paul Norwood, an endocrinologist out of Fresno, Calif., is not a fan of the ACA. He says all it did was give the “same lousy system” to more people. As such, he prefers a market-driven system with a lot less regulation, requiring patients to pay out-of-pocket costs for medication, establishing different types of hospitals that are based on the type of care patients are looking for, and transparent prices from physicians.

“The current system is not sustainable and Medicare will not survive,” Norwood says. “The danger to the economy is serious, with a $19 trillion debt; it’s unaffordable to keep [it] going.”

Fortunate has reached the same conclusion as Norwood, but takes a different path to get there. She says if we are going to keep the current system and improve it, “Universal Medicare” would have been the better option.

Zebley isn’t calling for a repeal, but he says the way the ACA is structured, it won’t work. It has thrown people at the mercy of the insurance companies, and like Blyth, he says the public option should have been kept in. He favors a two-tiered system, where patients buy health insurance for “big-ticket” items and pay out of pocket for less expensive health services.

COMING NEXT?

Whether it’s the insurance industry, the Obama administration, Congress, or another entity altogether, many in the physician community feel there is plenty of blame to be passed around when it comes to their frustrations with the ACA. Looking ahead, will the next four years be kinder to the ACA — if it even continues to exist? And will physicians across the country change their view of healthcare reform? A lot depends on the actions of the next administration and Congress.

*Editor’s note: Coming soon on PhysiciansPractice.com, we will explore answers from the GAP Survey on the 2016 election as well as the in-depth thoughts of this panel of physicians on what hopes, if any, they have for healthcare reform in the coming four years under a new president. Stay tuned.

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WHY PHYSICIANS ARE EMBRACING DPC PRACTICES

Direct primary care practices are growing in popularity, according to this year’s GAP Survey. Why is that the case?
BY JANET KIDD STEWART

After 11 years as part of a group family practice, Michael Iannotti had earned top marks from payers for his ability to demonstrate quality measures, but was frustrated that not everyone in the group shared his zeal for documentation.

“Physicians don’t like all these new quality metrics, and the hospitals and government agencies that hire the physicians aren’t good at it, either, so they end up losing a lot of money on employed physicians,” he says. “I decided to create my own practice and participate proactively to get my quality measures to where they needed to be,” he says.

Iannotti also knew that eventually he wanted to own his own medical building and didn’t particularly care for the one he was practicing in, so the Lafayette, Colo.-based family practitioner decided to go solo last year. Not only did he go solo, but this fall he’s launching a concierge practice in addition to his separate fee-for-service aesthetics practice.

More and more physicians can relate to the need for reinventing the primary-care model. In the most recent Great American Physician GAP Survey, more than two-thirds of the 1,314 physician respondents say they would consider switching to a direct-pay practice that doesn’t accept insurance, they already have switched, or are planning to make the change.

Under certain circumstances, would you consider switching to a direct primary care (direct-pay) practice that does not accept insurance?

62.1% Yes — if the circumstances were favorable
5.2% I’m already working in such a practice model or I’m planning to switch
29.1% No — Such a practice is not right for me
3.6% I think direct-pay practices are bad for the healthcare system

A year earlier, responding to a similar but not identical question, 43.2 percent said they were considering a direct-pay practice and 10.3 percent said they were planning to switch or already had. The surge is exacerbating an already serious shortage of primary-care physicians in employed situations and traditional fee-for-service practices, says Jim Stone, president of The Medicus Firm, a Dallas-based physician staffing and recruiting firm.

When a physician decides to open a concierge or direct-pay practice, it typically involves slicing off a small portion of patients, creating a service void that either a hospital or practice must back-fill, Stone says. He says his firm has also been hired directly by physicians transitioning to DPC to find physicians willing to take custody of medical records and bring in patients not coming to the new practice.

“In internal medicine we used to have a third of residents go on to specialize in pulmonology or other fields and two-thirds went into practice. Now, the reverse is true and we further slice up the primary-care area with hospitalist, concierge, or other non-traditional models, so it’s gone from bad to worse [with regard to the shortage of primary-care physicians],” he says.

WHY THEY LOVE DPC

Physicians working in these new models, however, say they are thrilled to be more in control of their practices, are making more money than in their previous practice or expect to shortly, and are hearing from patients that they love the change.

“I’m no longer beholden to the ‘meaningless abuse’ model of
checking boxes” to fill out payer codes, says Denver family physician Michael Keller, referring tongue-in-cheek to his thoughts on Meaningful Use standards. “It really frees you up again to enjoy the practice.”

At a July conference in Kansas City on direct primary care, hosted by the American Academy of Family Physicians, keynote speaker and a DPC family practitioner Julie Gunther noticed many attendees were physicians still part of traditional practices and only beginning to contemplate making a change. Typically, DPC practices charge monthly fees that cover most primary-care services and they don’t take insurance, as opposed to some concierge services that combine fees and third-party payments.

So, during some downtime the first night of the event, she grabbed a microphone and asked two other DPC doctors to join her for an informal Q&A session.

“We had 40 doctors sitting there for three hours,” she says. “We finally had to cut it off. There are some hitches in the giddy-up, but what we do is so simple and sometimes [physicians] are made to think this is so complex. It’s amazing what you can do with a stethoscope, an iPhone, and a brain. And it’s neat to see these docs have micro-epiphanies, realizing they can be the kind of doctor they want to be.”

“In internal medicine we used to have a third of residents go on to specialize in pulmonology or other fields and two-thirds went into practice. Now, the reverse is true and we further slice up the primary-care area with hospitalist, concierge, or other non-traditional models, so it’s gone from bad to worse [with regard to the shortage of primary-care physicians].”

—Jim Stone, recruiter

Though Iannotti’s model is more complex, combining some aspects of traditional insurance payers, concierge, and direct pay, the sentiment of finding a more fulfilling practice type reflects his professional and personal goals.

“First and foremost, I wasn’t satisfied professionally with my income or my job,” he says. “I wanted life for my kids, my patients, and me to be better. I wanted money to eventually be able to send my kids to college, time to play a round of golf twice a month, and a better environment for my practice and my patients. All of that played a role” in his decision to start a new practice, he says.

DPC RISKS
For Gunther, dissatisfaction and burnout also drove her decision to make a change two years ago. While employed, she recalls one particularly grueling day when she saw 17 new patients. There was also the day when a trusted, highly skilled nurse quit to join a much slower-paced practice, and was later replaced by a very inexperienced nurse.

Routinely, the practice ran out of supplies that weren’t reordered until she made a fuss. She even changed a few light bulbs in the office. Finally, she decided that if she was going to have to do all this herself anyway, she should take charge. “When someone explained that if I would just take insurance out of the mix, then I was able to see a path where I believed I could do it,” she says.

Before jumping ship like Gunther, however, physicians need to be aware of some barriers to entry and some significant risks:

• It can be hard to break away. While many legal experts today say non-compete agreements aren’t holding up in court, it can still take resources to fight the battle, says Gunther, who had to give four months’ notice when she left her traditional practice. So first, realize the process of shifting gears could take some time, during which you may need to moonlight or seek some other temporary income stream.

• It can be risky. Walking away from a guaranteed or RVU-based salary takes some guts, so being at least a little risk tolerant is essential, experts say. At the time she launched her direct-pay practice two years ago, Gunther still had...
about $170,000 in medical school loans left to pay. Today, that’s down to about $100,000.

On top of loans, there is the common need to borrow funds to start a practice. Gunther was able to secure a Small Business Administration loan to buy her office building, which she’s partially renting out to other professionals while she builds out her practice.

His practice growth rate was roughly twice what he expected when he started it. About 10 months into the venture, he had more than 600 patients, but says non-emergency after-hours calls are rare because patients typically feel they are getting all their questions answered in their office visits. Keller charges $89 a month for adult patients that are 27 and older, and $59 a month for younger patients.

To mitigate risk if funds are extremely tight, she says, consider starting out small by renting space in a medical complex and moonlighting to supplement income for a while.

• The hours can still be long.

While direct-pay practices typically reduce a physician’s panel size, they don’t necessarily create bankers’ hours. Most DPC practices strive to offer same-day or nearly same-day appointments, and many offer weekend and evening hours.

Keller, who switched to a direct-pay practice, Summit Primary Care, in October 2015, says he’s on call 24/7 and schedules patients six days a week, including two evenings.

“The difference today is that I’m seeing six to 12 patients a day, not 30. It’s much more manageable.”

– Michael Keller, DPC family physician

• Watching overhead is a must.

Unlike Iannotti, Keller focuses exclusively on the direct-pay model, so he doesn’t have to pay for any staff time to work with insurance companies. His wife, Audrey, works for the practice as a part-time practice manager and he employs a medical assistant who helps him room patients, among other routine tasks. When not with a patient, however, it is typically Keller at the front desk greeting people who come into the office.

“I’ve found patients really like that,” he says. “You have to keep overhead down.”

Gunther bought her office building and employed a second physician for the practice before taking a salary for herself, but says both moves have already paid off because the building has appreciated and the other physician is picking up the patient load she can’t handle right now.

Meanwhile, she watches the smaller expenses closely. She purchased office equipment at discount retailers, for example, and counsels physicians who can’t afford to purchase their buildings to shorten their leases from three years to one or two.

“There are opportunities to just hemorrhage money doing this,” Gunther says, so take a pass on equipment leases if it’s something you can purchase cheaply at a warehouse store.

• Detailed charting won’t be left behind. Despite the considerable reduction in staff time devoted to billing third-party payers for services, physicians can’t throw away those EHRs, experts say.

“I’m meticulous about charting and want complete family histories in the record, both for medical and legal reasons,” says Keller. “But without having to worry about checking boxes on ICD-10 codes, I get a thorough note that clearly says what is happening with the patient.”

• It could take a while.

Physicians switching to a direct-pay model need to be aware that fast growth doesn’t always occur, says Gunther. “I had a business person tell me half of all businesses fail in the first year and that if you make it through the third year, you’ll probably make it,” she says.

“So I tell physicians to plan for three years how they are going to survive if the business isn’t profitable. Having that in place decreases the startup stress and the likelihood you’ll scalp your mission to make more money, which can compromise you.”

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