

Direct Primary Care: A Descriptive Evaluation of a New Care Delivery Model

Teri Bunker, FNP

Oregon Health & Sciences University



DNP Clinical Inquiry Project Report & DNP Portfolio Approval

Student Name: Teri Bunker, MS, FNP

Degree: Doctor of Nursing Practice

Title of Clinical Inquiry Project:

Direct Primary Care: A Descriptive Evaluation of a New Care Delivery Model

APPROVED:

Committee Chair: Deborah C. Messecar, PHD, MPH Signature: (name and credentials)

Committee Member: Myra L. Thompson, RN, DNP, FA Signature: (name and credentials)

Committee Member: Signature: (name and credentials)

Christine A. Tanner, R.N., Ph.D, FAAN, Interim Dean, School of Nursing Signature:

Date: 6/1/12

Submit completed original form to the Graduate Program office.

Contents

Introduction: The Clinical Problem.....	7
I.A. Description and Significance of the Clinical Problem.....	7
I.A.1. Clear description of the problem.....	7
I.A.4. Background knowledge of the clinical problem and settings in which it occurs	11
I.A.4.(1.B) Critical synthesis of relevant literature	13
Table 1. Direct Primary Care Evidence Table	15
I.A.4 (I.B.2.) State of the science (what is known)	19
I.A.5. Organizational/local knowledge of the problem	20
I.A.6. Importance to advanced practice nursing	21
I.A.7. Identify desired outcomes with impact.....	22
I.A.9. Clinical inquiry question(s).....	23
I.B. Synthesis of Evidence (see background and significance above)	24
I.B.4. Summary: Why start this project?.....	24

I.B.4.a. Relate the evidence to the clinical problem, clinical inquiry purpose, changing practice	24
I.B.4.b. What is the next step that is needed to change practice or translate research into practice?	25
II. Methods	25
II.A. Clinical inquiry design	25
II.A.1. Specify the type of design	26
II.A.2. Relate to the broad clinical inquiry purpose	26
II.B.3. Identify tradeoffs in design selection.....	26
II.B. Setting	27
II.B.1. Describe project setting	27
II.B.2. Identify and characterize elements of the local site(s) most likely to influence change/improvement.....	28
II.B.3.Organizational/systems and individual readiness to change	28
II.B.4. Driving forces and restraining forces.....	28
II.C. Sample.....	29
II.C.1. Inclusion and exclusion criteria.....	29
II.C.2. Size and rationale	30

II.C.3. Sampling method and recruitment plan.....	30
II.D. Description of Intervention or Program Being Evaluated	30
II.D.1 The focus of this clinical inquiry was on an existing practice improvement effort.....	30
II.D.2. Describe the existing program	31
II.E. Measures	32
II.F. Data collection procedures (sources and process)	34
II.G. Analytic methods	34
II.G.1, 2, &3. Analysis plan including cost analysis and presentation of data	34
Question 1: What are the demographic characteristics of the Alianz Primary Care patients?	35
Question 2: What are the primary care utilization patterns of the Alianz Primary Care patients?	35
Question 3: Does preliminary data indicate that the Alianz Primary Care delivery model can cover existing overhead costs at BCFMC?	35
II.G.4. Brief description of data management plan	36
II.H. Protection of human subjects/ ethics.....	36
II.I. Plan for dissemination to key stakeholders.	37

II.J. Timeline for project.....	37
III. Results.....	37
III.A. Sample	37
III.B. Findings (organized by clinical inquiry questions).....	38
Question 1: What are the demographic characteristics of the Alianz Primary Care patients?	38
Question 2: What are the primary care utilization patterns of the Alianz Primary Care patients?.....	41
Question 3: Does preliminary data indicate that the Alianz Primary Care delivery model can cover existing overhead costs at BCFMC?	43
IV. Discussion.....	44
IV.C. Macro and/or Mico Financial Considerations	50
IV.D. Situation Analysis.....	51
IV.F. Limitations.....	53
V. References.....	55
VII. Appendices.....	67
Appendix A Privacy notice	68
Appendix B IRB Approval.....	72

VIII. CIP Executive Summary 73

Introduction: The Clinical Problem

I.A. Description and Significance of the Clinical Problem

I.A.1. Clear description of the problem

Currently the numbers of Americans without health insurance has grown exponentially due to the cumulative effects of a catastrophic recession, exploding health care costs, and draconian cuts in Medicaid (Institute of Medicine, 2009). Basic primary care services can address the gap in access to care created by a lack of health insurance (Stewart et al., 1997). This project explored the potential financial and user acceptability viability of a direct primary care business model in a primary care practice owned by a Nurse Practitioner. Under this model of payment, the client pays the provider an agreed upon flat monthly fee in exchange for a mutually agreed upon set of healthcare services. The healthcare provider does not bill any 3rd party insurance company. The client and the healthcare provider acknowledge that this agreement is not health insurance but rather is *health care*; a fine distinction rarely ferreted out when discussing the looming healthcare crisis in the United States (Coons, 2010).

Health care reform promises new fixes, yet continues to ignore the obvious--health insurance does equal, nor guarantee *health care*—the two notions are not synonymous nor do they always exist in tandem. However the interchangeable use of these terms is so deeply entrenched in modern culture and politics that most Americans believe that without health insurance they do not have health care. Even President Obama's frequently uses the terms interchangeably "Now is the time to deliver on health insurance. Now is the time to deliver on health care"(Huffington Post, 2009). Information sharing via the Internet also perpetuates the confusion of health care with health insurance. For example, the following website http://www.staysmartstayhealthy.com/health_care_history_inthe_united_states purports to

explain how healthcare evolved in the United States. The author obviously is describing how health insurance evolved not health care. Confounding health insurance with health care keeps us from developing innovations outside of the traditional health insurance approach to care.

To understand the current healthcare system it is important to understand the evolution of healthcare vis-à-vis health insurance in the United States. How did American's end up with a healthcare system that by in large was paid for by their employers? In 1900 the average American spent about \$5 per year on their health care, the equivalent of \$135 in today's money (Manuel,D., (2012). They did not have health insurance, as the cost of healthcare was quite reasonable. Prior to the 1920's, hospitals were mostly poor houses, constructed by the government or other charitable institutions to care for the indigent. Not until the advent of antibiotics and improvements in medical care did hospitals become places where people went to for the treatment of an illness instead of as a place to die. Over time, hospitals became accepted as places of healing instead of places of death. With empty beds to fill hospitals began marketing their services first to pregnant women as a healthier alternative to home birth. Baylor hospital in Dallas Texas was the first hospital to offer a pre-paid healthcare plan, coining it Blue Cross, which originally was marketed to groups of schoolteachers. Baylor hoped this group of young women would be willing to spend a small amount each month whilst saving up for more expensive health care, such as the future birth of baby (Public Broadcast System, 2000).

World War II was the second and most important catalyst for the modern health insurance system. Goods were in short supply and recruitment of employees was paramount to keeping the country working and producing for the war. The limited factories needed workers and lures to keep them satisfied. Health insurance was added to the list of various other non-tangible or "fringe" benefits. In 1943 and again in 1954 the Internal Revenue Service (IRS), sweetened the

deal for everyone through various rulings regarding the taxability of fringe benefits. Between 1940-1953, the percentage of Americans with employer sponsored health insurance climbed from just 9% to 63% and by the early 1970's the number swelled to over 70% of the American population (PBS, 2000). Healthcare and thus the cost of insurance began to rise dramatically in the 1980s and continue to rise today consuming nearly 18% of the Gross Domestic Product (GDP), by the year 2025 it is projected to consume 25% of the GDP (The Altarum Institute, 2011).

According to a recent report by the (Collins, 2011) approximately 52million people are without healthcare insurance. Approximately 41% of working age Americans have medical bill problems and medical bills are a major factor in more than 60 % of bankruptcies—and 75% of those who were forced to declare bankruptcy actually had health insurance (Collins, Kriss, Doty, & Rustgi, 2008). Health insurance may not guarantee that healthcare is affordable, but it is helpful. The number of uninsured Americans continues to climb. Ten years ago 38 million American's were without health insurance. Today the number has increased by 75% to 52 million (Himmelstein, Thorne, Warren, & Woolhandler, 2009).

Health insurance company executives continue to receive record salaries and stock options. In 2009, combined profits among US health insurance companies increased by 56% in to a record \$12.2 billion (Walker, 2010). Counter-intuitively health insurance rates charged to consumers continue to rise by as much as 60% in some areas of the USA (Helfand, 2011). Aetna's former Chairman and CEO Ron Williams took home \$68.7 million dollars in 2010. He left the company in April of 2011—his compensation for those 4 months was over eighteen million dollars (Strauss, 2011). Combined, the chief executives of the big five for-profit health insurance companies had combined salaries of about \$200million in 2009 (Levey, 2010a,).

Health insurance companies are big business and deep pockets for politicians, contributing an aggregate \$42 million in state-level campaign contributions since 2003 (Levey, 2010b)

Wages continue to rise disproportionately to health insurance costs. In the United States, wages increased 3.8% between 2000 and 2006, yet health insurance premiums increased by 87% (Kaiser Commission on Medicaid and the Uninsured, 2011). The United States has the most expensive health care system in the world. In 2010 the per capita cost of health care in the United States was approximately \$8000. The costs are expected climb to nearly \$14,000 by the year 2020 (Squires, 2012; Center for Medicare & Medicaid Services, 2011). Spending more money on the health care system or directly on health care has not made Americans healthier. The United States ranks 37th in world health even though it spends more money than any other country on health care (Squires, 2012; Squires, 2011; Murray, & Frenk, 2010).

I.A.2.&3. Population affected by the problem--Epidemiology

Young adults age 19-29 have the highest rate of un-insurance compared to 18% of those age 65 or older. Twice as many employed young people do not health insurance, compared to older working adults, this is due to various factors such as low wages, single marital status, and size of the company that they work for. The majority of 19-29 are healthy and require mostly preventative or acute health care services, however 66% of uninsured young adults report no regular primary care provider and 20% reported that they had a health care need but did not access care due to the cost of the services (Schwartz & Schwartz, 2008; Collins & Nicholson, 2010;). About 75% of people in this age group report that they are in excellent health, 5% rank their health as poor. About 10% of the population age 19-29 had medical expenses, Thus the actual amount of money spent on health care for this group of people is low Generation Y (born in the 1980's- 1990's) is about 26% of the entire population of the United States, and is three

times larger than generation X (1965-1970's). At 80 million, generation Y is slightly larger than the baby boomers, 10,000 of whom turn age 65 every day (Hewlett, Sherbin, & Sumberg, 2009; Lower, 2008; Webster, 2005).

Health care expenditure is strongly correlated with age, increasing exponentially after age 50. Annual costs for the elderly are 4 to 5 times greater than that for people in their teens. The oldest group (85+) consumes as much as 50% of the healthcare expenditure yet are only 5% of the total population. A key part of healthcare reform is mandatory health insurance for everyone starting in 2014. Young healthy adults will be subsidizing the health care of older adults however only a small percentage of that money will actually be spent on actual health care for them (Squires, 2012; Murray, 2009; Deyo, 2000). Total health care expenditure in the United States is \$2.2 trillion dollars each year and it is estimated that as much as \$1.1 trillion dollars is spent on unnecessary medical tests, treatments, and doctors' visits under the current fee for service payment system (National Center for Health Statistics, 2011).

I.A.4. Background knowledge of the clinical problem and settings in which it occurs

Consumers have been purchasing health care with other people's money and as such have historically had very little interest in the true cost of services. While catastrophic health care needs may be financially devastating to some, most people pay next to nothing for their health care. On average the person with a comprehensive employer sponsored health insurance plan spends 10 cents on the dollar for health care services. Those with Medicaid and Medicare likely spend nothing at all. There remains a lack of economic incentive to change the consumption of health care (Goodman, 2006).

There also remains lack of understanding of health care versus health insurance and a belief that adequate health care is not possible without health insurance (Coons, 2010). Research

has shown that when consumers are given control and financial incentive to manage their own health care, they tend to make much more economical choices, opting for generic medications, less expensive treatments, and inquiring about treatment costs. Furthermore, patients with chronic health condition are 20% more likely to carefully follow treatment regimes (Goodman, 2006). According to a survey conducted by the Commonwealth Foundation 28% of young adults said they would be very likely to pay \$100 a month for health care coverage given the opportunity (Mustapha Resch, Combs, Little, & Shalwitz, 2005). Even though young people are disproportionally less likely to need health care, they do purchase health insurance if they can afford it. Eighty-six percent of young adults with income in the top 1/3 have health insurance, compared to just 56% of those in the lower 1/3 of the income bracket (Rampell, 2010).

Unlike lawyers and other professionals, nurse practitioners and physicians do not routinely talk to their clients on the phone or via email—not even for prescription refills. There are many purported reasons, privacy concerns often being the most referenced, however the real reason is that these exchanges are not billable. Providers are usually only compensated when they see patients in a face-to-face visit in their office (Goodman, 2006). The fact that patients are unable to speak with their provider on the phone leads to unnecessary visits for minor ailments, such as a cold and is a barrier to people with chronic conditions that may readily be managed with a phone call (Goodman, 2006). The average person, regardless of health insurance status, has an office visit with their primary care provider from 1-4 times per year (US Census, 2012). Studies show that over 70% of all medical issues can be attended to in a much more timely and cost efficient way such as, the phone, email, text message or other tele-visit fashion (Sullivan, 2011; McConnochie, et. al., 2010; Chumbler, et. al, 2005).

Just as demanding is increasing exponentially for primary care providers, the physicians who have traditionally cared for the lion's share of patients needing primary care are abandoning or avoiding primary care as a job all together. Job satisfaction as a primary care provider for physicians is low due to high student loan debt, too many patients and too little time, along with the daily battle with health insurance companies for payment or to advocate for their patients needs (Levin & Bateman, 2012). Clearly there is a problem that needs to rapidly be solved. There is a need to restore affordability to health care and health insurance while at the same time increasing patient and provider satisfaction. The two concepts have been mutually exclusive for the most part in the past 30 years. Direct primary care may be the solution to the looming crisis in primary care.

I.A.4.(1.B) Critical synthesis of relevant literature

Direct primary care is the delivery of health care services for a pre-defined monthly payment regardless of the number of monthly visits or other encounters with the health care provider. It is a membership contract between the consumer and the health care provider wherein the service or product is health care. No healthcare insurance is billed for the services rendered although the consumer may have health insurance for more costly services. This practice may also be referred to as concierge or retainer health care. There is much opinion in the healthcare literature about direct primary care or concierge care (Arene & Baker, 2002; Carroll, 2003; Linz, Haas, Fallon, & Metz, 2005; Lucier, et al., 2010; Portman, R. M., & Romanow, K. (2008), however there is little research regarding it (Saultz, et. al. 2010; Gorroll, Bagley, Harbrecht, Kirschner, Kenkeremath, 2010; Huddle & Centor, 2011)What research there is does support the notion that primary care can be provided for a reasonable monthly fee (Ganz, Goldman, & Thompson, 2006). Saultz, et. al. (2010) has conducted the most compelling research regarding

this topic at an academic clinic at Oregon Health and Sciences University. Data from this demonstration project supported strongly the financial viability of direct primary care. In 2011, Oregon became the third state to oversee the practice of direct primary care.

The battle cry of health care reform is disruptive solutions to the current high cost, low yield health care system, such as the looming requirement that every person purchase health insurance by the year 2014. As mentioned earlier, the cost of traditional health insurance is out of reach for many and it does not guarantee health care. Direct primary care has the ability to greatly reduce waste. Over 50% of every health care dollar is spent on administration and nearly half of every dollar spent on health care is wasted on unnecessary care (Weiss, 2002). By removing barriers to reimbursement, most patients, especially those with chronic illnesses, will actually get *more* care under the direct primary care model. The elimination of the fee for service model (FFS) greatly reduces unnecessary office visits, tests and other services. Providers have time to spend with their patients instead of rushing them through the office visit. Increased time spent with patients improves care and patient satisfaction. A summary of the studies and or policy papers regarding direct primary care studied thus far appears in Table 1.

Table 1. Direct Primary Care Evidence Table

Study	Sample	Measurement	Design	Outcomes
Saultz, et.al (2010)	N=600	Demographic Characteristics of patients (age, sex) Relative Value Units Number of visits Return visits Telephone calls Specialty referrals Financial viability	2 year descriptive study Compared to usual care Access Assured offered: office discount for those enrolling for a year had to enroll for a minimum of 6 months	Financially viability demonstrated Increased utilization among women (26%) Age significant predictor of return visit rate Factor in visit Rates were adjusted for poverty levels, but surprisingly, 50% of enrollees were above the 200% poverty level
Hargrave, ., Mahmud, Quirk, Summer, & Hoadley,	N=756 retainer physicians identified nationally	Interviewed physicians using one of three models of retainer	Stakeholder Interviews N=28 n=16 Physicians	Primary Care was the majority practice type Interviewees reported increased access to primary care provider

Study	Sample	Measurement	Design	Outcomes
(2010).	by online survey;	practice: Fee for extra care Fee for care (similar to direct primary care) Hybrid (elements of both	interviewed in-depth n=6 Fee for extra service n=6 Fee for Care n=4 Hybrid; n=12 other stakeholders Literature Review identified 20 journal articles on topic	Greater satisfaction for the MD provider
Gorroll, Berenson, Schoebaum & Gardner, 2007	Policy article proposing a new payment model for primary care	Suggested piloting in a variety of practice settings and wide spectrum of patients: First studies might simply test	Payment reform Uncoupling primary care from other services by using care coordination	And pt Reduce wasteful spending Increase primary care provider access Large cost savings Decreased administration overhead

Study	Sample	Measurement	Design	Outcomes
		feasibility	Incentive bonus	

Health care is truly one of the areas that entrepreneurs have yet to tackle. There is a rapidly expanding pool of Do-it-Yourself (DIY) Health Reformers (HR) who believe the only way to fix the system is to blow it up and start over (David Chase, 2011, personal interview December 2, 2011). One DIY HR is Dr. Forrest who has decided to take on the system without waiting for someone else to fix it. The DIY HR are having impressive results as they report the fix to better health care is not more regulation but more innovation (Fernandopulle, 2011). According to Dr. Frenandopulle too many companies look to address market imperfections or loopholes for greater reimbursement by doing more of things that aren't necessarily going to improve health but are going to generate revenue.

Direct primary care history

The roots of the direct primary care movement can be traced to Seattle Washington and what started as an answer to the problems that a group of physicians were having at the end of the health maintenance organization (HMO) era in the late 1990s. The Seattle group started a concierge medical practice limited to only 50 patients each, Drs Howard Maron and I. Scott Hall named this practice MD² squared ([MD² The Definitive Provider of Concierge Medicine, 2010](#)). This was truly an exclusive concierge practice with premiums per person upwards of one thousand dollars a month and each only accepted 50 families. The focus of this practice changed and as an offshoot the founders of MD2 started a less high end but still someone exclusive

practice in downtown Seattle called Seattle Medical Associates. Dr. Garrison Bliss, MD, cofounded Seattle Medical Associates (SMA) in 1997, as low cost, low overhead way to work directly for patients. They promised excellent care at a rate that the working uninsured could afford--\$65/month with rates rising to \$95/month by the time 2007 rolled around. The practice was entirely funded by the patients. The community was receptive and from a provider perspective the financials were rewarding. Bliss understood that SMA was not scalable but a lower cost version would be. Thus Qliance was formed. The original goals in 2007, were to further expand primary care services to include pediatrics, geriatrics, and gynecology; comprehensive in-office procedures such as X-rays and blood draws; a range of discounted prescription medications; and greater availability on weekends to address emergency room overutilization—all for an even lower monthly fee than SMA, an average of \$55 per person, per month (Bliss, 2010; The Physician’s foundation, 2010).

Over the past 10 years many variations of concierge medicine have sprung up around the United States. The exact number of practices is unknown, although Bliss co-founded a Direct Primary Care coalition, the website lists 80 direct primary care practices in 21 states <http://www.dpcare.org/practices> (The Physician’s Foundation, 2010). In 2007, the State of Washington passed legislation that allowed for the official designation and separation of direct primary care from the highly regulated Insurance Division. Qliance and a handful of other clinics began to offer direct primary care. At times in the past this practice has been criticized on moral and legal grounds and referred to as “boutique medicine” however many understand that this is affordable primary care redesigned into a care delivery model with broader appeal. Indeed direct primary care may be the answer to what ails primary care—access and affordability (Goodman, 2006; Huddle & Centor, 2011).

I.A.4 (I.B.2.) State of the science (what is known)

The Medical Home Model

In 2014, direct primary care practices will be recognized as “qualified health plans” under the health exchange rules resulting from Affordable Care Act and will qualify to operate as Medical Homes (Berry 2012; Gallegos, 2011). To comprehend the direct and indirect advantageous of the direct primary care model of care it is important to have an understanding of the current FFS system. The average full-time primary care provider has a panel of 2000-6000 patients and sees from 18-60 patients per 8 to 10 hour clinical day. Given the constraints of time it is not possible to spend more than 7-17.6 min per patient (Goodman, 2006; Murray, Davies, & Boushon, 2007). There is nothing else to be squeezed from primary care. Under the direct primary care model it is possible and preferable to take care of the patient in the best and most effective manner possible. Up to 70% of the time the patient’s needs may be attended to in a non face-to-face visit. Thus saving the patient the hassle of taking off from work, time to commute to the office during a narrow time and the ability to avoid a crowded medical office during which time he or she may actually contract an illness.

The Primary Care Workforce

A recent report from the Kaiser Family Foundation found that the vast majority of Nurse Practitioners (NP)s work in the area of primary care. NPs are also, by far, the fastest growing segment of the primary care professional workforce; between the mid 1990s and the mid-2000s, their numbers (per capita) grew an average of more than 9% annually, compared with about 4% for PAs and just 1% for primary care physicians. According to one account about 10,000 NPs run their own practices (Kaiser Commission on Medicaid and the Uninsured, 2011). Approximately 83,000 NPs and 26,000 PAs practice in primary care today (Kaiser Commission

on Medicaid and the Uninsured). In 2009, NPs were 27% of the primary care providers in the USA, and PAs, 15%. The report also found that NPs and to a lesser degree PAs tended to fill a much greater primary care need in densely populated and less urban/lower income levels, as well as in Health Professional Shortage Areas. There is much research that demonstrates that NPs and PAs are the most likely providers ascribed to taking care large numbers of minorities, the underserved and Medicaid beneficiaries. Nurse practitioners are well poised to assume the lion's share of primary care delivery in the United States. Research has shown that NPs perform as well as or better than MDs in clinical outcome measures such as mortality and management of chronic and acute health conditions. Patients report being very highly satisfied with care received by NPs. Many studies have shown that patients are more satisfied with care provided to them by a NP when compared to a MD, and report receiving more appropriate advice regarding their health care needs. In general NPs and MDs provide care to a similar mix of complex patients and achieve the same or better results based on health outcomes and patient satisfaction studied (Kaiser Commission on Medicaid and the Uninsured, 2011).

I.A.5. Organizational/local knowledge of the problem

Direct Primary Care in Oregon

In 2011 the regulation of direct primary care practices in Oregon became the purview of the Department of Consumer and Business Safety (DCBS), the regulatory arm of the health insurance system. Providers offering direct primary care services must register and report annually to the DCBS. Oregon's laws on direct primary care closely mirror Washington State's Insurances law on the same type of practice. The direct primary care practice that is being evaluated in this project closely mirrors the Washington direct primary care practice, Qliance. Reports to the state of Washington from Qliance have been very favorable (Washington

Insurance Commissioner, 2011). The Washington State Insurance Commission has noted no complaints from Qliance and their consumer ratings are in the top 1% of all service industries in the United States (Bliss, 2010).

I.A.6. Importance to advanced practice nursing

Aside from restrictive practice laws, which vary from state to state, the primary barrier to NP success regarding independent practice is related to reimbursement and the insurance industry. In Oregon, while those barriers are not as prevalent, they have been relevant non the less. The insurance industry seeks the weakest link by which to either increase premiums or decrease reimbursement. In the 2010 Oregon legislative year NPs unsuccessfully attempted to stop the practice of private insurance companies decreasing NP reimbursement to 85% that of physicians for the *first time* in the history of Oregon. In 2009 Psychiatric Mental Health Nurse Practitioners (PMHNPs) in Oregon experienced a similar drastic reduction in re-imburement rates by as much as 50% compared to MD psychiatrists with no explanation from the insurance companies. Unlike most primary care NPs, most PMHNPs in Oregon are in a high demand setting or are self-employed. As such many PMHNPs addressed the problem by opting out of the insurance panel by becoming non-participating providers, thus passing the costs to the individual patient (personal communication Kathleen Sheridan, PMHNP 2011). Nurse practitioners in primary care in Oregon are predominately employed by physicians and as such do not have the ability to “opt out” of participation in insurance networks. We need more NPs in private practice and need to add to already published strategies to make that possible (Barry, 2005; 2006; Bergmann, 1998; Brown, 2007; Buppert, 1996; Crow, 1996; Dirubbo, 2005a;2005b; 2007; Klausner, 2005; Malone-Rising, 2007; Martin, 2005; Martin, 2002; Reel, 2003; Robnett, 2003; Tumolo, 2004; 2005; 2006).

I.A.7. Identify desired outcomes with impact

The future of primary care

Direct primary care is a low-overhead, cash-based primary care business model. Revenue is not dependent upon the volatility of the FFS model of care. Nurse practitioners are trained specifically to approach healthcare from a very holistic and economical position. Nurse practitioners are on track to be the most numerous primary care providers in the United States. Healthcare insurance is increasingly being recognized as having a non-viable future in the redesigned delivery of primary care. In March of 2010 the Patient Protection and Affordable Care Act (PPACA) was signed into law, section 1301 (a)(3) allows direct primary care to participate in the insurance exchanges beginning in 2014. People will be able to select the direct primary care option for their primary care and to match that with a high deductible (HD) health care insurance plan.

Possible pitfalls to this model

The traditional system of fee for service is deeply entrenched in the psyche of the American consumer. The Supreme Court may overturn the PPACA; an opinion is expected in June of 2012. In 2014, the PPACA mandates will include direct primary care options. Health care remains a very politically charged topic. If President Obama is not re-elected it is possible that a new administration might likely abolish the entire health care reform legislation thus leaving direct primary care with perhaps a limited marketability.

What are the Desired Outcomes?

The desired outcome of this model is that the business of primary care to become less reliant upon the traditional FFS payment system. A primary care clinic operating under a FFS

business model could readily shift completely to a direct primary care model or a hybrid mixed direct care and FFS model.

Long Term Goals

The long-term goal is to shift from FFS to a majority direct primary care. It is estimated that each primary care provider could adequately care for 800- 1200 direct care patients, which would generate revenue of approximately \$1million dollars per year per provider. Additional goals are to expand the direct care practice to other geographical areas in the Portland, Oregon area.

I.A.8. Purpose statement

The purpose of this project was to describe the demographic characteristics, and care utilization patterns of those patients enrolling from June 15, 2011 through April 15, 2012 of the direct primary care program called Alianz Primary Care at Bridge City Family Medical Clinic in Portland Oregon (BCFMC). In addition, the cost per visit for all people who signed up as members of the Alianz Primary Care plan were compared to the historic overall cost per visit for traditional fee for service patients at BCFMC. This final report includes utilization data and a discussion of the financial aspects of this care delivery model and projections based on this model of care delivery.

I.A.9. Clinical inquiry question(s)

The clinical inquiry questions for this pilot project were:

1. What are the demographic characteristics of the Alianz Primary Care patients?
2. What are the primary care utilization patterns of the Alianz Primary Care patients?
3. Does preliminary data indicate that the Alianz Primary Care delivery model will cover overhead costs at BCFMC?

I.B. Synthesis of Evidence (see background and significance above)

I.B.4. Summary: Why start this project?

Reliance on the health insurance industry to fix the problem of health care is similar to asking the proverbial fox to guard the hen house. Health insurance companies have a vested interest in maintaining the status quo. Demand will continue to exceed supply if favorable solutions are not employed. The main complaints from primary care providers and the reasons for primary care provider burn out are primarily an increasing administrative workload, which accounts for up to 50% of the primary care providers time—and for 50% of the healthcare dollar and decreasing revenue, despite the fact that the price of health insurance is on the rise. It is no surprise that many primary care providers or would be primary care providers do not view primary care a long-term viable career choice.

I.B.4.a. Relate the evidence to the clinical problem, clinical inquiry purpose, changing practice

Starting in 2014, the demand for primary care providers is going to be much greater than ever before. The cost of health care is out of control and is on track to consume close to 20% of the GDP in the next 10 years. Primary care providers are in greater demand than ever, however they are also exceedingly burned out on the current system. Demand for primary care providers is expected to greatly increase in the near future. There is a need to address the supply of primary care providers, and the cost and quality of health care services provided. The purpose of this clinical inquiry project is to evaluate a innovative model of primary care that has the potential to reduce cost, increase quality and increase job satisfaction among primary care providers. Nurse practitioners are poised to become the most numerous primary care providers in the United States. Many nurse practitioners are interested in becoming business owners. This model of

primary care delivery simplifies the very complicated and expensive process of getting paid for services rendered.

I.B.4.b. What is the next step that is needed to change practice or translate research into practice?

Nurse practitioners have very little training regarding the business of healthcare. The very idea of private practice ownership is a daunting prospect. One of the major obstacles to overcome in the process is credentialing and payment by health insurance companies who's main objectives are to cut costs and increase profit. Direct primary care removes many of the obstacles to private practice ownership by simplifying the payment methodology.

II. Methods

II.A. Clinical inquiry design

This project described demographic characteristics and care utilization patterns of those patients enrolling in the direct primary care A P C pilot project from June 15, 2011 through April 15, 2012 at BCFMC. First, data collected from the electronic health record, was used to describe the four key demographic characteristics of the Allianz Primary Care patient enrollees that in prior studies (Salutz et al.) predicted health care utilization. These data were abstracted from the electronic medical records system at BCFMC and included the following: gender, age, marital or partnered status, and highest level of education. In addition, data were collected to describe visit and phone call utilization, the type of care provided and for what diagnoses, and the amount and type of ancillary services used (e.g laboratory, imaging, etc.). Revenues collected over the pilot period were also tabulated.

II.A.1. Specify the type of design

This was a formative practice evaluation design project that examined questions of practicality for an existing pilot program of direct primary care called Alianz Primary Care. A formative practice evaluation design is ideal for piloting innovative ideas and collecting preliminary data about their utility. In formative evaluation, the focus can be on implementation and or progress. Implementation evaluation asks question like: who will sign up? How much will they participate or use a service? Are there unanticipated problems? In general, an implementation evaluation asks whether or not an intervention or pilot program is feasible (Nutbeam & Bauman, 2006). This project sought to describe the characteristics of patients who did enroll in a pilot direct primary care program, to describe their care utilization patterns in terms of numbers of visits and types of diagnoses, and to determine if the revenue collected would cover the basic costs of providing care. The financial feasibility of this model was evaluated by looking at utilization and cost per visit data on patients who self-selected to participate in the Alianz Primary Care program.

II.A.2. Relate to the broad clinical inquiry purpose

The financial viability of this practice model was examined. The implications for advancing the Nurse Practitioner (NP) profession are as follows. Decreasing overall health costs is a priority for NPs, as is providing more care for the underserved. This project evaluated an existing model of direct primary care that is currently ongoing at BCFMC. The emphasis on service and access in is more in keeping with values from the foundations of the nursing model.

II.B.3. Identify tradeoffs in design selection

Formative evaluation is directed toward questions about the practicality of different program approaches to a difficult to solve practice problem. This type of evaluation focus is

different from an outcomes evaluation where a more mature practice approach is tested to see if it is successfully achieving its goals. The early stage of development of direct primary care as a practice innovation was a large factor in selecting a formative evaluation approach. Direct primary care is a new care delivery model that so far is not well established in the health care world. There were no other justifiable design selections to evaluate such a new practice.

There were very little data on the financial feasibility of this model as there continue to be very few direct care practices. Those who are in practice were not willing to divulge the financial details of their business plan. Beginning descriptive studies of the financial feasibility of this approach were and continue to be needed. Nurse Practitioners contemplating piloting this type of care delivery need this basic information about utilization and costs before further work can be done regarding patient outcomes.

II.B. Setting

All patients enrolled in Alianz primary care at Bridge City Family Medical Clinic from June 15, 2011 to April 15, 2012 were to be part of this evaluation project. BCFMC is described in detail below.

II.B.1. Describe project setting

Bridge City Family Medical Clinic (BCFMC) is fully owned by Teri Bunker, FNP. Founded in 2003, the existing location is a 5,500 square foot primary care clinic, which is well appointed and aesthetically pleasing. There are 6 full time equivalent primary care positions and a total of 17 employees. One of the providers is a Doctor of Osteopathy; the remainder of the primary care providers are Nurse Practitioners. The clinic serves people of all ages. Special services at the clinic but not included as part of the Alianz Primary Care plan are osteopathic manipulation, allergy and asthma specialty treatment, house calls, and therapeutic massage.

Evening hour appointments and Saturday appointments are available for all patients. Alianz Primary Care patients have access to their primary care provider through traditional office visits, email, and phone call appointments.

II.B.2. Identify and characterize elements of the local site(s) most likely to influence change/improvement

The location provided an ample selection pool of patients who chose the Alianz Primary Care plan. The care delivery system is changing rapidly and will be fundamentally very different in 2014 and the employees and the owner of BCFMC are very adept at keeping abreast of the latest changes to the healthcare system. Bridge City Family Medical Clinic is situated in a very convenient Portland location, easily accessed from all directions. It is a convenient location for those who live in the immediate and not so immediate neighborhood. The setting is pleasing and well appointed conveying a sense concierge care.

II.B.3. Organizational/systems and individual readiness to change

There is a very cohesive team of providers and ancillary staff at Bridge City Family Medical Clinic. The successful owner entrepreneur encourages change and invites the staff to engage in the challenge of health system redesign. The staff is open to changes and eager to greet the challenges of the health care system with energy and enthusiasm.

II.B.4. Driving forces and restraining forces

There are multiple driving forces for a project such as this and they include the following: the existing FFS model is no longer a financially sustainable business practice; the current FFS has created a environment of stress which has led to high provider burn out; the current health care system is top heavy with specialists and other ancillary services, partly due to hurried

primary care providers who do not have the time to fully assess or research their patients' healthcare need during the primary care visit.

Restraining forces that influenced this project were not knowing the willingness or availability of patients who were willing or able to pre-pay for health care. The notion that health insurance is equivalent to health care is not true and the possibility that providers will simply chose to continue the treadmill of primary care under the direct primary care model to increase profit and chose not to change the system by seeing fewer patients and providing more services to their patients.

II.C. Sample

The sample consisted of all patients from BCFMC who signed up for Alianz Primary Care from June 15, 2011 through April 15, 2012. Demographics, utilization patterns, and cost per visit for those patients were evaluated. Historical data collected on cost per visit data on FFS BCFMC patients was compared descriptively with the data collected on the Alianz Primary Care patients.

II.C.1. Inclusion and exclusion criteria

Inclusion criteria: All self-selecting patients who enrolled in Alianz Primary Care from June 15, 2011 to April 15, 2012. There are no medical or pre existing exclusions. None. This is not health insurance. No health insurance will be billed for services rendered under the Alianz Primary Care plan therefore all patients who selected this plan were eligible to participate in this evaluation.

Exclusion criteria: Over or equal to age 65 with Medicare; any other form of health insurance that is not a high deductible plan. Alianz Primary Care

II.C.2. Size and rationale

The Alianz Primary Care program was and still is in its infancy and as such there was a need to determine the financial viability of such a business plan. As such the sample size included all patients enrolled in the plan between June 15, 2011 and April 15, 2012. The sample size included every patient in order to gain the most insight into the utilization of primary care services and the demographics of the population, as well as the financial viability of this practice model.

II.C.3. Sampling method and recruitment plan

Only de-identified data pulled from the electronic record systems was used to address the clinical inquiry project. No HIPAA personally identifying data was used (eg. birthdates, names, addresses). Data from the records of patients meeting the inclusion criteria was pulled to describe the demographic and utilization patterns of the Alianz Primary Care members. To be clear, we did not recruit patients for this project, rather existing data were collected via the electronic medical records systems for evaluation. All new patients at BCFMC signed a Privacy Notice Acknowledgement that allowed the clinic to use de-identified data from the electronic medical records system for practice improvement, see Appendix A

II.D. Description of Intervention or Program Being Evaluated

II.D.1 The focus of this clinical inquiry was on an existing practice improvement effort

The focus on this clinical inquiry was on an existing practice improvement innovation called Alianz Primary Care. The formative evaluation specifically focused on the utilization data and cost of care delivery per patient. There were no interventions. This was a descriptive analysis from a unique business perspective that compared data collected on utilization and cost per visit data on BCFMC Alianz Primary Care Patients.

II.D.2. Describe the existing program

In Alianz Primary Care, the annual fee covers the availability and complete supervision of health care 24 hours a day, 7 days a week, including coordination of all consultative or emergency care. Email and telephone appointments are also available for no additional fee. Comprehensive primary care medical services available at Bridge City Family Medical Clinic are covered 100% with no additional out of pocket expenses to patients including:

Testing:

- All in house tests or laboratory testing completed at the clinic office.
- Send out laboratory testing as indicated including: pap smear (yearly), complete blood count (CBC), cholesterol, thyroid testing, urine culture, basic or comprehensive metabolic panel, urinalysis, vitamin D, testosterone, and hemoglobin A1c.
- X-rays at Epic Imaging at 65% discount from standard pricing. Once a year chest radiograph as needed.

Exams:

- Annual physical exams
- Gynecological examinations

Specific procedures as needed or indicated:

- Electrocardiograms
- Spirometry and oxygen saturation
- Tetanus, flu and pneumonia vaccines

Additional services:

- Significant discounts negotiated for you with other health care providers

- Assistance when necessary to obtain free or discounted medication for those who qualify due to income or other criteria as established by the pharmaceutical company.

II.E. Measures

Age: Age was abstracted by using the birth month date and then calculating age for each Alianz Primary Care member as of June 15, 2011. In the data set for the evaluation project, the age in years was reported without using actual birthdates.

Gender: A field in the electronic medical record labeled gender was used to indicate gender of Alianz Primary Care members.

Education level: A field in the paper initial history form labeled education was used to describe highest level of education of Alianz Primary Care members.

Marital or partner status: A field in the paper initial history form labeled education was used to describe highest level of education of Alianz Primary Care members.

Active chronic illness diagnoses: A field in the electronic medical record labeled active problem list was used to identify the chronic diagnoses of Alianz Primary Care members.

Status as prior existing patient: A field in the electronic medical record labeled date first established with BCFMC was used identify which of the Alianz Primary Care members were existing patients prior to signing up for Alianz Primary Care.

Total number of Alianz Primary Care visits: A field in the electronic medical record labeled encounter visit was used to identify the number of visits made by Alianz Primary Care members.

Total number of paid member months: A tally from the billing department of total number of memberships paid for each month.

Total revenue generated: A tally from the billing department of the total fees paid.

Total number of Alianz Primary Care telephone calls: Any notes in the electronic medical record where a telephone encounter was recorded was used to identify the number of telephone calls that were made to Alianz Primary Care members.

Total number of Alianz Primary Care specialty referrals: Any notes in the electronic medical record where a specialty referral was made and was recorded were used to identify the number of specialty referral made for Alianz Primary Care members.

Total number of Alianz Primary Care laboratory tests and associated costs: the aggregate billing statement from June 15, 2011 through April 15, 2012 from LabCorp was used to identify the name of and cost of all laboratory testing for Alianz Primary Care members.

Total number of Alianz Primary Care imaging tests ordered and associated costs: the monthly bill for EPIC imaging was used and designated the name of and cost of imaging testing for Alianz Primary Care members.

Total number of Alianz Primary Care electrocardiograms (ECG) were identified during the chart review for any electrocardiograms performed on Alianz Primary Care members.

Total number of Alianz Primary Care spirometry and oxygen saturation were identified during chart review for any of these services performed on Alianz Primary Care members.

Total number of Alianz Primary Care of vaccinations: the chart designated any vaccinations performed on Alianz Primary Care members.

Total revenue for the Alianz patients per the nine-month period of practice evaluation: fees collected in the BCFMC billing department determined the total revenue collected.

Average overhead visit cost for fee for service model: calculated by taking total clinic overhead per month of \$140,000 and then dividing it by 20 business days per month (on average), this was then divided by the number of providers and then by 8 hours per day to

calculate that 3 patients per hour per day per provider must be seen in order to cover the overhead costs to completely. Cost per visit, 60 patients per day = \$62.50. In some months not enough visits were made and in some months more visits were made. This was the target for each month for the FFS patients. The cost to deliver care to the Allianz Primary Care patients was expected to be the same compared to the FFS patients. The Allianz Primary Care program is not dependent upon FFS payment, the patient was not required to make a face-to-face visit to have their healthcare needs addressed. Revenue was based on the overall service not FFS per visit. It was anticipated that there would be fewer face-to-face visits with the primary care provider. The overhead visit cost was used to determine if the revenue generated by the Allianz Primary Care program was at a minimum covering existing operating costs of BCFMC.

Did revenue from the Allianz Primary Care program cover the average cost per visit operating overhead for BCFMC? This was determined by taking the total revenue for all the Allianz Primary Care patients and dividing that by the total number of visits of these patients to determine if at baseline the revenue covers the existing overhead costs for the clinic.

II.F. Data collection procedures (sources and process)

The process of data abstraction was outlined in the description of the variables that were used in the evaluation (see measures). Data were pulled from the electronic chart records system and the billing records by the clinical project inquiry investigator. An Excel 2007 database was created with all of the abstracted data. As stated previously, no identifiable patient data was exported (such as birth dates, names) to the Excel 2007 database that was used for the analysis.

II.G. Analytic methods

II.G.1, 2, &3. Analysis plan including cost analysis and presentation of data

The analysis was described for each clinical inquiry question.

Question 1: What are the demographic characteristics of the Alianz Primary Care patients?

The demographic characteristics of the Alianz Primary Care patients were analyzed using Excel 2007 and a table depicting these results was created. The table included mean age for all participants, the percent in each age category for the fee structure for Alianz Primary Care (monthly fees are based on age of the patient), Gender, Marital/Partner status, and Education. Also the percent of patients who were new versus those who were existing patients prior to enrollment in the Alianz primary care plan. The percent of patients who could be considered complex chronic illness patients based on having two or more chronic diagnoses was also included.

Question 2: What are the primary care utilization patterns of the Alianz Primary Care patients?

The next results table cross references utilization of services for all Alianz Primary Care patients by age category. Categories that were included for all patients, and per age category were: total number of visits; total number of telephone calls; and total number of specialty referrals. The total number and costs of laboratory tests; imaging procedures; electrocardiograms; spirometry and pulse oximetry and vaccinations were recorded in the aggregate and reported by category. The patterns of ICD9 codes recorded for all visits were described by categorizing the codes in order of how frequently they appeared in the records. Many patients had more than one ICD9 code recorded, so the total number of codes recorded was counted and their frequency was noted.

Question 3: Does preliminary data indicate that the Alianz Primary Care delivery model can cover existing overhead costs at BCFMC?

This was determined by taking the total revenue for all the Alianz Primary Care patients and dividing that by the total number of visits of these patients to determine if at baseline the

revenue covers the existing overhead costs for the clinic. Given the pilot nature of this project, this simple model for examining the feasibility of this type of care seemed warranted. Previous reports that have examined the pros and cons of providing concierge medicine (a model of care that is similar to direct primary care) (Saultz, et al. 2010) used cost analysis by relative value units. Relative value units (RVUs) (Uwe, 2010) are a measure of value used in the Medicare reimbursement for medical services and are part of Medicare's resource-based relative value scale (RBRVS). In this prior study, the researchers calculated a reimbursement rate for their services per RSU by combining the membership fee, visit fee collections, and other receivables. Because of the small number of participants in this pilot project, this model seemed a less useful way of calculating the break even costs than the approach taken which is by total revenue divided by total visits.

II.G.4. Brief description of data management plan

After data were abstracted from the BFCMC electronic medical records and billing systems, they were entered into the Excel 2007 database. As stated previously, no identifiable patient information data were exported (such as birth dates, names) to the Excel database that was used for the analysis. No patient or chart data left the BFCMC premises. Only de-identified data were used for analysis.

II.H. Protection of human subjects/ ethics

This clinical inquiry project received an expedited review status from the OHSU IRB review. A copy of the approval memo from the OHSU Institutional Review Board appears in Appendix B. The project examined existing medical and billing records data to evaluate a practice improvement project. No identifiable patient data was used in this project. In addition, this practice evaluation examined data from an existing innovation in care delivery at BCFMC.

II.I. Plan for dissemination to key stakeholders.

The key stakeholder is the student Teri Bunker, FNP who conducted this clinical inquiry project at BCFMC to improve practice. This information was used to internally evaluate the financial viability of the Alianz Primary Care practice model.

II.J. Timeline for project

Date	Event
February 2012:	Abstract data from electronic databases at BCFMC
	Create Excel database with de-identified data
March 2012	Prepare descriptive statistics on Alianz Primary Care
	Prepare utilization statistics on Alianz Primary Care
	Calculate total visits and total revenue
	Prepare data displays for Clinical Inquiry Project write up
	Complete revisions of Clinical Inquiry Project intro and other sections
April 2012	Write up results
May 24, 2012	PowerPoint presentation for defense

III. Results

III.A. Sample

A total of N=46 patients enrolled in Alianz Primary Care during the period of June 15, 2011 to April 15, 2012. Fifty percent of the enrollees were prior patients of the BCFMC clinic. Over 85% of the enrollees in Alianz Primary Care continue to be active participants. Only six patients dropped out of the Alianz care program and just one patient was dismissed from care due to narcotic drug seeking behavior. Reasons given for leaving for the Alianz care program

included: (n=1) obtaining health insurance through OHP, (n=2) not feeling that they were using the service enough to warrant continuing to pre pay the costs, and (n=3) or not being able to pay the monthly fee. This analysis of the pilot data included all of the original enrollees including the 15% who had dropped out. Of the 46 patients enrolled, over 70% were 40 years old or older. Half of the patients were male and half were female. The mean number of years of education was $M=13$; $SD=.23$. A little less than half of the sample had greater than a high school education and reported having attended at least some college level education institution. A large percentage of patients were categorized as having more than two chronic conditions (65%).

III.B. Findings (organized by clinical inquiry questions)

Question 1: What are the demographic characteristics of the Alianz Primary Care patients?

Table 1. depicts the details of the demographic characteristics of the Alianz Primary Care patients. The table included mean age for all participants, the percent in each age category for the fee structure for Alianz Primary Care (monthly fees are based on age of the patient), Gender, Marital/Partner status, and Education. The sample was mostly middle-aged or older, and only 3 patients were younger than 30 years old. Even though the pricing was considerably cheaper for younger enrollees, few individuals in those age categories chose to sign up. Participants were equally divided among male and female gender. Almost all of the enrollees had at least a high school education (only one enrollee reported that they held less than a high school education. Also in Table 1, the percent of patients who were new versus those who were existing patients prior to enrollment in the Alianz primary care plan is reported. The percent of patients who could be considered complex chronic illness patients based on having two or more chronic diagnoses was also noted. Only four patients had no chronic conditions.

Table 1. Demographics Alianz Primary Care Patients

Demographic Characteristic	Total N=46
	%(n)
Prior Patient (yes)	50% (n=23)
Enrollment Status as of 4/15. 2012	
Withdrew	13% (n=6)
Active	76% (n=35)
Active (paid in full)	9% (n=4)
Dismissed*	2%(n=1)
Total Active Patients	85%
Age	
	M=45 (11.7); Md: 46
	Range: 19-64
Age categories	
19	2% (n=1)
20 -29	4% (n=2)
30 - 39	24% (n=11)
40 - 49	26% (n=12)
50 - 59	35% (n=16)
60 - 64	9% (n=4)

Demographic Characteristic	Total N=46
Gender	
Male	50% (n=23)
Female	50% (n=23)
Education	
M=13 (.23); Md=12	
Range :10-16	
Less than High School	2% (n=1)
High School	54% (n=25)
Beyond High School	26% (n=12)
Bachelor's degree	17% (n=8)
Current Partner (yes)	48% (n=22)
Range of Number of Chronic Illness Dx	
0	9% (n=4)
1	26% (n=12)
2	37% (n=17)
3	24% (n=11)
4	4% (n=2)
Two or More Chronic Diagnoses	65% (n=30)

*Patient dismissed due to drug seeking behavior

Question 2: What are the primary care utilization patterns of the Alianz Primary Care patients?

Table 2. cross references utilization of services for all Alianz Primary Care patients by age category. Categories that will be included for all patients, and per age category are: total number of visits; total number of telephone calls; and total number of specialty referrals. As expected, the older patients make more visits. The number of calls was low, with the exception of one patient for whom ten phone calls were made. This patient really enjoys contact with the providers and is a bit atypical in this regard. No specialty referrals were made.

Table 2. Utilization of Services (Visits, Phone calls, Referrals)

Age Categories	Percent age category	Total # Visits N=135	Total # Calls N=17	Total # Referrals N=0
19	2% (n=1)	0.7% (n=1)	0	0
20 -29	4% (n=2)	1.5% (n=2)	1	0
30 - 39	24% (n=11)	18.5%(n=25)	0	0
40 - 49	26% (n=12)	27.4%(n=37)	1	0
50 - 59	35% (n=16)	35.5%(n=48)	15*	0
60 - 64	9% (n=4)	16.3%(n=22)	0	0

*one patient had 10 phone calls

Table 3. lists the total number and costs of laboratory tests; imaging procedures; electrocardiograms; spirometry and pulse oximetry and vaccinations were recorded in the aggregate. The total numbers of ancillary services and their costs have not been data that were routinely collected as part of practice monitoring activities among the other BCFMC patients.

Table 3. Total Number and Costs of Laboratory Tests, Imaging Procedures, EKGs, Spirometry and Pulse Ox, Vaccinations

Type of ancillary services utilization	Total Number	Total Costs
Laboratory tests	N=119	\$842
Imaging procedures	N=1	\$35.00
Electrocardiograms	N=0	\$0
Spirometry and Pulse Oximetry	N=0	\$0
Vaccinations	N=0	\$0

Table 4 lists the ten most common diagnoses for the Alianz Primary Care Patients. The third column in the table identifies whether or not the ICD9 code falls into one of the Patient Protection and Affordable Care Act (ACA) qualified chronic conditions. This distinction was made due to the rapidly changing focus of Medicare and Medicaid on these issues and additional funding that is being directed to care for this population. A qualified chronic condition is defined in the ACA as a serious mental health condition, substance abuse disorder, asthma, diabetes, heart disease or having a body mass index (BMI) over 25 (Carroll & Roddin, 2012). Note that very few of the Alianz Primary Care Patients were seen for ACA-qualified chronic conditions. Only three out of the nine most common ICD9 codes fall into this category of condition.

Table 4. Ten Most Common Diagnoses for the Alianz Primary Care Patients.

ICD 9 codes frequency	Total Number of ICD9 N=74	ACA-qualified Chronic conditions categories

401 to 401.9 (Hypertension)	23% (n=17)	Not an ACA-qualified CC
300 (Anxiety)	12% (n=9)	Not an ACA-qualified CC
272 (Hyperlipidemia)	11% (n=8)	Not an ACA-qualified CC
311 (Depression)	8% (n=6)	Not an ACA-qualified CC
302 (Gender Dysphoria)	4% (n=3)	Not an ACA-qualified CC
278 (Obesity)	4% (n=3)	ACA-qualified CC
244 (Hypothyroidism)	3% (n=2)	Not an ACA-qualified CC
296 (Bipolar Disease)	3% (n=2)	ACA-qualified CC
250 (Diabetes Type II)	3% (n=2)	ACA-qualified CC
Other ICD 9 codes recorded:	Only one diagnosis per category for these codes	
493, 309, 314		ACA-qualified CC
795, 789, 722, 714, 627, 555, 275, 257, 256, 209, 305, 307, 327, 340, 346, 396, 429, 477, 491		Not an ACA-qualified CC

Question 3: Does preliminary data indicate that the Allianz Primary Care delivery model can cover existing overhead costs at BCFMC?

This was determined by taking the total revenue for all the Allianz Primary Care patients (\$17,086.00) and dividing that by the total number of visits (n=135) of these patients to determine if at baseline the revenue covers the existing overhead costs for the clinic. For each visit, the clinic collected \$126.56 in revenue. The overhead costs for every clinic was calculated

by including the costs from paying clinic personnel and providers, rent, utilities, maintenance and cleaning, supplies, professional services, and payroll taxes and other expenses directly related to clinic operations. On average at BCFMC the overhead cost for providing one clinic visits was \$62.50. Preliminary data seemed to indicate that, in spite of the assumption that only patients with high utilization needs would purchase direct primary care, revenue from this model of care exceeded the cost of providing care for these patients. The total number of member months was calculated at 166. The revenue per member per month (PMPM) was \$105.50.

IV. Discussion

IV.A. Interpretation

The results of this formative evaluation of this pilot project support the practical and financial viability of a pre-paid direct primary care practice model. These findings mirror those of others who have studied the direct primary care model (Saultz et al. 2010). First and foremost, the formative evaluation indicated that patients would enroll in Alianz Primary Care and for the most part, would remain enrolled. Only six patients dropped out of Alianz Primary Care. Most of those who did drop out did so for overwhelming financial reasons. A retention rate of 85% among the Alianz Primary Care enrollees indicates that this model shows promise of being highly sustainable.

Next, the population of enrollees shared many characteristics in common with FFS patients. Among the Alianz Primary Care enrollees, the typical patient was male or female (50/50 split) age 40 to 50 and visited the clinic about 3 times over the period of 10 months. Three visits per year compares to the average number of visits that the typical clinic has per year/per patient under the FFS system reported nationally (Murray, Davies & Boushon, 2007). Consistent with data from national surveys (Murray et al.), the data presented in Table 2 indicated that older

enrollees had higher visit rates than younger persons in general. In addition, six of the ten most common visit diagnoses recorded for Alianz Primary Care patients matched the ten most frequent primary care diagnoses nationally by the CDC (Schappert & Rechtsteiner, 2007). The top three diagnoses for the Alianz Primary Care even more closely copied those seen nationally, and included the top two conditions hypertension and hyperlipidemia. Two top diagnoses on the Alianz Primary Care list that were not on the national list included depression and bipolar disease. Anxiety was a frequent diagnosis for both the national sample and Alianz Primary Care. It might be possible that Alianz Primary Care is fulfilling an important need among patients with mental health issues that are not able to access primary care in typical FFS models.

Revenue from the Alianz Primary Care group, (generated from the monthly retainer fee), was double compared to what would have been expected under the FFS model based on BFCMC history with their FFS patients and data collected in this formative evaluation. In the aggregate, the Alianz Primary Care patients visited the clinic a total of 135 visits times over a 10 month period of time, or about 3 times per person, which is the average number of visits reported in the literature among the FFS population. This formative evaluation project demonstrates that the Alianz Primary Care patients behaved very similar to the FFS patients. This should reassure those who might be concerned that patients would over-use the system or conversely that providers might not provide appropriate services. With direct primary care there is no incentive for providers to generate additional income through unnecessary appointments.

Implementation of direct primary care as piloted in this project could be a good decision for businesses to purchase for their employees along with a high deductible plan. Direct primary care is a business relationship between the patient and the primary care provider without the involvement of health insurance. Removing the health insurance company from the equation has

been reported to result in a cost savings of about 40% (Crane, 2005). Employers might save as much as 25-35% in insurance premiums. When employees are ill, because they have a direct relationship with their provider and their provider is much more available, the employee might not need to leave the employment setting for a visit to the provider's office, again saving money for the employer, the employee, and the provider. Direct primary care is a viable care delivery option to reduce health care costs for individuals, and businesses, and to increase job satisfaction among primary care providers.

There is potential with this model of direct primary care to improve work quality of life for providers. It is important that the job satisfaction and emotional well being of the primary care provider be considered an important variable in the health of patients. Patient satisfaction and provider satisfaction go hand in hand. Excessive provider burn out is the negative byproduct of the treadmill FFS approach to primary care (Baron, 2010; Berry-Millett, Bandara, & Bodenheimer, 2009; Chen, Hollenberg, Michelen, Peterson, & Casalino, 2011), which coincidentally also increases the between visit workload as well (Doerr, 2010; Schattner, 2011). The lower business overhead model of direct primary care reduces expenses by as much as 40%, thereby allowing the primary care provider to assume responsibilities for a much lower number of patients (Crane, 2005). Instead of the usual 2,000-3,000 patients the provider usually assumes primary responsibility for (Edsall, 2007; Eichler et al. 2010; Green, Savin, & Murray, 2007), a model of 800 to 1200 patients per provider becomes possible (Davies & Boushon, 2007; Goroll, Bagley, Harbrecht, Kirschner, Kenkeremath, 2010; Goroll, Berenson, Schoebaum, & Gardner, 2007).

Better care for patients might also be possible. Primary care is essential to the well-being and ongoing health of every patient. At the core of the primary care is a clinic and an individual

relationship with a provider. Patient care and thus patient health suffers when there is a lack of a consistent primary care provider. Patients often fall through the cracks when they do not have a consistent primary care provider. Primary care providers have a short tenure at a practice that does not meet their financial or mental health needs. Patients are also having trouble getting access to primary care (Kontopantelis, Roland, & Reeves, 2010) because the field is not attractive to providers. When there is not the pressure to generate revenue the provider and the patient are free to pursue whatever form of communication needed to meet the healthcare needs of the patient and frequently this can be accomplished in ways that are not usually recognized as legitimate billable patient encounters, such as email, telephone or video visits.

Primary care providers are also able to provide a higher quality of care during visits if they are not required to flood their office with thousands of patients (Antonucci, 2008). A smaller pool of patients allows primary care providers to spend more time with each patient. Instead of rushing through a visit in 7 to 10 minutes patients are allocated the time needed to fully comprehend their problems and make appropriate recommendations, including shared decision-making visits (Chen, Hollenberg, Michelen, Peterson, & Casalino, 2011). For patients with chronic health care needs such as diabetes, congestive heart failure or asthma, the unrestricted access to a primary care provider may have dramatic effects on the health of the patient as well as result in tremendous savings to the health care system as a whole.

Preliminary demonstration of the feasibility of direct primary care makes it possible to imagine someday decoupling the provision of primary care from health insurance. Primary care, much like the routine care of an automobile is predictable. Imagine if automobile insurance paid for oil changes. The insurance company would have to credential each shop, decide how often oil changes would be paid for, how much oil each car would be allowed, what kind of oil, who

would be a qualified oil changer, how would the shop bill for the oil change, etc. The cost of each oil change would rise dramatically. In life accidents or unexpected situations occur. Insurance should be reserved for sudden unexpected or unforeseen situations that are not predictable, not for everyday routine needs such as oil changes or primary care. Preventive care makes more sense (Rasmussen, 2007). When healthcare needs are within the realm of primary care or when costlier, unexpected medical care is needed; ideally the patient has some additional resources to pay for this, such as a high deductible plan.

It is useful to consider the changes in total health spending that might result from implementation of this model of direct primary care. The majority of the uninsured in the United States are working families (Berg, 2008). The annual income from a full-time minimum wage job is only a few hundred more dollars than the cost of the average family insurance plan. Yet unpaid medical bills are a huge cause of bankruptcy in the US (Himmelstein, Thorne, Warren, Woolhandler, 2009). Direct primary care coupled with a low-premium, high deductible insurance plan for everything except primary care has the potential to reduce costs to families by as much as 50% (Collins, Kriss, Doty, & Rustgi, 2008). As noted earlier, employers may save as much as 20-35% on comprehensive health benefits for employees, while employees receive more care since with direct primary care there are no co-pays or deductibles to meet (Crane, 2005). The average expenditure in the United States will decrease as less money is spent on unnecessary diagnostics, specialists and hospital and/or emergency room use (Deyo, 2000). Healthier populations who have more convenient access to primary care are also more productive workplace members as there is a lower rate of absenteeism among healthy workers who have alternative options for primary care rather than taking time off during the day to visit the primary care provider's office.

Direct primary care has the ability to reinvigorate primary care. The elimination of health insurance frees the primary care provider to focus on taking care of patients. Through the direct primary care approach field tested in this formative evaluation primary care providers have the potential to build deeper and more personal relationships with their patients, which gives them much more ability to diagnose and treat underlying health problems. Less stress at work and more meaningful relationships with patients improves the work-life balance that many providers are seeking in their everyday life.

IV.B. Context

The results of this pilot project are similar to other research (Saultz, Brown et al. 2010) and the experiences of other primary care clinics (Bliss, 2010) in that direct primary care is not only a financially viable option compared to FFS but is indeed more profitable. A direct primary care arrangement will not cover catastrophic health care needs of patients and as such is best paired with a high deductible healthcare insurance plan or a health care savings plan to cover incidences that primarily may result in a hospital stay. An advantage of direct primary care is that typically the fees are paid over time rather than directly as a FFS payment. The primary care provider is financially incentivized to promote the long-term health of the patient. The provider does not have to be compensated for each visit and is free to spend as long with the patient as is necessary to meet the existing health care need. Patients and providers may choose to talk on the phone, to email, to have video visits or to have face-to-face visits. The focus on preventative health care, and patient satisfaction will likely provide the primary care provider with the greatest financial gains over the long run. When providers are able to spend more time with each patient they are likely to order fewer laboratory tests, fewer imaging studies and refer patients to

fewer specialists. The Allianz Primary Care program had no specialist referrals and only 1 chest x-ray.

IV.C. Macro and/or Mico Financial Considerations

As has been the experience of others (Saultz, 2010; Saultz, et. al. 2010; Saultz et. al 2011; The physicians foundation, 2010), direct primary care is a viable business model and suitable replacement for FFS primary care providers, it also may be much more profitable. Business modeling using the data from this project demonstrates potential income from only 800 direct primary care patients would generate practice revenue in excess of \$1million per year. In 2008, the average primary care provider carrying a panel of 2251 patients in private practice generated FFS revenue of \$621,338 per primary care physician, or about \$276 per patient. In 2010, Qliance reported that based on \$60 per member per month the annual revenue to the practice per patient enrolled was over 2.5 times higher than that of FFS at \$720 per year (The Physicians Foundation, 2010).

The key to ensuring the viability of this plan is patient satisfaction and quality care. For example, at Qliance providers are paid bonuses based on patient satisfaction and satisfactory performance on quality benchmarks (Bliss, 2010). Being more available and more responsive to patient needs has been shown to decrease costs through reduced specialty referrals, decreased diagnostic testing, and decreased hospital visits, especially emergency department utilization (The Physicians Foundation, 2010). This formative evaluation demonstrated that there were no specialty referrals; others have reported that in general specialist referrals were decreased by 54% and emergency room use was decreased by 62% (Fontaine, Flottemesch, Solberg, & Asche, 2011).

Future implementation steps for a direct primary care practice should certainly take into consideration patient satisfaction and quality benchmarks as factors in the compensation package of primary care providers. This has already been implemented by Qliance in Seattle (Bliss, 2010). Obviously collecting patient satisfaction data and tracking primary care quality benchmarks would be an important ongoing part of developing this model. This was not a focus of this initial formative evaluation as the primary question that had to be answered was whether or not patients would sign up for this program and if the costs could be covered by the monthly membership fees. Having determined this was possible, next steps are to add more process evaluation measures to the ongoing assessment of Alianz primary care at BCFMC, which would include patient satisfaction and benchmark measures.

IV.D. Situation Analysis

This formative evaluation project was prompted by a need to evaluate a practice improvement idea from a business perspective at BCFMC. The project started in the summer of 2011 with the identification of a need at BCFMC to evaluate a new way of delivering primary care that did not include the use of health insurance. In June of 2011, BCFMC unveiled a direct primary care plan of care called Alainz Primary Care. The start of the new plan at BCFMC coincided with inspiration to do a formative evaluation of this pilot program. In the late summer and fall, the review of literature was written and the clinical inquiry questions were developed. During the Winter term of 2012, plans for the formative evaluation were refined and the Clinical Inquiry Project proposal defense meeting was held with committee Chair Dr. Deborah Messecar, PhD and Dr. Myra Thompson DNP and DNP student Teri Bunker. The committee approved the proposal and it was sent to the OHSU Institutional Review Board (IRB) for review. Subsequently the proposal was granted an IRB expedited review status and data collection

began. In March and April of 2012, the data were analyzed and tabulated using simple descriptive statistics functions possible in Excel 2007.

The project demonstration was very successful and the formative evaluation was crucial for documenting this. The hypothesis that direct primary care as piloted through the Allianz Primary Care model would be a practical and financially viable business approach and would prove to be a sustainable alternative to FFS was demonstrated. The lessons learned in carrying out the Clinical Inquiry Proposal were to keep motivated and try to work on the project a little bit most days to prevent large amounts of work from piling up. BCFMC administrative staff were instrumental in creating the Excel 2007 spreadsheet shell that was used for data collection. The work to conceptualize and then actually collect the data needed for this formative evaluation has helped the DNP student to identify how future practice monitoring activities should be structured. For example, BCFMC did not have the means with their prior EMR system to track number of visits for a certain number of years and collected revenue. A new EMR system at BCFMC has now been implemented that will make this possible from this point forward. Detailed profiling of utilization will facilitate going on to the next stage of evaluation, which will include a process evaluation that will track patient satisfaction and primary care practice benchmarking.

IV.E. Outcomes

This project has helped to answer beginning critical questions about Allianz Primary Care that needed to be ascertained to further the business model development of direct primary care at BCFMC. Basically, to determine long-term feasibility, BCFMC needed to know if patients would join such a program, what those patients would be like, and whether or not revenues collected could cover expenses. This project demonstrates that this is a practical and financially

viable health care delivery model. Patients without health care will benefit from a low cost healthcare option that is not health insurance. It is the hope that this project will help to reinvigorate primary care at BCFMC as the providers struggle with burn out to the same degree that many primary care providers in other practices do. When providers have high job satisfaction they are likely to provide a higher quality of care, which directly benefits patients and society by reducing costs and improving health.

IV.F. Limitations

A formative evaluation of a pilot practice innovation has limitations that are inherent to groundbreaking undertakings. The Clinical Inquiry Project has by necessity, a short study period. But this short time frame was not inconsistent with a formative evaluation approach because the goals of this analysis were first to determine if this concept was going to work. As a result, at the time of the data analysis, several of the patients had only been in the program a few months. This meant we had only a short time in which to conduct visit frequency and utilization analyses. The short study period and newness of the practice innovation also meant that the sample size for the descriptive analysis was small (N=46); thus the sample was small and the time period of evaluation was limited. Another limitation of the short time frame for data collection was that the financial revenue might be overestimated due to the one time initiation fee of \$99. Although not every patient was charged the full initiation amount, due to various discounts or a waiver of the fee at the discretion of the practice owner, because this is higher than the monthly fee, it may have inflated revenues.

Another limitation necessitated by the nature of pioneering endeavors is that those that self-select into such programs are possibly not typical of the general population because they are early adopters of an innovation. In this project, as noted, the patients did self select and in

addition to being early adopters may have been higher utilizers of health care, especially those who were not prior patients of BCFMC. It is also possible that the group was healthier than the majority of the patients at BCFMC as most patients did not have any ACA qualified conditions.

A third limitation associated with evaluating something as new as direct primary care is that there are limited reports in the literature of similar evaluations to help guide evaluation design. Hence selection of variables to measure at this early stage of development has to be based purely on practice experience and is further constrained by the properties and capabilities of existing electronic medical records. One such limitation encountered in this project was the difficulty in extracting detailed visit utilization data. To verify visit data, each electronic record has to be examined by the DNP student in detail to make sure that correct data were entered into the Excel 2007 spreadsheet – it was not possible to export this directly into Excel. Next stage process evaluations of Alianz Primary Care will be done with a new electronic medical record system that should make data management far easier.

G. Conclusions

The US has the most expensive health care in the world health. The US spends \$8000 per capita--62% more--than the #2 and #3 ranked Norway and Switzerland respectively. Despite spending the most in the world on health care, the US ranks an abdominal 37th in world health, far behind Norway or Sweden who rank 11th and 20th respectively (Squires, 2012). Solving the health care crisis in the US is one of the most important issues facing the USA today and there are many ideas about the best way to achieve this goal. The most popular idea is that the government mandate insurance for every citizen. It is time to step back and take a closer look at what role health insurance should play in the health care of the US people. Some say that the definition of insanity is doing the same thing over again and expecting a different result.

Continuing to fund the health care of the US based primarily on an insurance-based system is to continue a system that has already been proven to be too expensive and not conducive to the quality of health that US citizens should expect. There is a large amount of money that is going to unnecessary care, primarily care that could be prevented with the common sense approach of direct primary care. Money is the common language used to communicate the value of goods and services. In health care for far too long the purchaser of the health insurance, i.e. the employer has been the real customer and not the consumer. Employers hold the key to control the cost of health care vis-à-vis health insurance. Empowering consumers is perhaps the best way to control the expenses of the current system. A consumer based system. In a consumer based system patients have been found to ask about costs twice as much and three times more likely to choose a less expensive treatment option (Goodman, 2006). Insurance is a critical element in the health care of Americans - *for expensive, unusual, unpredictable events*. It creates significant problems when used as a payment system for everyday health care. The insurance infrastructure actually makes primary care more expensive and less effective.

V. References

- Altarum Institute. (2011). Health Care Spending Share of GDP Reaches 18 percent. Retrieved from: <http://www.altarum.org/health-systems-research-news-releases/12Aug11-health-briefs>.
- Antonucci, J. (2008). Is 'busy' good?. *Family Practice Management*, 15(8), 52.
- Arene, I., Baker, S. (2002). Applause, catcalls greet retainer medicine. *Managed Care*, 11(11), 40-42.
- Barry, P. (2005). Perspectives on private practice. The logistics of setting of a private practice. *Perspectives in Psychiatric Care*, 41(3), 136-138.

- Barry, P. (2006). Perspectives on private practice. Professional malpractice insurance and practicing within professional guidelines. *Perspectives in Psychiatric Care*, 42(3), 201-203.
- Berry, E. (2012). Oregon requires concierge physicians to register with insurance department. AMED news. Retrieved from: <http://www.ama-assn.org/amednews/2012/01/30/bise0201.htm>
- Baron, R. J. (2010). What's keeping us so busy in primary care? A snapshot from one practice. *New England Journal of Medicine*, 362(17), 1632-1636.
- Berg, T. L. (2008). Cost of the uninsured. *South Dakota Medicine: The Journal of the South Dakota State Medical Association*, 61(6), 206-207.
- Bergmann, P. A. (1998). Invest in yourself. Lessons learned from nurse entrepreneurs. *Nursing Forum*, 33(3), 17- 21.
- Berry-Millett, R., Bandara, S., & Bodenheimer, T. (2009). The health care problem no one's talking about. *Journal of Family Practice*, 58(12), 633-637.
- Bliss, E. (2010). Qliance staff. Retrieved from: <http://www.qliance.com/our-clinicians-seattle.html>
- Brown, D. J. (2007). Consumer perspectives on nurse practitioners and independent practice. *Journal of the American Academy of Nurse Practitioners*, 19(10), 523-529.
- Buppert, C. (1996). Nurse practitioner private practice: Three legal pitfalls to avoid. *Nurse Practitioner*, 21(4), 32- 34.
- Carroll, J. (2003). Concierge care by any name raises ethical concerns. *Managed Care*, 12(11), 48-51.

Carroll, S., & Roddin, D. (2012). Health homes for the chronically ill: An opportunity for states.

The Commonwealth Fund. Retrieved from:

<http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx>

Center for Medicare & Medicaid Services. (2011). National Health Expenditure projections

2010-2020. Retrieved from:

<https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>

Chen, M., Hollenberg, J., Michelen, W., Peterson, J., & Casalino, L. (2011). Patient care outside of office visits: A primary care physician time study. *Journal of General Internal Medicine*, 26(1), 58-63.

Chumbler, N., Vogel, B. Garel, M., Qin, H. Kobb, R., Ryan, P.(2005). Health services utilization of a care coordination/home-telehealth program for veterans with diabetes: a matched-cohort study. *The Journal of ambulatory care management*. Volume: 28, Issue: 3, Pages: 230-240.

Colling, S. (2011). Help on the Horizon. Retrieved from:

<http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Mar/Help-on-the-Horizon.aspx>

Collins, S. R. & Nicholson, J. L. (2010) Rite of Passage: Young Adults and the Affordable Care Act of 2010. *The Commonwealth Fund*. May 21, 2010 | Volume 87. retrieved from:

<http://www.commonwealthfund.org/Publications/Issue-Briefs/2010/May/Rite-of-Passage-Young-Adults-and-the-Affordable-Care-Act-of-2010.aspx>

- Collins, S., Kriss, J. Doty, M. & Rustgi, S. (2008). Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007. August 20, 2008 | Volume 99.
- Coons, S. (2010). Health care reform in the united states: So near and yet so far. *Clinical Therapeutics*, 32(3), 544-545.
- Crane, S. (2005). Low-overhead practice models and the uninsured: Harnessing the power of small scale to address large unmet health needs. *North Carolina Medical Journal*, 66(3), 205-207.
- Crow, G. (1996). The business of planning your practice: Success is no accident. *Advanced Practice Nursing Quarterly*, 2(1), 55-61.
- Davies, M., & Boushon, B. (2007). Panel size: How many patients can one doctor manage? *Family Practice Management*, 14(4), 44-51.
- Deyo, R. (2000). Cost-effectiveness of primary care. *Journal of the American Board of Family Practice*, 13(1), 47-54.
- Dirubbo, N. (2005a). The cost of getting your business off the ground. *Nurse Practitioner*, 30(11), 22.
- Dirubbo, N. (2005b). What does "self-employed" mean? *Nurse Practitioner*, 30(2), 6.
- Dirubbo, N. (2007). Risk management for the NP business owner. *Nurse Practitioner*, 32(3), 12.
- Doerr, E., Galpin, K., Jones-Taylor, C., Anander, S., Demosthenes, C., Platt, S., & Ponkshe, S. (2010). Between- visit workload in primary care. *Journal of General Internal Medicine*, 25(12), 1289-1292.

- Edsall, R. (2007). The right number: Optimizing panel size. *Family Practice Management*, 14(4), 10.
- Eichler, K., Imhof, D., Moshinsky, C. C., Zoller, M., Senn, O., Rosemann, T., & Huber, C. A. (2010). The provision of out-of-hours care and associated costs in an urban area
- Fernandopulle, R. (2011). Health and Healthcare Series III, Innovating for Value in Health Care Delivery: Better Cross-Border Learning, Smarter Adaptation and Adoption. Presented at Salzburg Global Seminar, Sun 25 Sep - Sat 01 Oct, 2011
- Fontaine, P., Flottemesch, T. J., Solberg, L. I., & Asche, S. E. (2011). Is consistent primary care within a patient-centered medical home related to utilization patterns and costs? *Journal of Ambulatory Care Management*, 34(1), 10-19.
- Gallegos, 2011. New Direct Primary Care Plans ByPass Insurers and Regulators. San Francisco Daily Journal. Retrieved from:<http://www.arentfox.com/pdf/SFJ0223001.pdf>.
- Ganz, D., Goldman, E., & Thompson, T. (2006). Concierge care can cut costs. *AHIP Coverage*, 47(2), 49-50.
- Goodman, J. (2006). Consumer directed health care. Retrieved from:
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=985572#PaperDownload
- Goroll, A. H., Bagley, B., Harbrecht, M., Kirschner, N. Kenkeremath, N. (2010 June). *Payment reform to support high-performing practice*. Report of the Payment Reform Task Force of the Patient-Centered Primary Care Collaborative. Washington, DC: Patient-Centered Primary Care Collaborative.

Goroll, A., Berenson, R., Schoebaum, S., & Gardner, L. (2007). Fundamental reform of payment for adult primary care: Comprehensive payment for comprehensive care. *Society of General Internal Medicine*, 22: 410-415.

Green, L. V., Savin, S., & Murray, M. (2007). Providing timely access to care: What is the right patient panel size. *Joint Commission Journal on Quality & Patient Safety*, 33(4), 211-218.

Hargrave, E., Mahmud, A., Quirk, K., Summer, L., & Hoadley, J. (2010). Retainer based physicians: Characteristics, Impact, and policy considerations. MedPac. Retrieved from: http://www.medpac.gov/documents/oct10_retainerbasedphysicians_contractor_cb.pdf

Hewlett, S. A., Sherbin, L., & Sumberg, K. (2009). How gen Y and boomers will reshape your agenda. *Harvard Business Review*, 87(7-8), 71-76.

Himmelstein, D. U. Thorne, D. Warren, E. Woolhandler, S. (2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *The American Journal of Medicine*, Vol 122, No 8, August 2009

Huddle, T. S., & Centor, R. M. (2011). Retainer medicine: An ethically legitimate form of practice that can improve primary care. *Annals of Internal Medicine*, 155(9), 633-635.

Huffington Post, (2009). Obama: 'Time To Deliver' On Health Care (VIDEO). Accessed at: http://www.huffingtonpost.com/2009/06/06/obama-time-to-deliver-on-_n_212136.html?

Institute of Medicine. (2009). America's uninsured crisis: consequences for health and health care. Washington DC: The National Academies

- Kaiser Commission on Medicaid and the Uninsured. (2011). Improving access to adult primary care in Medicaid: Exploring the potential role of nurse practitioners and physician assistants. Retrieved from: <http://www.kff.org/medicaid/upload/8167.pdf>
- Klausner, T. I. (2005). Make your practice distinct. *Advance for Nurse Practitioners*, 13(10), 15.
- Kontopantelis, E., Roland, M., & Reeves, D. (2010). Patient experience of access to primary care: Identification of predictors in a national patient survey. *BMC Family Practice*, 11, 61.
- Levey, N. (2010a). Executives at health insurance giants cash in as firms plan fee hikes. LA Times. Retrieved from: <http://articles.latimes.com/2010/aug/11/business/la-fi-insurance-salaries-20100811>
- Levey, N. (2010b). Lawmakers in most states have little control over healthcare premiums. LA Times. Retrieved from: <http://articles.latimes.com/2010/aug/12/business/la-fi-healthcare-states-20100812>
- Levin, P. & Bateman, R. (2012). Organizing and investing to expand primary care availability with nurse practitioners. Retrieved from: <http://www.medscape.com/viewarticle/760226>.
- Linz, A. J., Haas, P. F., Fallon, L. F., Jr, & Metz, R. J. (2005). Impact of concierge care on healthcare and clinical practice. *Journal of the American Osteopathic Association*, 105(11), 515-520.
- Lower, J. (2008). Brace yourself. Here comes generation Y. *Critical Care Nurse*, 28(5), 80- 85.
- Lucier, D. J., Frisch, N. B., Cohen, B. J., Wagner, M., Salem, D., & Fairchild, D. G. (2010). Academic retainer medicine: An innovative business model for cross-subsidizing primary care. *Academic Medicine*, 85(6), 959- 964.

- Malone-Rising, D. (2007). From employee to self-employed. *Advance for Nurse Practitioners*, 15(10), 21.
- Manuel, D. (2012). Dave Manuel.com blog. Inflation calculator. Retrieved from:
<http://www.davemanuel.com/inflation-calculator.php>
- Martin, R. H. (2005). Six steps to startup success. *Advance for Nurse Practitioners*, 13(6), 20.
- Martin, S. (2002). Choosing a business structure. Beyond the standard employer- employee relationship. *Advance for Nurse Practitioners*, 10(6), 43-44.
- McConnochie K, Wood N, Herendeen N, ten Hoopen C, Denk L, & Neuderfer J (2010). Integrating telemedicine in urban pediatric primary care: provider perspectives and performance. *Telemedicine Journal E Health*. Apr;16(3):280-8.
- MD² The Definitive Provider of Concierge Medicine, 2010; accessed at:
<http://www.md2.com/Murdach>, A. D. (2007). Situational approaches to direct practice: Origin, decline, and re- emergence. *Social Work*, 52(3), 211-218.
- Murray M, Davies M & Boushon B. (2007). Panel size: how many patients can one doctor manage? *Family Practice Management*, 14(4), 44-51. Retrieved from
<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med4&NEWS=N&AN=17458336>
- Murray, C. J., & Frenk, J. (2010). Ranking 37th--measuring the performance of the U.S. health care system. *New England Journal of Medicine*, 362(2), 98-99. Murray, M.,
- Murray, S. (2009). Young adults may pay share of health care reforms cost. The Washington post. Retrieved from:

<http://www.washingtonpost.com/wpdyn/content/article/2009/09/15/AR2009091503716.html>

Mustapha M, Resch E, Combs N, Little, M. & Shalwitz, J. (2005). The Real World: Young Adults and the Health Care Crisis.” San Francisco, CA; Health Insurance for Young Adults Project: Adolescent Health Working Group & Coleman Advocates for Children and Youth, January 2005.

Newcomer, L. N. (2002). Better outcomes for less than \$15. *Medical Economics*, 79(22), 33- 34.

Nutbeam, D. & Bauman, A. (2006). Evaluation in a nutshell. New York: McGraw Hill.

Obama, (2009). Obama health care speech. Retrieved from
http://www.huffingtonpost.com/2009/09/09/obama-health-care-speech_n_281265.html?view=print&comm_ref=false

Public Broadcast System. (2000). Healthcare crisis. Retrieved from:
<http://www.pbs.org/healthcarecrisis/sitecredits.html>

Portman, R. M., & Romanow, K. (2008). Concierge medicine: Legal issues, ethical dilemmas, and policy challenges. *Journal of Health & Life Sciences Law*, 1(3), 1.

Rampell, C. (2010). Driving the young from the insurance pool. Retrieved from:
<http://economix.blogs.nytimes.com/2010/02/26/driving-the-young-from-the-insurance-pool/#>

Rasmussen, S. R., Thomsen, J. L., Kilsmark, J., Hvenegaard, A., Engberg, M., Lauritzen, T., & Sogaard, J. (2007). Preventive health screenings and health consultations in primary care increase life expectancy without increasing costs. *Scandinavian Journal of Public Health*, 35(4), 365-372.

Reel, S. J. (2003). Developing a business plan. Getting down to specifics. *Advance for Nurse Practitioners*, 11(6), 53-54.

Reinhardt, U. (December 10, 2010). The Little-Known Decision-Makers for Medicare Physician Fees. The New York Times. Retrieved from:
<http://economix.blogs.nytimes.com/2010/12/10/the-little-known-decision-makers-for-medicare-physicians-fees/>.

Robnett, M. (2003). Planning your private practice. Setting realistic expectations. *Advance for Nurse Practitioners*, 11(6), 48-49.

Saultz, J. (2010). Concierge care at a discounted price. *Managed Care*, 19(7), 11.

Saultz, J. W., Heineman, J., Seltzer, R., Bunce, A., Spires, L., & Devoe, J. (2011). Uninsured patient opinions about a reduced-fee retainer program at academic health center clinics. *Journal of the American Board of Family Medicine: JABFM*, 24(3), 304- 312.

Saultz, J., Brown, D., Stenberg, S., Rdesinski, R., Tillotson, C., Eigner, D., & Devoe, J. (2010). Access assured: A pilot program to finance primary care for uninsured patients using a monthly enrollment fee. *Journal of the American Board of Family Medicine: JABFM*, 23(3), 393-401.

Schappert SM, Rechtsteiner EA. Ambulatory medical care utilization estimates for 2007. National Center for Health Statistics. Vital Health Stat 13(169). 2011.

Schattner, A. (2011). Patient care outside of office visits. *Journal of General Internal Medicine*, 26(3), 234.

Schwartz, K. & Schwartz, T. (2008). Medicaid and the uninsured. Kaiser Family Foundation. Retrieved from: <http://www.kff.org/uninsured/upload/7785.pdf>

Squires, D. (2012). [Explaining](#) high health care spending in the united states: an international comparison of supply, utilization, prices, and quality. Retrieved from:
<http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/High-Health-Care-Spending.aspx>

Squires, D. (2011) retrieved from:
http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jul/1532_Squires_US_hlt_sys_comparison_12_nations_intl_brief_

Stewart AL, Grumbach K, Osmond DH, Vranizan K, Komaromy M, & Bindman AB. (1997). Primary care and patient perceptions of access to care. *Journal of Family Practice*, 44:177– 85.

Strauss, G. (2011) Outgoing Aetna chairman gets a \$68.7 million goodbye. USA Today. Retrieved from:
<http://www.usatoday.com/money/companies/management/2011-04-11-ceo-pay-aetna-williams.htm>

Sullivan, P. (2011). Revolutionized health care. Retrieved from:
<http://www.thesuitmagazine.com/health/business-health/21620-revolutionized-healthcare.html>

The Physicians Foundation. (2010). Health reform and the decline of private physician practice. A white paper examining the effects of the patient protection and affordable care act on physician practices in the united states. Retrieved from:
<http://www.physiciansfoundation.org/uploadedFiles/Health%20Reform%20and%20the%20Decline%20of%20Physician%20Private%20Practice.pdf>

Tumolo, J. (2004). Captains of their ships. Four NPs who took the plunge and started their own practices. *Advance for Nurse Practitioners*, 12(6), 47-50.

Tumolo, J. (2005). Ownership ups and downs. *Advance for Nurse Practitioners*, 13(6), 45- 46.

Tumolo, J. (2006). Thinking outside the box. How nontraditional practice is paying off for some NP entrepreneurs. *Advance for Nurse Practitioners*, 14(4), 37-38.

Walker, (2010). Retrieved from: <http://abcnews.go.com/Health/HealthCare/health-insurers-post-record-profits/story?id=9818699#.TySPqphi8f1>

Ware, L. A. (2006). Novel ways to attract patients. *Advance for Nurse Practitioners*, 14(4), 16.

Washington Insurance Commissioner (2011). Direct practices annual report to the legislature. Retrieved from: <http://www.insurance.wa.gov/legislative/reports/2011directpractices.pdf>

Webster, L. A. (2005). Sharpen your communication skills here comes generation Y. *Mgma Connexion/Medical Group Management Association*, 5(8), 42-47.

Weiss, G. G. (2002). Expense survey: What it costs to practice today. *Medical Economics*, 79(23), 36-38.

VII. Appendices

Appendix A Privacy notice

BRIDGE CITY FAMILY MEDICAL CLINIC

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type of Protected Health Information That We May Obtain About You:

Demographic Information: Including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: Including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: Including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, drugs, family life and living situation, your current ongoing health problems, including medication, allergies, advised treatment and outcomes of treatment.

Payment Information: Including your insurance carrier, your record of charges, adjustments and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:

We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

- A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:

- ❖ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
- ❖ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- ❖ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- ❖ *We may share information about you with another provider who is on call in the absence of your provider.*

- B. **For Payment:** We may use and disclose your information to obtain payment for services you receive.

For example:

- ❖ *We may use or disclose your information to determine eligibility for insurance or benefits.*
- ❖ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
- ❖ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*

- ❖ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
- ❖ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*
- ❖ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. **For Health Care Operations:** We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier and conduction or arranging for other business activities.

For example:

- ❖ *We may use information about you to evaluate the performance of our staff in caring for you.*
- ❖ *We may use your information to evaluate our efficiency.*
- ❖ *We may use your information to evaluate and respond to a patient complaint.*
- ❖ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by the organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:

- ❖ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
- ❖ *We may provide information to our accountant in order to prepare our organization's financial reports.*
- ❖ *We may share information with qualified consultants in order for them to provide business management advice.*

Other Contract Situations:

- ❖ *We may use your information to call and remind you of an appointment in our office.*
- ❖ *We may tell you about or recommend possible treatment options or alternative that may be of interest to you.*
- ❖ *We may tell you about health-related products or services that may be of interest to you.*

Special Situations:

Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required By Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:

- ❖ *To prevent or control disease, injury or disability.*
- ❖ *To report births or deaths.*
- ❖ *To report child abuse or neglect.*
- ❖ *To report reactions to medications or problems with products.*
- ❖ *To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.*
- ❖ *To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.*

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections, and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety of the person or the public.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:

Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:

Protected Health Information Use and Disclosure That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights As a Patient:

- ❖ You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy Officer.

- ❖ You have the right to request a restriction of your protected health information. You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy Officer.

- ❖ **You have the right to request confidential communications from us by alternate means or at an alternate location.**
You may request that we communicate with you in certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

- ❖ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.
- ❖ **We may not grant your request if we determine that the protected health information that is the subject of your request:**
 - Was not created by our organization.
 - Is not a part of your medical or billing records.
 - Is information that you are not permitted to inspect or copy.
 - Is already a complete and accurate record.

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy Officer for a form.

- ❖ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:
 - To carry out treatment, payment and health care operations as described above.
 - To persons involved in your care or for other notification purposes as provided by law.
 - For national security or intelligence purposes as provided by law.
 - To correctional institutions or law enforcement officials as provided by law.
 - That occurred prior to April 14th, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy Officer to obtain a form.

- ❖ **You have the right to file a complaint.**
If you believe that your privacy rights have been violated, you have the right to file a complaint in the form of a written letter with our office and the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with the office should be sent to our Privacy Officer at the address listed below.

- ❖ **You have the right to request a receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Office Administrator.

Office Administrator Name: Mé Mé Sanna

Address: 1410 NE 106th Ave. Portland, OR 97220

Phone Number: 503-460-0405

Appendix B IRB Approval



Research Integrity Office, L106-RI

3181 SW Sam Jackson Park Road

Portland, OR 97239-3098

(503) 494-7887

Memo

Date: 4/3/2012
To: Deborah Messecar, PhD
From: Susan B. Bankowski, M.S., J.D., Chair, Institutional Review Board
Kathryn G. Schuff, M.D., M.C.R., Co-Chair, Institutional Review Board
Kara Manning Drolet, Ph.D., Associate Director, OHSU Research Integrity Office
Subject: IRB00008146, Direct Primary Health Care: A Descriptive Evaluation of a Existing New Care Delivery Model

Special Communication for Exempt Research

This protocol meets the requirements for Exemption from IRB review and approval in accordance with 45CFR46.101(b)[4], research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens if the sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

You are required to submit any future revisions to this research activity for prospective IRB review via Modification Request. The IRB will determine whether or not the revision affects the study's Exempt status.

Additionally, the requirement to obtain HIPAA authorization has been waived as the use or disclosure of the Protected Health Information (PHI) involves no more than minimal risk to the privacy of individuals based on, at least, the presence of the following elements.

- An adequate plan to protect the PHI from improper use and disclosure;
- An adequate plan to destroy any identifiers contained in the PHI at the earliest opportunity consistent with the research;
- Adequate written assurances that the PHI will not be reused or re-disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted;
- Whenever appropriate, the subjects will be provided with additional pertinent information after participation;
- The research could not practicably be conducted without the waiver or alteration; and
- The research could not practicably be conducted without access to and use of the PHI.

This waiver of authorization applies only to the PHI for which use or access has been requested and described in the approved request for waiver.

VIII. CIP Executive Summary

Abstract

This was a formative evaluation of a pilot project, which explored the potential financial, and user acceptability and viability of a direct primary care business model in a primary care practice owned by a Nurse Practitioner. In exchange for a monthly membership fee patients received unlimited access to primary care services, including phone, video and email visits. Data were extracted from the electronic medical records to describe the demographics, characteristics, and utilization patterns of those patients during the first 10 months of the program. A total of 46 patients visited the clinic 135 times during the study period. The retention rate of patients at the 10-month mark was 85%. Demographic characteristics were similar to non-membership patients of the clinic and of those reported nationwide. Revenue from the membership patients was double compared to non-membership group. Implementation of direct primary care is a practical and financially viable business approach and would prove to be a sustainable alternative to fee for service.