

Access Healthcare: A Model to Provide Improved Access to High-Quality and Affordable Healthcare

Brian R. Forrest, MD

The Access Healthcare model is based on a combination of new and vintage approaches to patient care that work together to provide reasonable solutions to some of the current problems in the healthcare system. The hypothesis of the Access Healthcare model is that if practices can decrease overhead and collect payments at the time of service (i.e., eliminating practice-based insurance billing), then they can reduce fees and increase revenue.

I performed an evaluation of several existing North Carolina family medicine practices and then opened a practice based on a model that would address some of the problems that had been observed. This commentary describes the Access Healthcare model and discusses what has been learned from it.

Background

The Access Healthcare model began as an observational study of existing practice models in the piedmont and triad areas of North Carolina. This particular evaluation began five years ago (2000) and involved several different practices and more than 50 providers. Various types of offices were studied, including a large group practice, a small group practice, and a multi-specialty group practice. The main aspects observed were patient flow, time spent in the waiting room, billing, patient check-in and check-out, verification of insurance, and DNKAs (number of patients who did not keep their appointment). For 42 of the providers, the average charge was \$93 per patient visit, the average collection was \$39 per patient visit, and the total average overhead was \$50 per patient visit. Even though this is an average, it represents an \$11 loss per patient seen. Additional study over a 16-month period and review of other innovative approaches from articles in *Family Practice Management*, *Family Practice News*, *American Medical Association News*, local newspapers, and magazines, helped me conceptualize the Access Healthcare model.

For three and a half years, the Access Healthcare practice (located in Apex, North Carolina) has provided continuity care

for more than 2,000 patients. Practice overhead is consistent at 25%. Charges/collections average \$65 per patient. The net practice profit is \$48 per patient.

The \$65 average is made up of the \$45 office visit added to the average lab and supply cost of about \$20 per patient. This means that the supplies and labs are paying the overhead and the office visit charge is basically the net profit for each provider. This makes it possible to charge less, see fewer patients, and still net a higher reimbursement per encounter than most providers due to the reduced overhead and higher collections. Also, it only takes about three to four patients per day to break-even (and pay overhead costs) with this model.

The Access Healthcare Model Key Concepts

Patient Cost and Charges. At Access Healthcare, costs are less than half what they are in other practice settings, which results in patient charges being significantly lower. Since practice costs are lower, these savings can be passed on to the patient. Cost reductions come primarily from reduced overhead, which normally accounts for 50-60% of a "traditional" practice's costs. Patients understand and appreciate the shared cost savings and are, therefore, more likely to return and to "spread the word." Word of mouth from satisfied patients represents the largest new patient referral base for the practice.

Collections. With patients expected to pay the full balance at the time of service, collection rates are two times that of other practices.¹ The net result of collecting the payment sooner and reducing the costs associated with collecting the revenue is a collection rate of more than 99% after three and a half years.

Office Visit Length. The true joy in practicing medicine is spending time with patients and helping them with their health problems. In most practices, the high volume of patients that must be seen reduces the time a clinician can spend with each patient. The Access Healthcare model helps optimize patient

Brian R. Forrest, MD, is the founder of Access Healthcare, PA. He can be reached at questions@acchealth.com or 1031 W. Williams St., Suite 106, Apex, NC 27502. Telephone: 919-363-0190.

encounters by increasing the amount of time the provider can spend with each patient. Being able to spend enough time with the doctor is the top reason that most patients give for returning to the practice. People are willing to spend money on something they value, and they value time with the doctor. This is truly a win-win situation for both the doctor and the patient.

Patient Satisfaction. If patient demand is a barometer for patient satisfaction, then patients are very satisfied with this model of care. The practice averages 15 new patients per week, even when no advertising is taking place. Anecdotal evidence also gives us reason to believe the patients are satisfied. In many informal encounters in the town where the practice is located, patients report a high level of satisfaction and persons who have never been to the practice report that they have heard very positive things about Access Healthcare.

The Access Healthcare Model: Implementation

In April 2002, I opened the Access Healthcare Practice in Apex, North Carolina. Apex is a mix of suburban and rural, well-insured and uninsured, and self-employed and under-employed. Within a two-mile radius of the Access Healthcare office are million dollar houses and the local community health center—affluent and indigent. This population mix is reflected very evenly in the practice. Roughly 30% of the patients served in this practice have no insurance at all. Fifty percent have traditional prescription and copay coverage. Another 20% are catastrophically insured with high deductibles or hospital-only coverage.

Decreasing Overhead. Decreasing overhead is crucial to making Access Healthcare viable. Staff size is usually the largest burden for practice overhead. The Access Healthcare practice has one staff person per provider rather than the normal 4.6 per provider, which is the national average.² Cross training and investment in each employee is crucial, and keeping turnover low is a must. Each medical office assistant is responsible for scheduling, check in/out, phones, referrals, chaperoning exams, and setting up basic tests like urinalysis and streptococci tests for the provider.

The provider has responsibilities, which are not typical in other practices, such as providing their own phlebotomy, giving injections, and returning and making patient phone calls with lab results. While these activities reduce costs, they also contribute to high patient satisfaction, as the patients are not “handed-off” to others, and they receive lab results very quickly.

Operational costs have also been reduced. Since there is no insurance to file, no billing equipment or software is necessary.

Only one computer is needed for scheduling, accounting, and word processing. Due to lower patient volume, minimal inventory is required so there is no concern for wasted storage space or expired medications.

Utility costs are kept low by turning off lights that are not in areas being used and by operating the thermostat on a timer. Easy listening radio run over a wireless intercom for background music saves hundreds of dollars per year over “Muzac” type services.

The Access Healthcare practice even provides its own janitorial services. All duties are split among employees (including the physician). Many practices pay \$10,000-\$15,000 per year on these services. Access Healthcare employees are asked if they would rather have that amount divided and added to salaries for 15 minutes of work per day or hire someone to do it. Everyone always answers the same way.

Technology can cut costs too. A four-line phone system that uses wireless technology is utilized so the traditional key system with hard-wired lines is not needed. This saved about \$7,000 in initial phone costs and has required no maintenance. This system also has an advanced digital answering system that can triage calls and page the provider, so there is no need for an operator or an answering service.

Setting Fees. After analyzing the cost and charge ratios from the practices studied, a flat office-visit fee was initially set at \$40 per patient visit (now \$45). Whether a patient is in the office for five minutes or 50 minutes, the basic charge is the same for visits with Current Procedural Terminology (CPT)[®] codes 99211-99215.* The average office visit at the Access Healthcare

“The true joy in practicing medicine is spending time with patients and helping them with their health problems.”

practice is 30 minutes. The model works because the average visit at a primary care practice is a code 99213 (a 30-minute visit with a problem-focused history and exam and a low-complexity medical decision). Over time, if the practice gets \$45 for both a 90-minute physical and a 20-minute visit, this will equate to the average charge for a code 99213.

The Access Healthcare practice charges patients an additional fee for lab tests (based on cost), but pays the lab company directly for the tests. Payment-in-full to the lab companies is certain because Access Healthcare is able to pay companies without rejecting claims due to incorrect ICD-9 codes or diagnosis/CPT mismatch. Lab companies are able to pass on some savings they

* Clinicians use the CPT series of codes 99211-99215 to describe the five levels of intensity for evaluation and management services provided in office or other out-patient settings for established patients. For example, a 99211 could be a five-minute visit with a nurse, and a 99215 would be an extensive evaluation and physical exam of multiple medical problems that could take an hour or longer.

realize from not incurring the expenses of billing patients or insurance companies, and their payment is guaranteed. For these reasons, discounts may be as much as 50-90% off list price, which means most patients pay an average of \$20-25 for lab tests that would have cost more than \$100 if the lab company billed the patient or the insurance company directly.

Scheduling patients. Advanced Access scheduling is used at Access Healthcare. This is beneficial in several ways. For the practice, Advanced Access scheduling cuts lost productivity and revenue from “DNKAs.” Advanced Access scheduling also increases the practice’s revenue by attracting patients that might otherwise go to urgent care or to the emergency department for non-emergent care. Patients appreciate being able to see their primary care provider on a “same-day” basis when needed, especially when going to an urgent care or emergency department can be much more costly for them. This increases patient satisfaction and patient loyalty to the practice. Many patients who need brief encounters such as flu shots and blood draws appreciate seeing the physician and having minimal wait times for these services.

The scheduling template is filled by scheduling eight to ten patients a day for appointments and leaving the rest of the day for same day call-in or walk-in patients. Normally, same day call-in/walk-in patients fill DNKA patient slots. This arrangement allows each full-time provider to treat 15-16 patients each day—a lighter patient load than for providers in a traditional practice. This means a less hectic office. It makes it easier to maintain privacy, cuts the risk exposure for medical mistakes and malpractice, and allows time for adequate documentation during the workday rather than dictating at the end of the schedule.

House Calls. Access Healthcare has gone back to yesteryear by reinstating house calls. This can be done without the contractual restrictions for charges that exist in insurance agreements. It is a joyful way to practice medicine, and physicians around the country are going back to it. House calls are great for homebound patients who are unable to get other physicians to come out to their house. The Access Healthcare practice charges a \$150-cash rate for house calls.

Patient Billing. The Access Healthcare model makes it easy for patients to know what their bill will be and increases the underinsureds’ ability to pay at time of service. One reason for this is that all charges are clearly identified on an *a la carte* sign in the waiting room.

However, a major portion of the patients have health insurance. When the practice opened, it was anticipated that 90% of patients would be uninsured. However, as the word of mouth about Advanced Access and hour-long office visits spread,

patients who could submit their own insurance and get reimbursed (preferred provider organizations, State Employees, etc.) began to fill the practice. These patients now represent the majority (about 65%) of the practice.

Many insurance co-payments for urgent care visits are \$50 now—more than a code 99215 at Access Healthcare—and some plans’ office-visit co-payments are \$35 or \$40, which is very close to the office-visit charge at Access Healthcare. For most plans, patients can simply submit their Access Healthcare encounter form/receipt, and their insurance company will

“Most patients have a very positive reaction to this ... Insured patients value increased access and longer visits ... Uninsured patients are ... charged a fraction of what they are charged at an office that accepts insurance.”

reimburse them (less their respective copay for out of network providers). While most physicians say they wait months on reimbursement from insurance companies, most Access Healthcare patients report receiving reimbursement within a few weeks. In the current healthcare system, this is due to the fact that physicians have surrendered their power to insurers by signing contracts. However, patients, who are the clients of the insurer, have the real power. If claims were denied or delayed to patients who filed, those patients would likely pick another insurer or pressure their employer to do so.

Medicare. The Balanced Budget Act of 1997 gives physicians and Medicare patients the freedom to privately contract outside the Medicare system. If a physician opts-out of Medicare, he or she agrees to bill patients directly and forgo any payments from Medicare. Once out, the physician may not submit claims to Medicare for any Medicare patients for a two-year period. Since Access Healthcare has never taken Medicare, the practice can treat Medicare patients as long as Medicare patients sign a private contract with the physician/practice stating that no charges incurred at Access Healthcare can be billed by the practice or by the patient to Medicare.

Patient Reaction. Most patients have a very positive reaction to this practice model. Insured patients value increased access and longer visits more than the inconvenience of filing their own insurance. Uninsured patients are also very receptive to this model. They are charged a fraction of what they are charged at an office that accepts insurance. Uninsured patients at traditional practices are often paying more for healthcare than anyone else, when they should be the ones getting discount care. This occurs since practices that file insurance have to

charge the uninsured the same or higher rates due to insurance contracts and increased overhead.

Outcomes: Retention of patients has been outstanding with greater than 98% of all patients keeping Access Healthcare as their primary care provider after three years. There only have been around 15 hospitalizations out of this patient population exceeding 2,000 over last three years, despite the fact that many patients have multi-system diseases and 10% are more than 65 years of age. Because of the time spent with patients, providers can practice with good continuity and within current treatment guidelines. The practice participated in a study being conducted by Wake Forest University based on chart audits, which found that, for diabetes and hypertension management, the Access Healthcare practice is in the upper echelon of practices' adherence to current recommended standards.

On several occasions, estimates of the "normal-visit cost" for an insurance-accepting practice have been done, and it has been determined that insurance companies saved approximately \$25,000 per month on average and that the insured (as a group) have paid \$400 to \$500 per month in higher out-of-network copays. The uninsured (as a group) saved \$5,000 to \$10,000 per month in out-of-pocket expenses over what they might have paid at a conventional practice.

Conclusion

We have learned several lessons. From the beginning, the Access Healthcare practice should have clearly explained and marketed the fact that insured patients could file their own claims and receive reimbursement for treatment at the practice. Many patients are surprised to find out that if they send in the encounter form they get a check back in a couple of weeks. The practice would have benefited from more thorough market research (e.g., local demographics, major employers, etc.) as well.

There are potential drawbacks to this model. One potential drawback is working with insured patients who need out-of-network referrals. This can be a hassle when services require prior approval from an "in-network" primary care provider. For some patients, the co-pay may be higher for an out-of-network provider, and this is the biggest reason for patient attrition, though attrition has been very low. Having a small staff means there is less reserve if illness or turnover occurs. However, the practice is fortunate to have many well-trained volunteers who can step in when needed.

Access Healthcare has been fiscally sound from day one and has never taken out loans for any operating expense. All start-up costs were taken care of through savings accumulated for nine months prior to opening. Expansion plans are under consideration with the potential for several new Wake County locations. The providers at the Access Healthcare practice hope that other physicians will adopt innovative practice models to improve their satisfaction, bottom line, and, most of all, patient care in the coming years. **NCMedJ**

REFERENCES

- 1 Guira PA. Four steps for improving efficiency and cash flow. *Family Practice Management* 1999;6(9):14-15.
- 2 Reeves CS. How Many Staff Members Do You Need? *Family Practice Management* 2002;9(8):45-49.