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# Direct Primary Care and **On-Site/ Near-Site** Strategies

**As employers continue** to navigate the ever-increasing costs of healthcare, consultants are having to become more knowledgeable about alternative models of care as well as cost mitigation strategies to achieve better care, lower costs and increase employee benefit offerings. When it comes to lowering total healthcare costs, improving patient access and increasing quality of care, Primary Health Care (PHC) is the foundation and key to achieving these goals. According to the World Health Organization scoping review Building the Economic Case for Primary Health Care, "what we can deduce about the economic benefits of PHC is derived from measurable outcomes such as mortality, hospital admissions and healthcare costs."

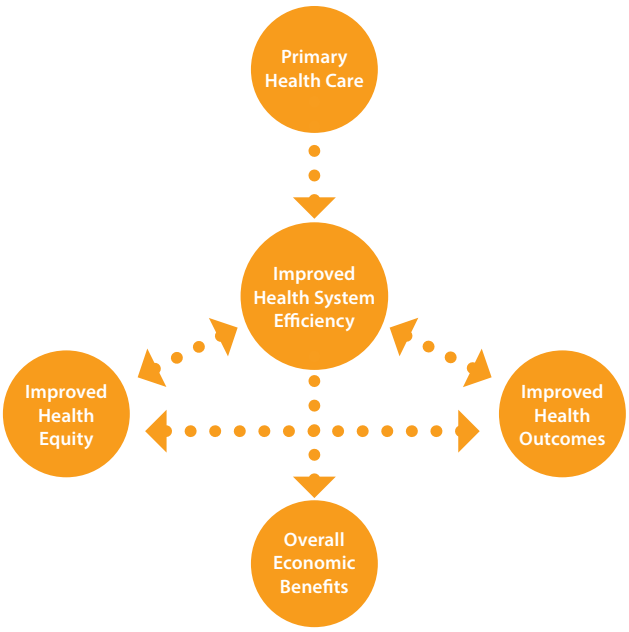
The framework from Figure 1 illustrates how PHC is linked to improved health outcomes.

Three strategies are used most to solve the PHC need for employers and achieve the goals of improving clinical outcomes, lowering cost, bettering patient experience and improving physician satisfaction:

1. Traditional fee-for-service primary care
2. On-site/near-site clinic
3. Direct primary care (DPC)

(Telehealth is a potential fourth strategy, but its limitations dictate that it be used in conjunction with primary care rather than as a standalone strategy.)

**Figure 1. Conceptual Framework for Economic Case for PHC Investment**



Done properly, a primary care strategy can lower total cost of care 20% or more.

## On-Site/Near-Site Clinic and Direct Primary Care

These two strategies help address the access and cost issues in primary care and also optimize and increase the odds of achieving PHC's goals of achieving better care, lowering total healthcare costs, improving patient access and increasing quality of care. The two strategies of on-site/near-site and DPC have different economics for an employer in addition to pros and cons. However, when it comes to deciding which primary care strategy should be implemented, one of the most important details to determine is what problem we are trying to solve for an employer:

- Are we targeting employees or dependents based on claims?
- Is the employer prepared to implement a multi-year strategy?
- Does the employer want to incur the cost to build a clinic on-site?
- What scope of services are they looking for?

With questions like these, we can pinpoint the problem and begin developing a strategy to address it. Page 3 shows a general list of areas to focus on to help determine the best clinical strategy to implement and the best vendor to partner with.

# Clinic Strategy and Vendor Selection Discovery

## I. Scope of Services

- Flexibility/customization
- Primary care services
- Urgent care
- Preventive care
- Chronic condition management
- Behavioral health support
- Wellness services
- Health coaching
- Virtual care/telehealth services
- Pharmacy
- Lab
- Occupational health
- Referral management
- Other services

## II. Staffing Model

- Overall staffing approach
- Physician panel size: target number of patients per physician
- Physician qualifications
- Physician compensation methodology
- Nurse practitioner qualifications
- Medical assistant qualifications

## III. Client/Vendor Partnership

- Pre-planning
- Clinic location selection criteria
- Clinic design
- Implementation plan/timelines
- Staffing model
- Process for selecting physican(s) and care team
- Training
- Communication plan for rollout
- Performance management
- Frequency of meeting reviews
- Metrics reviewed
- Clinical indicators tracked and reviewed
- Process for initiating change or adding services

## IV. Technology

- Electronic medical record capabilities
- Telehealth modalities
- Ability to integrate with other health vendor partners
- Reporting
- Data security

## V. Employee Engagement

- Historical percentage of employee participation/dependent participation
- Vendor definition of engagement
- Strategy/tactics for driving employee engagement
- Strategy/tactics for driving dependent participation
- Sample communication materials
- Employee utilization percentage and goals

## VI. Financial

- Services included in proposed pricing which are fixed costs
- Services not included in fixed price (i.e., dispensed drugs and lab tests initiated in clinic)
- Methodology for measuring employer savings
- Methodology for measuring employer ROI

## VII. Performance Guarantees

- ROI/employer savings
- Employee clinic participation
- Employee waiting times
- Employee satisfaction
- Clinic operations guarantees

## Designing a Direct Primary Care Strategy

One of the biggest considerations when determining a primary care strategy of on-site/near-site clinic and DPC is upfront costs to the employer, in addition to continuation of cost for the program.

On-site/near-site clinics are typically capitalized by the employer (typically around $250k upwards of $1M dependent on build out and location) and typically become economically feasible when you have 1,500+ employees in a focused geography. This allows the clinic vendor to regain the investment for the client over a period of several years and begin to generate an ROI (typically a three-to-five-year recovery of initial investment). Continuation of clinical operations for an on-site clinic typically ranges from $300k+ per year for one provider, two staff, medical supplies, and management fees and increases depending on the scope of services provided and pass-through costs such as medications and labs.

In contrast, DPC is capitalized by the doctor who owns the facility so there is initially no capitalization required by the employer and typically no minimum requirements for the size of an employer. The continuation costs of a DPC clinic range from $50–$100 PEPM without any additional costs for the provider, clinic staff, medical supplies or management fees. The limitations of DPC may be lack of footprint in a specific geography as this is a growing field, but should be evaluated on a case-by-case basis with each employer to determine geographic coverage. A sample comparison of on-site and DPC strategies in the chart on Page 5 can be used as a quick reference, but this is not a comprehensive list.

The comprehensive approach in determining which primary care strategy works best for each client varies tremendously and is unique to every client. Detailed claims data should be thoroughly analyzed as a starting point to better identify the economic opportunities to help determine which strategy best accomplishes that target.

Discussing financial tolerance for short- and long-term investment and recovery, employee retention, employee recruitment, wellness, prevention, behavioral health, employee satisfaction, ROI requirements and commitment to a long-term primary care strategy with an experienced professional is necessary to gain a better understanding of which strategy to implement. Benefit plan design becomes a huge component in whether the strategy implemented is successful, and one size never fits all scenarios.

Understanding how DPC or on-site clinics interact with a TPA, stop loss carrier, PBM and provider network outside the primary care clinic strategy plays a critical role in the success of the program. These primary care strategies, specifically DPC, have been able to leverage decreased premiums with TPAs, stop loss carriers and payers secondary to how patients are managed within a DPC clinic and navigated throughout the healthcare system as a whole.

## The Results of a Strong Primary Care Strategy

When done properly, a primary care strategy mitigates the total cost of care and not just primary care. DPC and on-site clinics have been known to decrease the total cost of care on average 15%–20% (at times much greater) in addition to flattening the curve of year-over-year premium trends. An effective primary care strategy can mitigate most avoidable emergency room visit claims, 80%–90% of all urgent care claims, unnecessary specialty referrals, polypharmacy from multiple providers and inappropriate lab and imaging testing. This is all accomplished when the appropriate amount of time is given to the doctor-patient interaction, appointment access is barrier free, cost is eliminated or minimized to access the DPC or on-site/near-site clinic, and trust is restored within the sanctity of the patient-doctor relationship. As a result of restoring doctor-patient sanctity, patients become recommitted to their health, wellness, prevention, and chronic disease compliance, spend less total healthcare dollars within the system, and are healthier in general.

The decision to implement a DPC or on-site/near-site clinic is multifactorial, complex and must be integrated within the plan design to optimize the ROI and achieve success. When a primary care strategy is implemented correctly, it is a win-win-win scenario for the employer, employee, and healthcare system as a whole and mitigates total cost of care dollars.

**This sample comparison of on-site and DPC strategies is a good quick reference, but not a comprehensive list of all the factors:**

| | Direct Primary Care | On-Site Clinic |
|---|---|---|
| **Program Description** | Small to large employer group, not capitalized by employer | Large employer group, on-site clinics capitalized by the employer |
| **Preferred Employer Size** | 1–35,000+ | 1,500+ |
| **Typical Provider Panel Sizes** | 600–800 per provider | 800–1,500 per provider |
| **Scope of Services** | Newborns to elderly | Typically adult-focused |
| **Copays** | $0 | Vendor- and plan-specific |
| **Same Day/Next Day Access** | • | • |
| **Appointment Times** | 30–60 minutes | 20–30 minutes |
| **Telemedicine** | • | • |
| **Text Your Doctor** | • | • |
| **Your Doctor's Cell Number Provided** | • | Not typically |
| **24/7 Personal Provider Access** | • | On-call provider group typically |
| **In-House Dispensing** | State dependent | State dependent |
| **Wholesale Medication** | State dependent | State dependent, pass through to client |
| **Wholesale Labs** | • | Pass through to client |
| **Wholesale Imaging** | • | Not typical |
| **Facility Capitalization** | None | Capitalized by employer |
| **Dependent and Children Accessible** | • | Vendor dependent |
| **Integrated Care Plans** | • | • |
| **Preventative Focused** | • | • |
| **Chronic Disease Management** | • | • |
| **Urgent Care Access** | • | • |
| **Bill Insurance** | No | Vendor dependent |
| **Specialty Navigation** | • | • |
| **Pricing** | Monthly PEPM ranges from $50–$100 | Costs typically pass through with management fee attached or pass through PEPM |
| **Facility Location** | Near- or on-site | On-site |

[1] Michael Anderson et al. Building the Economic Case for Primary Health Care, World Health Organization, 2018, p. 5; https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf?sfvrsn=8d0105b8_2

[2] Pamela Ballou-Nelson. "How Long Are Patients Waiting for an Appointment?" Medical Group Management Association, 2018; https://www.mgma.com/data/data-stories/how-long-are-patients-waiting-for-an-appointment

[3] 2017 Survey of Physician Appointment Wait Times, Merritt Hawkins, 2017; https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf

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