Direct Primary Care: Concierge Medicine for the Common Folk
By Philippa Stasiuk

Direct Primary Care (DPC), buzzword of major news outlets and healthcare pundits alike, isn’t, as it turns out, a new model at all. It’s based on the old fashioned family practice of yesteryear - where the doctor made house calls and was sometimes paid in chickens instead of cash.

While no two DPC practices are exactly alike, they are similar in fundamental ways:

DPC is:

- **A membership-based practice.** Anyone wanting to join signs a contract to pay a membership fee. The average scaled-to-age adult fee is $80 dollars a month. Children are between $10 - 20 dollars per month.

- **Insurance-free, co-pay free, deductible-free medicine.** While there are a few hybrid practices, most DPC doctors bill no services to insurance companies. And insurance companies, in turn, have no weigh-in on patient care. Patients are, however, encouraged to get a high-deductible healthcare plan to cover the cost of hospital, emergency, and specialist care.

- **A primary care model** based on wellness, not sickness treatment. DPC doctors believe the doctor/patient relationship is a key component of medical care and spend longer time with fewer patients.

- **Unrestricted care.** There are no limits to how many times or how often a patient can see the doctor and no costs for visits. That fee is built into the monthly fee.

- **At-cost lab tests and prescriptions:** DPC docs negotiate directly for sometimes dramatically lower rates and pass on savings to their patient

- **Access friendly:** Most DPC doctors give their members a direct phone number to call any time, if they need the doctor. Telehealth is also common.

DPC was born from concierge medicine, a care model begun over 20 years ago whereby doctors, for a five-figure annual fee, would provide elite care and access for wealthy patients. But doctors soon saw the model’s potential to scale to a wider clientele.

As a practice model, it is spreading rapidly, with upwards of 20,000 DPC physicians in the United States, up from around 4,000 in 2015. Both patient and doctor demand are driving the rapid growth.

“My patients run the gamut,” said Dr. Todd Johnson, who opened Nebraska’s first DPC clinic, Access Family Medicine, in Lincoln. Sponsored by Senator Merv Riepe of District 12, the bill legalizing DPC in Nebraska (LB 817) passed unanimously in March 2016 and Johnson opened his clinic four months later.

“Many have jobs but no insurance so now they come here and leave the free clinic to those who can’t afford anything,” said Johnson. “Some already have a high deductible plan and having switched, find they’re saving enormous money by adding this. Some are CEOs. They’re all happy. They’re now getting the best care of their life.”
For doctors, the near-universal driver of switching to the DPC model is job dissatisfaction in primary care, a condition that is only expected to worsen. According to a 2012 Urban Institute Survey, nearly a third of all primary care physicians ages 35-49 were expecting to quit within the next five years. Many migrate to specialties for higher pay and better hours, or retire early.

DPC supporters say their model, which med students are already being exposed to in school, will bring doctors back to primary care. This, they say, will also resolve the potential primary doctor shortage the growing DPC model could exacerbate in the short term, as DPC physicians generally have smaller patient panels than traditional doctors’ offices.

“I always missed my kids’ baseball games. Now I’m coaching the team.”

Dr. Vance Lassey, a 41-year-old physician operating Holton Direct Care in rural Kansas since 2015, said his own quality of life drove him to take the plunge and open his clinic, though he’d been intrigued with the model for years.

“I was working 14-hour days. Then on top of that I was on call for weekend shifts. I would work 62 hours straight. A mundane night was the straw that broke the camel’s back. I hadn’t seen my kids in a long time and I was filling out forms for insurance companies at 1:30 in the morning.”

When reflecting on ending his nine years as part of a local hospital practice, Lassey says it was like being freed from prison.

“I’m finally on the outside now. Seventy percent of practicing on the inside was the struggle of my conscience every day, talking to me and questioning whether what I was doing was right. The entire system on the inside incentivized me to go faster. The devil was saying ‘Hurry, maybe you can see your family tonight.’ But the angel was telling me to spend more time with my patient. Maybe my patient was suicidal. My instinct was telling me I wasn’t doing what I was supposed to do and I knew there was a better way. The system makes you hate the thing that God made you to love.”

For Johnson in Lincoln, a focus on achieving the triple aim drove him to attend a 2015 Kansas conference on DPC, the same conference Senator Riepe cites as the inspiration for him championing the model in Nebraska.

“I’ve always looked for efficient ways to do things,” said Johnson. “In my previous practice we wanted to improve the triple aim: high quality care, high patient satisfaction, and low cost. We also added a 4th: physician satisfaction. We learned that if we could hit the first three, the staff were miserable. People are calling DPC the triple aim on steroids. That’s how well it works.”

**Rural implications: the one-stop-shop**

According to Dr. Janelle Ali-Dinar, COO of Medfirst Partners and a rural health expert at Healthcare Solutions Connections, there are massive potential benefits for DPC in rural Nebraska.

“Every critical access hospital has at least one rural clinic. But they close by seven p.m. Rurally, most accidents happen after seven. So patients have to go to the emergency room for care. If the community had a DPC physician, they’d have the doctor’s direct number. They could call her or him up and say I have a wound and I think I need stitches. And the cost of that injury was already built into the membership fee. They’re spending pennies and not thousands of dollars. DPC is a one-stop-shop.”
Ali-Dinar also cites the rural spirit of working together as another reason DPC would work. “Nobody does collaboration better than rural,” said Dinar. “DPC is a collaboration-based model. And it allows the entrepreneurial spirit to thrive.”

Lassey, who grew up on a Kansas farm, said DPC synthesizes well with his broad role in the community. “Rural family medicine is a totally separate specialty. Here, we do a lot more stuff than they would in the city. A good example is psychiatry. We do mental health, skin cancer and vasectomies all in one clinic.”

To help him, Lassey contracts with RubiconMD, an e-consult start-up based in San Francisco that connects physicians to top specialists around the world and promises consultations within twelve hours.

Dr. J Nwando Olayiwola, Chief Clinical Transformation Officer of RubiconMD confirms rural physicians are one of their target markets.

“If you need a specialist’s opinion in a rural town that could take months. And if you’re uninsured and rural that could take forever. We provide a platform of specialty expertise within one business day. Asking someone to go miles and miles for a specialist’s opinion like some who live rurally is disruptive. We aim to empower the PCPs in rural settings who are probably already doing more on the spectrum of care anyway.”

Lassey also pays to have access to a DPC-specific electronic medical record system called Atlas MD. Doctors at its namesake clinic in Wichita, early DPC adopters, designed the program so that physicians changing over to the model can quickly master the business side of running the office.

“It’s modeled after our model,” said Cristyn Dulaney, a registered nurse at Atlas MD. “Physicians can open a DPC practice and use auto draft billing on accounts, prescribe meds from in-house pharmacies and print labs in house. When they get our software, they already have both lab integration and buying power with a medical wholesaler, with whom we’ve already negotiated the rates.”

Dulaney says over 300 physicians are already using their software and that their office is actively connecting doctors curious about the DPC model with those already practicing throughout the United States.

For doctors not connected to a larger entity like Atlas MD, negotiating rates is one of the first hurdles. Dr. Marshal Harpe, a DPC physician who opened a clinic in rural Trout Lake, WA in February, now sends his lab work nearly a three-hour drive away because the local lab company still wants to charge him ‘inside’ prices. Harpe, a retired naval physician, said he also got the idea to open a DPC clinic after attending the 2015 conference in Kansas City.

Harpe, Lassey and Johnson all say the biggest learning curve for them has been mastering the business side.

“At first, I didn’t know anything about running a business,” said Lassey. “I had to learn about payroll taxes and business insurance and workman’s comp. I also had to learn about how corrupt health insurance companies are because I’m an alternative to that.” Lassey said his wife, who owns a coffee shop in Holton, has helped to manage a lot of the business side of his clinic.
In Trout Lake, Harpe said what’s helped him was taking time to put together a business plan. He interviewed several doctors practicing DPC in the Northwest and made his projected income growth extremely conservative. A military pension and moonlighting ER work has also helped soften the financial blow of starting over. Once he has a full panel (generally, the optimum panel for DPC docs is around 600 patients), he plans to begin practicing what he describes as Robin Hood medicine, providing medical care to those who can’t afford anything at all.

“The secret sauce to running DPC is running lean,” says Johnson. He’s reduced the overhead from his traditional practice by 40%, most of that being savings from not needing administrators to handle insurance claims.

For Lassey, running lean is a way of life. He and his father, a retired teacher, installed the cabinets and flooring in his clinic themselves. Much of the medical equipment he got surplus, including the exam table, and he found many of his medical instruments on eBay.

Same with the hyfrecator he used recently to treat the cancer on the nose of one of his low-income patients. She had no insurance and had been quoted thousands of dollars for the procedure. With the used equipment and guidance from a cancer specialist through RubiconMD, Lassey removed the cancer. The Salvation Army donated $150 dollars to his clinic. He charged his patient $100.

“It was a great example of the power of doing,” said Lassey. “No clinic would have done a procedure that invasive, or charged that little. But I have no boss. I do what I want.”

Five Facts about Direct Primary Care:

1. To date there are around 20,000 physicians practicing DPC in America, up from around 4,000 in 2015.
2. While long-term outcome and cost studies are spare, according to Qliance, one of the largest DPC practices in the United States with 35,000 patients, DPC makes healthcare 20% less expensive than traditional fee-for-service yet leaves patients feeling more satisfied with their care*.
3. In the same 2015 study, Qliance reported a 14% reduction in ER visits, 60% reduction in inpatient stays and 14% reduction in specialist visits for patients in their DPC clinic*.
4. Physicians in 42 states are currently practicing DPC and 13 states support the model with actual legislation.

Dr. Vance Lassey, in his DPC clinic in Holton, Kansas.