Is direct primary care doomed to fail?

NIRAN S. AL-AGBA, MD | PHYSICIAN | JUNE 19, 2017

A recent Medical Economics article asked “Is the DPC model at risk of failing?”
The piece focuses on two large DPC-like organizations, Qliance Medical Management of Seattle, Washington and Turntable Health of Las Vegas, NV, working in partnership with Iora Health, which recently closed their doors. Qliance and Turntable were not actually DPC practices by strict definition; they were innovative large business operations providing health care services to patients and excluding third party payers. Their idea was commendable, but their closure indicates little cause for concern in regard to the growing direct primary care movement.

Robert Berenson, MD, who admits to not being a fan of the DPC model, said “Qliance has been the poster child for DPC … If that one can’t make it … it suggests the business model (of DPC) is flawed.” He is correct about one thing: The “business” model of medicine is certainly flawed.

What Dr. Berenson fails to realize is that DPC is not a “business” model; it is a “care” model. Whether accepting insurance or DPC in structure, we already know solo, and two-physician practices deliver the best care and have been doing so for the past 100 years. These intimate clinics know their customers better than anyone else in the industry, and can devote the time necessary to their clientele; these micro-practices should be known as the small giants of health care.

Strictly defined, direct primary care is a practice model centered on an arrangement wherein a patient and physician enter into a contract to provide unlimited primary care services for an affordable monthly fee (less than $100 per month.) 80% of health care needs can be met in a DPC practice. The typical DPC practice has 1 or 2 physicians, 600 patients maximum per physician, and on average each physician sees ten patients per day. Employees are minimal, usually including a receptionist and/or a medical assistant. Only minimal office space is required to run such a lean operation, so overhead remains low. Supplies, medication, and equipment are purchased on an as-needed basis and used only when necessary.

Qliance, founded in 2007 by Dr. Garrison Bliss and Dr. Erika Bliss, charged $64 per month for adult members and $44 per month for children. They had 13,000 patients in total including primary care and emergency care services, more than 20 times the number of patients compared to a traditional DPC clinic. They were trying to use a model embraced by direct primary care practices yet scale it into something entirely different. After ten years, the experiment failed.

Iora Health, vying to become the “Starbucks” of health care, was in partnership with Turntable Health utilizing a “team-based” concept. Each “team” included a physician, nurse, and a health coach. This model contracted with individuals, but also employers and unions already paying for health care by offering improved access to primary care services and pocketing a portion of the savings that materialized. In this model, physicians usually had 1,000 patients and each health coach with a few hundred. Turntable charged $80 per month for adults and $60 per month for children to have access to their vision of a “wellness ecosystem,” which included yoga, meditation, and cooking classes.

An article in the New York Times quoted Duncan Reece, the VP of Business at Iora Health, “We wanted to do something radically different and show this isn’t your grandfathers’ doctor’s office.”
I get it. This is the kind of things that VPs of business say.

Let’s walk it back. Can someone please tell me what was wrong with that model? It was a quintessential small giant of the business world. My grandfather was an outstanding general practice physician with a small office and one nurse on staff. He made house calls. He did appendectomies, tonsillectomies, C-sections, vasectomies, and met most of his patients’ basic primary health care needs for 40 years. Why do we need something radically different?

The bottom line is health care requires two participants.

One physician and one patient. While it is a nice idea, we do not need yoga, massage, or smoothie bars in our clinics to improve patient outcomes. Adequate medical knowledge and time for meaningful conversations is essential; something the small giants of health care are experienced in providing. The vision of a "wellness ecosystem" should probably go the way of the "patient-centered medical home," as there is little cost savings or difference in outcomes compared to the traditional fee-for-service system.

So what qualities make the best practices? According to a study conducted by The Peterson Center on Healthcare at Stanford, the very best primary care practices have either one location or a small handful of them. Stanford compiled a list of 10 distinguishing features of these top practices, and many are commensurate with being a "small giant" of the business world. My favorite characteristic on the list is to invest in people, not space or equipment. By lowering overhead, physicians are not relying on patient volume to generate adequate income. These practices are consciously choosing to stay small by renting minimal space and investing in added services only when believing them to be more cost-effective.

The government and insurance companies cannot fix health care. It is up to physicians and patients– one micro-practice or DPC clinic at a time. Dr. Kimberly Legg Corba, owner of Green Hills Direct Family Care, said "The DPC model is growing and practices are converting all the time. Some are opening by transitioning an established practice, some are physicians starting clinics fresh out of residency from scratch, and others are leaving employed positions to return to practicing medicine in a way they love."

While my practice is not DPC, it is a small, old-fashioned clinic serving families for as long as three generations. Our records are still on paper, a real human being answers the phone when it rings, and for occasional emergencies, patients stop by my house for a "reverse house call." My belief in the DPC model is steadfast because any "care" model placing control directly into the hands of physicians and their patients is worth fighting to preserve and protect. The more small giants able to thrive in the constantly evolving health care landscape, the greater chance physicians have of inciting a large scale revolution to benefit patients everywhere.

Since the Affordable Care Act legislation went into effect, mergers and consolidations have increased by 70%, at the expense of care becoming less personalized and increasingly fragmented. These large institutions are profit centers for CEOs and business executives who have very little knowledge of what goes on between a physician and a patient. They need the independent practice model to fail so patient choice is no longer an option.

The small giants, micro-practices and DPC clinics, will continue to prosper and grow because a "care" model devoted to preservation of the physician-patient relationship cannot be defeated. Physicians must stop being afraid to take that leap of faith, leave employment, and go back to doing what we love most, caring for our patients and improving their lives. Physicians should be standing at the bedside, not in front of computer workstations. Direct Primary Care is a model for which we should all be rooting; it is transforming the physician-patient relationship and restoring the practice of medicine to its noble roots, allowing for the art, the science, and the wholly fulfilled physician.

My advice for patients everywhere: Whenever possible, find an independent practice, whether a solo doctor or direct primary care clinic, and patronize that physician. Your care will be more personalized, cost less in the long run, and your health will be better for the investment you made in yourself.

Niran S. Al-Agba is a pediatrician who blogs at MommyDoc. This article originally appeared in the Health Care Blog.