DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 98: Take Back Control With A Direct Primary Care Practice

With guests Dr. Prisiliano Salas Jr., and Dr. Monica Salas

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PS: "Lifestyle medicine revolves around six pillars of health. Exercise, nutrition, sleep management, stress management, social connectedness and avoidance of toxic substances. Those are the six pillars of lifestyle health."

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hello, hello and welcome back to the Doctor's Crossing Carpe Diem podcast. You're listening to episode number 98. Today you're in for a special treat. I have my second married couple on the podcast, and they're here to talk to us about having a direct primary care practice.

While we do cover a lot of nonclinical options here, I'm always excited to share stories about how physicians are finding ways to take back control of the doctor-patient relationship and love medicine again.

Our wonderful guest, Dr. Prisiliano Salas Jr. and his wife, Dr. Monica Salas are going to talk about how they went from being burned out family practice physicians to running their own direct primary care practice, loving what they do while having more time and making more income.

We're going to dive into a lot of the details for those of you who may be curious if the direct primary care model also known as DPC might be of interest to you. And of note you do not need to be a primary care physician to consider this approach. If you're interested in lifestyle medicine, we'll also be hearing about how the Salas' decided to pursue this additional training and how they incorporate lifestyle medicine into their practice. It is my true honor and delight to welcome Dr. Monica Salas and Dr. Prisiliano Salas Jr. to the podcast. Hello. Hi guys. How are you?

PS: Hi, how are you? We're doing well.

MS: We are doing well. Thank you so much. Thanks for having us.

HF: Yeah, I'm super excited. And I have to say I wanted to find someone who had a direct primary care practice. So I went on LinkedIn and I searched and you came up right at the top and I saw you had also gone to UTMB, where I did medical school in Galveston and that was extra wonderful.

PS: Yeah, that was great. It was great to see your message on LinkedIn, a fellow UTMB grad.

MS: It's great to know the LinkedIn algorithms are working.

HF: Absolutely, absolutely. It is a great place to find people, find jobs. And it's interesting how that alumni connection makes such a difference. We didn't go at the same time, but there's something that bonds us and you said “yes” right away. So thank you again.

PS: No, you're welcome. I’m always glad to help a fellow alum.

MS: Yeah. Thanks for having us. We are excited to be here.

HF: Yes. And also fellow Texans. You're in San Antonio.

PS: That's a cherry on top right there.

HF: Right. Now, let's begin with just a brief definition of what is direct primary care. We'll be going into a lot more details, but just in case some of the listeners aren't really familiar with it.

PS: Sure. Direct primary care or DPC essentially is a membership model type of healthcare. Patients will pay a monthly membership where they will then have access to you as their physician. A true DPC practice does not bill insurance, unlike concierge practice. So we strictly just do memberships.

MS: That's kind of it in a nutshell. And the reason that this model exists is because it kind of eliminates third party involvement in the patient's care. It creates sort of a direct relationship between you as a physician and the patient. And it's a way of bringing back the emphasis to the doctor-patient relationship.

HF: Excellent. Again, we'll be getting more details on this, but would you like to begin with your story of how you got into this? And I know Prisiliano you got in first and then we'll also have Monica join in to tell when she entered in.

PS: Sure. Yeah. I started our current DPC practice, Salveo Direct Care in 2018. Prior to that, I actually opened a traditional insurance based practice straight out of residency with another fellow resident. And we did that for about four years, but then by that time, honestly, I was very burnt out. We were very busy, had over 8,000 registered patients between the two physicians. So it was go, go, go. And there was very little time really to enjoy life at home with the kiddos. At this point, we had two kids. Actually, our third was just born the year before. So we were quite busy.

I heard about DPC in the spring of 2018, and I fell in love with the model because that was exactly how I wanted to practice, but I just didn't know that DPC existed, to be honest. And then, I went to a conference in July with the AFP DPC summit. By August I started the entity, by October I started seeing patients. And then in January of that next year 2019, I was completely out of my old practice and full-time DPC.

HF: Wow. That's a really fast ramp up. You must have been really inspired by that summit.

PS: I was very inspired, honestly, very inspired. And a little disclosure. Since I did start the previous practice from scratch and it was an insurance based practice, I had the knowledge of how to start a practice already. So the switch was actually very easy and I think that's why it was very quick.

MS: He told me that starting a DPC practice was much easier than starting a traditional insurance based practice. So I think that helped.

HF: Yeah. So much simpler model. And you don't have to have all this staff, which can be hard too, just hiring the right people and training them.

PS: Right. It's less staff. You don't have to even be dealing with billing departments, to billing insurances, contracting with insurances, et cetera, et cetera. So it's a much simpler process. Still, it can be challenging, but much simpler.

HF: Monica, what did you think when he came home on fire from the summit?

MS: He came home such a cheerleader for DPC. I thought, "Well, why not? Let's just give it a try and see how this goes." I hadn't heard of it either. It sounded amazing. It sounded like a great way to practice and really take back medicine. And so, I supported him in that and things got off to a really great start.

Just a little background about where I was coming from. I was employed by a traditional insurance based practice, my first job post residency, while he was running this other insurance based practice that he had opened.

As he mentioned, we became very busy with having kids and both working full time and him being a business owner. I started to get kind of burnt out on that, being at home, trying to close out charts while you're breastfeeding late at night isn't really very conducive to work life balance.

So I started looking at other options, moved on to work with an employer based healthcare group, which was really a great job overall. But at the same time our family became bigger. We became busier and being employed by another group, I just didn't really have a lot of flexibility and wasn't able to achieve the work-life balance that I needed to feel fulfilled as a mom, as well as a physician.

And so, then fast forward to April of 2021 coming up on a year and a half ago, that's when I decided to make the switch and join him. I actually was very supportive of DPC and on fire from it from the beginning, whenever he introduced it to me, just felt like we kind of needed to give it a try with him first and see how things go. And then when the timing was right for us, then I made the switch to and I haven't looked back since.

HF: And you both met in medical school, is that correct?

MS: Yes. That's correct.

HF: What year was it in medical school?

PS: We met in 2008. I was a second year. She was a first year.

HF: Okay. And you both went into family practice and then you did different practice models. And now you're both in this DPC practice. Can you give us an idea of what this practice looks like and your day to day?

PS: Sure. Unlike a traditional practice where you're seeing 20, 30 patients in a day, in a DPC practice, you're seeing half to 40% of that. Starting out in the beginning, you're going to be slower. So you may see zero or just a small handful of patients, but then that allows you the time to get to know your model, get to know the business of medicine, which is one of the big challenges of just owning a practice.

But you have a lot more time to do research on clinical conditions, message with your patients about different things that might come up, because again, you're not dealing with insurance so you have a much better communication with your patients outside of just the office visit.

In a typical day, we may see five patients in the office, but then we may do a couple of telemedicine visits via video. And then we may have some messaging or some asynchronous visits that we're also doing throughout the day, kind of sprinkled out. So it keeps you still busy, but it's a much more flexible type of busy.

MS: And a pace that's much more conducive to providing comprehensive care to your patients too, which we really like and feel like our patients really appreciate that. In the past I felt like a lot of times my patients would leave with more questions and answers.

And now I feel like that they, for the most part, get all their questions answered whenever they're here.

HF: And you mentioned flexibility, Monica, which is often one of the first things my clients say when I ask them, "Well, what do you want going forward?" And so often it's flexibility to do things with the kids, to be a person, to just feel like you have more autonomy over what your schedule is. Are you both working five days a week? Do you work three days a week? How do you figure out your schedule?

MS: Yeah. That's a great question. And that's something that's really been great about not only being a business owner, but specifically direct primary care as we both have been able to be a lot more flexible with our schedules. And so, as Prisiliano mentioned, we do a lot of telemedicine, a lot of asynchronous visits, meaning that we take care of health problems through a secure messaging system a lot of times, for less complicated issues, of course.

And so, what that allows us to do is let's say for example one of the kids has an event at their school or a meeting that I need to go to during the middle of the day, but a patient need comes up that I feel like shouldn't wait until the next day, or I don't want to wait until the next day. Oftentimes I can send a message and let them know, "Hey, I'm going to be out for a short period of time. But as soon as I'm done I'll respond right back to you." And we can often address the health issue in that manner rather than telling them, "Okay, you've got to come in for an office visit." And then they come in, wait for an hour while I finish up seeing other patients. It's just a much less complicated way of providing care for straightforward needs that you can kind of squeeze in around events in your schedule.

HF: How many hours overall would you say you each work a week on average?

PS: We try to split our days precisely because we have three kiddos and they're all under 10. And so, inevitably things come up with them, but also so that we can maintain somewhat of a lifestyle ourselves, take care of ourselves. Practice what we preach.

I would say on average it's about 30 hours on a busy week. Some weeks, honestly it might only be 20. It just really depends on that. And our schedules are essentially alternating so that we have that flexibility. Again, if something comes up, one of us is available without having to reschedule patients.

MS: And in addition to that amount of time, there is some additional time that we're spending, just doing business planning stuff, administrative work and things like that. So that kind of rolls into it. And the total amount of time is probably closer to 40 hours a week, but the patient care is less for sure.

HF: I had mentioned in the intro that you don't have to be a primary care physician to do this model. What are some other specialties that you've seen doing a direct primary care practice?

MS: There've been a few other ones that we've encountered. For example, we have a colleague that we know very well, that's an endocrinologist for adults and she is doing a direct care model, very successful with that. There's a pediatric endocrinologist that we know as well. A pediatric cardiologist. We've come across a few different specialists that are utilizing this model and seem to be doing well with it.

PS: Yeah. Pediatricians, obviously primary care, but pediatricians, family doctors, internal medicine doctors. Specialties that do more procedures I think it's harder to do that, with the cardiologists, endocrinologists, primary care for the most part, you're not really doing much procedures. It's more educating, counseling, management, medication changes, things like that. So it's a lot easier for mostly primary care and non-surgical specialties.

HF: Yeah. I want to talk a bit about the finances, how you figure out how many patients, how much to charge, how patients are in terms of paying cash. But before that, I want to take a quick break to share some resources and then we'll be right back. Don't go away.

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My LinkedIn for Physicians course shows you how to create your own standout profile, have success networking and land nonclinical jobs. To learn more about this online course, go to doctorcrossing.com/linkedincourse or simply visit the Doctors Crossing website and hit the products tab at the top of the page. Now back to our podcast.

All right, we are back here with Monica and Prisiliano Salas and we are talking about income, which is everybody's big question.

MS: It's always a million dollar question, right?

HF: Right, exactly. The million dollar question. So, talk to us about how to even think about this kind of practice and income.

PS: Yeah. Honestly, when it boils down is what your goals are, what your goal is, where you want to be. Some people might be comfortable just working 20 hours a week, making $100,000 and that's all they need. And that's really it. Others may have different goals just depending on finances or if they want to do investing or whatever, whatever your goal is. Honestly, it's a wide range of income, and it really boils down to what you as a physician want to do.

MS: Yeah. And I would second that. For people like us, we'd like to make a nice, comfortable income, but by the same token, since we're also lifestyle medicine physicians try to practice what we preach. We don't want to be so overly busy that we're not maintaining a healthy lifestyle and achieving that work-life balance that we discussed.

Our goals are kind of more in the middle range, but some other people may say, "I have certain financial goals that I want to achieve so I want to work a lot." And you certainly can do that and be very, very busy as a DPC doctor. That's just something you kind of have to decide for yourself. But the nice thing is that there are a lot of options and a lot of flexibility.

HF: And I imagine when you're doing this, you're doing some research to see "Is this a good demographic for me to have this kind of practice? Am I going to have enough patients? Are there a bunch of other practices around me that would be in competition?" Is it hard to really figure out whether, if you build it, they will come and then you'll be able to reach your goals?

PS: Yeah. I have two experiences with that. If you build it, they will come. No, they won't. You still have to do the groundwork. You still have to do the marketing. You still have to put your name out there, word of mouth, et cetera, et cetera. So, it depends on how busy, how much you want to hustle at that and how quickly or how soon you become "full", whatever you're "full" is. Whether it's a couple hundred patients, or 500, which is about the average for a DPC doctor, or even some practices go up to 1,000 patients per doctor, which that's still less than 50% of a traditional insurance based panel for a primary care who carries on average 2,500 patients. So it's just finding your happy place and what works best for you, and then doing the legwork to get there.

HF: Now, Monica, you did not have your own practice that you started, but you've sort of seen this from the outside and you're also in it. If a physician is wondering right now, "Ah, I'm not entrepreneurial. I've never had my own business. This sounds

overwhelming to me, but I think I might like to try it." What words of advice might you give them?

MS: I would advise them to maybe seek out an established direct primary care practice and see if they can kind of get their feet into the direct primary care arena that way first to get a taste for it and see if it's something that they really like and enjoy. And then if a physician does that and then feels inspired to maybe start their own practice or become more involved with the administrative side of their existing practice, if that's an opportunity for them, I think that it is a lot easier to do than it is in a traditional practice.

So I don't have any formal business training at all, to be honest, but after joining Prisiliano I have learned a lot just by working with him and him sort of showing me the ropes. Not only is he a great husband, he's a great teacher as well.

HF: That's sweet.

MS: Because I needed a lot of it since I didn't have any of that experience. But I think that for me, the transition has been pretty smooth. And so, I think that if someone really is interested in providing this type of care, but is just a little overwhelmed by the business aspect of it, that would be a good way to go. See if there's an existing practice that they can kind of jump into and then go from there.

HF: That's a really good point. Do you see in your experience that direct primary care practices tend to like to hire outside physicians to come in and join them versus have it be their own thing?

PS: Yeah. Honestly, once you get to, again, whatever your comfort zone is, and if you want to grow from there, or maybe your goal is actually to have multiple locations, obviously you need more doctors. And so, whatever that threshold is for you then definitely it's no

different than in another practice. DPC doctors are always bringing in new physicians as well. But the caveat is a lot of times you're starting from scratch.

So, that's one thing to consider. When you're joining a DPC practice, you may not have a full panel of thousands of patients. You may start at a much lower patient panel and therefore your income in the beginning is not going to be where you think you will be. It's going to take time to build that panel. Actually a lot of DPC doctors, whether they start their own or join another practice, a lot of times they will actually have side jobs or hustles or moonlight somewhere else in the meantime, while they're building up a DPC panel.

HF: Well, yeah, I like that option because you can learn, like you said so much from someone who has already invented the wheel and you can get some mileage out of their experience.

PS: Yeah. No point in reinventing the wheel.

HF: Right. Exactly.

MS: And the DPC movement has really just exploded over the past few years. So I think there are lots of opportunities out there for people.

HF: Yeah. That's really encouraging and that's showing that it's working too. So, that's good validation. We had also mentioned lifestyle medicine. How did the two of you decide to get your certification in it? And can you give us some examples of how it fits into your practice?

PS: Sure. Just like DPC, I learned about lifestyle medicine I think in 2019, going into 2020 right before the pandemic and realized that, “Hey, this is how I've always wanted to practice. I'm already in DPC and now I find out there's lifestyle medicine. That's great.

Why don't I just get the certification? Because again, I'm already doing that. So this'll at least legitimize what I'm already doing." I learned about it. I went to a conference very similarly.

HF: And came home inspired and on fire.

PS: Got inspired and on fire. And then did some additional CME online, like a plant-based certification because lifestyle medicine promotes plant-based nutrition, the following summer. And then 2020 is when we got our certification. So I started in 2019 and then 2020 fall, that's when we both got certified, actually.

MS: Yeah, this was another situation of, I had never heard of it, but somehow he fell upon lifestyle medicine and introduced it to me. And I was like, "Wow, that sounds amazing." And it works really well with the direct primary care model. And so, that's why we both decided to pursue the certification because at the time I was still employed, but I knew that my eventual goal was to join him and practice as a DPC physician. So we both got certified as he mentioned, November of 2020 that was a fun year. And then since then have really enjoyed utilizing that in our practice.

Because we are in a DPC model we have more time with each of our patients. So we're able to sort of use more of the lifestyle medicine in our treatment plans with our patients. We don't feel pressured or rushed to sort of get through the visit. So we spend a lot of time talking with them about their nutrition, about their sleep, exercise, and stress management. All those sorts of things.

HF: So those are the four main components of lifestyle medicine.

PS: Yeah. Lifestyle medicine revolves around six pillars of health. Exercise, nutrition, sleep management, stress management, social connectedness, and avoidance of toxic substances. Those are the six pillars of lifestyle health.

HF: Oh, okay, okay. Yeah. I only knew about four of them.

PS: We got four out of the same. That's good.

HF: Yeah. There's a lot of interest by the physicians I talked to in lifestyle medicine. And one thing you told me before we were doing this recording is about you have these different tracks that a client or a member can choose a patient. And what are those different tracks and what are some different offerings that they have through your program?

PS: Yeah, that's a great question. Again, once you're in DPC, you can structure things however you want. The way we structured it, as far as how we practice at our clinic is we decided to actually offer a mental health track or a personal fitness track. Not only does a patient or a member get access to their doctor through the membership, but they also get access to a mental health counselor and to a personal trainer as well.

There are different ways you can structure it. You can do it all as part of the membership fee, you can charge a copay for an office visit. However you want to do it, there's multiple ways of skinning a cat, but we chose to do that.

MS: We also have a 3D body scanner that we use as well. It's a noninvasive infrared 360 picture of a patient's body. And we use that to kind of help calculate health risk and look at things like visceral versus subcutaneous fat, muscle mass versus fat mass and things like that. We use that a lot with patients who have goals of weight loss, or sometimes we have patients that are very physically fit already, maybe athletes, and they're looking at their muscle gains in different areas and things like that to make sure they're on the right track with their workout plans. That's something our patients have enjoyed as well. And then also we actually have a meditation room with an antigravity massage chair.

HF: Nice.

MS: That's been popular as well. It's just a nice, quiet, serene space that we created. We have the massage chair, we have a yoga mat. We have a diffuser, a meditation device where a patient or a staff member or physician, we use it ourselves too.

HF: Make sure the chair is working properly.

PS: Exactly.

MS: Exactly. Quality control.

PS: There's going to be some perks too, right? If we have it for patients.

MS: But yeah, you can play meditation or white noise, things like that. And it's just a nice space to relax and kind of de-stress. So that's something we offer to our members as well.

PS: In summary, we're trying to cover as many of the pillars as we can as part of our service. And again, this is just the way we do it. There are clinics that do it differently or add more things or less things. It just really depends on how you want to structure it and what you want to offer. But this is what works for us.

HF: That's beautiful. You can have the flexibility to make it your own, which we've lost so much control that I'm sure that's an appealing part of this practice. Now we're getting close to the end so I have some rapid fire questions for you to just to cover some things before we wrap up. One is can you give us a brief description of the difference between direct primary care practice and a concierge practice?

PS: Sure. In direct primary care you're strictly just doing a monthly membership fee and that gives the patient access to you as their physician in your clinic. Concierge practices, for

the most part, they also can do a monthly fee or sometimes a yearly retainer fee, but there are also billing your insurance on top of that.

MS: We provide the same level of service we would say. We just don't deal with insurance companies at all.

HF: Okay. We're catering to the patients, to the members. I know sometimes people get concerned are there going to be high maintenance patients who are going to have these unrealistic expectations and then at 2:00 AM, they want you to come in and do something for them. So, how have you found it to be in terms of managing expectations?

PS: Yeah, some of that is inevitable.

MS: It's a legitimate question.

PS: Legitimate question. And some of that is inevitable. You are going to get some higher maintenance patients. And that is honestly one of the things other physicians worry about. However, it really boils down to how you want to do things. Whenever you meet a new patient, and this is very standard, you provide them with a membership agreement. And in there you basically outline whatever rules, regulations, or procedures you want to go over with them down to there's a practice that puts in there. The doctor is allowed up to four weeks of vacation time per year, which at that point your doctor may not be available. Just kind of an FYI.

Different things like that. You set those expectations up front with your patients. And honestly, we found that patients are very understanding. They're very reasonable. They respect that upfront. They respect you as a person and they understand that you have a life too outside of the clinic.

MS: Yeah. Especially when you're upfront and communicative with them about these kinds of things. I think it's when you don't do a good job of relaying that information, that it can create some tension. But yeah, it hasn't been a big issue.

PS: It's no different than when they teach us about informed consent. Whenever you're doing a procedure, for example, you got to inform the patient of everything possible.

HF: It's so true. Expectations are everything. Yeah, that makes a lot of sense. One of the things you told me about that I found really interesting was the number of staff that you have to help you run this practice and at what you start and who you started with too.

PS: Yeah. So who I started with.

MS: The lone ranger here.

PS: The lone ranger. I was wearing 10 hats in the beginning from fall of 2018 until spring of 2021. It was literally just me doing everything. Answering the phones, finalizing the patients, calling in prescriptions. I was doing everything myself. Then she joined luckily, patients, I guess like her more than me. So we started growing very quickly.

Then we added a part-time medical assistant, the summer of last year. Then she became about three quarters time, maybe around the winter or beginning of this year. And then just over this summer, we just hired a second medical assistant, but she's part-time. So we're still working with very minimal staff.

HF: It just shows you how much extra staff insurance requires. And I think you two gave me some figures about the difference in your overhead when you were in that private practice before compared to your direct primary care practice.

PS: Yeah. A traditional practice for those of you that don't know, and this can be across the board, it's anywhere from 60 to 70 plus percent of your revenue is overhead. When it comes to DPC, sort of a benchmark or a goal to get to is about 20%.

HF: Yeah. I think that's so beautiful. And that helps you not have to work so hard too. You have to work the whole week to make a little bit of money.

PS: Yeah. That's how I felt in my traditional practice honestly. When I looked at the numbers every quarter, it's like what am I really working for? Just to pay 70% of what's coming in is going out the door, not even to me. So that was very eye opening.

HF: Yeah. Yeah. I hate to wrap this up because I could go on and ask more questions of the two of you. This is really fascinating, but do you have a couple steps you'd like to mention to a physician who might be interested in exploring this topic?

PS: Yeah. The first thing I think, especially if you're a family physician, is attend a DPC summit that's put on every year, I believe, in July by the American Academy of Family Physicians. That's a great conference. That's again, the one I went to and very quickly enthusiastically fell in love with it. And it's very, very, very informative. There is another summit called the Hint DPC summit. That's usually something, once you're in DPC then you go to the Hint summit and learn a little bit more about the business of DPC. I think those two are some key conferences.

MS: And also just reaching out to a local DPC doctor and just kind of picking their brains. We're happy to if anyone would like to reach out to us, take questions from them. I haven't had the chance to go to any of these summits. As I mentioned, I mostly just learned about it from him. But we're definitely open to helping fellow physicians who might have any questions about how to get started or how it works.

HF: Oh, that's lovely of you to offer that. I'll link to those conferences, the summits and the show notes as well as your website and information. And it's really been lovely to have you here. I want to come down and try out that massage chair in the meditation room.

MS: Yeah. Anytime. We'll give you a standing order for it.

HF: I love it. I love it. All right. Well, thank you so much guys. And for our listeners, I think this is wonderful to think about this option if you have that heart for medicine, you don't want to leave, you want to be the kind of physician that you went into medicine to be, and it would work with your specialty, I think it's worth giving some thought to. So, I hope this has been helpful. Don't forget to carpe that diem. I'll see in the next episode and bye for now.

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Podcast details

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