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

TRANSCRIPT

EPISODE 214 Freedom and Financial Control: The DPC Model for Primary Care And Specialty Physicians

With guest Dr. Maryal Concepion

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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.

Hey there, and welcome to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 214. One of the most unfortunate things I hear when talking with physicians is that they still love caring for patients and truly want to make a difference, but they're deeply frustrated by the system.

How many of you envisioned this would be an issue when you started on the path to becoming a doctor? My guess is not too many of you. A big part of the frustration comes

from not having enough time to truly care for your patients the way you know they deserve. Instead of focusing on what would genuinely improve the health of the person in front of you, you often have barely enough time to get through the visit, write some prescriptions, and move on to the next patient.

The frustrations don't stop there. They're compounded by system inefficiencies and conflicting goals that feel far beyond your control. But here's the good news. Some physicians are taking matters into their own hands. They're creating new models of care that align with their values and the kind of doctor-patient relationship they've always wanted to nurture.

These models include direct primary care, also known as DPC, niche practices, concierge models, and even direct specialty care, also known as DSC practices. What many people don't realize is that the DPC model isn't just for primary care physicians. Specialists can also use this approach, building cash-based practices where they have the freedom to spend more time with their patients and practice medicine on their own terms.

Sounds good? Well, joining me today to discuss this exciting topic is an expert in the field, Dr. Maryal Concepcion. Dr. Concepcion is a family medicine physician and the founder of Big Trees MD, a direct primary care clinic in rural North California. She's also the creator and host of the podcast, My DPC Story, where she educates and inspires by featuring physicians who are redefining medicine through the DPC and DSC models.

Today, she'll share the ins and outs of these innovative practice models, the freedom they offer, and how they're helping both primary care physicians and specialists regain their autonomy, rediscover their passion for medicine, and achieve a more fulfilling work-life balance. Without further ado, it's my honor and pleasure to welcome Dr. Maryal Concepcion to the podcast. Hey, hey, well, welcome.

MC: Thank you so much for having me. It's such a pleasure to be here.

HF: Yes, I'm excited. I found your podcast, and I could not believe all of the different physicians and specialties that you interview in your episodes, and they're fantastic.

MC: Yeah, I love that you picked up on that. I am so honored to, just as you are with your guests, this is a time in medicine where physician autonomy is a thing. It's like we didn't really think about that as a culture for a very long time, and I'm very proud of all of us for realizing that, "Hey, you know what? Autonomy matters in medical practice, wherever you're at."

And for the podcast, just to go back to the why I did the podcast, I would go to these summits about direct to primary care, because I was looking for another way to cross over, so to speak. And what I found was when I left the conferences, I didn't have anybody to listen to anymore. The five-minute versions of people's stories on a panel were something that I was like, "Okay, I've listened to this on repeat so many times, and now I want to know if there's something else out there."

And so, when I was 28 weeks pregnant, and I was about to my sixth year in fee-for-service, I was told that I was going to be fired unless I signed a very nasty contract. And I decided that that was my ripping off the band-aid. And I went into creating this podcast, My DPC Story, as a platform for other physicians to see themselves in each other. As we share our stories, if you're dermatology, if you're rural medicine in doing internal med-peds, if you're a person who's doing OB call and still doing deliveries and C-sections as a family physician, I am so proud, again, of all of us being able to share our stories on the podcast, and your podcast too, about what physician is still there, what human being is still there, in addition to our medical degree.

HF: Well, this is great. And we're going to launch into a lot of details. But before we do that, Maryal, I'd love it if you could tell us how you decided to start this practice. I know you said that you were going to be fired, you were pregnant if you didn't sign this contract,

but someone else might've said, "Well, I'm going to find a different W-2 job." It's a big deal, especially when you're going to have a young one, a baby, to think of starting your own practice.

MC: Yeah, absolutely. And it's a wonderful question. It was actually my second baby at the time. I had a almost three-year-old, and then I was going to have our second. And to answer that question, what I would say is that the experience that I had in fee-for-service, I am very much the more reactive rather than the serious planner and strategic planner. I'm like, I'm not going to do that anymore.

And so, I had heard from our lawyer. Unfortunately, she's passed away by this point. But she had said, look if you're going to not do medicine for two years, could you survive? And financially, the answer was yes. And so my husband, who's also a family physician, he was going to plan to stay at the practice. My plan was to leave the practice as soon as I finished my maternity leave.

And financially, I looked at it to say, if I don't do anything, if I have zero patients, zero patients paying membership into a practice that I'm building from scratch, could we survive? And the answer was yes. That really was the foundational, like, "Okay, this is not me just being a reactive 16-year-old. This is me being, I am a physician. I am not being treated as such. I cannot do this anymore. Can we survive financially and put food on the table, pay our bills? Fantastic. Let's do this."

HF: I love your boldness. And as physicians, often we feel like we need to meet expectations, stay in the box, sort of do what we're told. And for a lot of us, it can feel very risky to go on a venture like this. And everyone has a different personality that we deal with. But when you were thinking about this, what gave you the confidence? You said, okay, I can go for two years without money. But what gave you the confidence that told you I can make this work?

MC: It was hearing fellow physicians share their stories on stage. It was hearing fellow physicians in person when I would visit a DPC clinic and see, like, oh my gosh, this isn't a magical unicorn. This is a person who doesn't have an MBA, who has an MD or a DO. And they full out opened a DPC practice. And now they have members paying into a salary that is giving them more financially than they had in fee for service. And they have more time to spend with their family. My goodness, I am now developing the confidence. And that's what happened prior to me getting that contract.

I was very grateful that for about maybe a year and a half prior to that, I had attended DPC summits. I had talked with people. And I was just slowly just taking notes in the back of my head and saying like, "Wow at the end of the day, you need your license. Fantastic, got that. You need to figure out a plan for malpractice in California. We're very blessed to have a very amazing option that is not going to put us into the poor house just to pay for malpractice and be a private physician."

And I was able to say, "Look, I just need a way to communicate with my patients reliably." And that isn't that expensive. When you look at big EMRs, the Sooners, the Epics, you pay thousands and thousands of dollars, $40,000 a year for one of them that they're using locally. And we're talking hundreds of dollars each month just to make a practice. Yes, you have to have your annual fees for the state of California in terms of business. And there are certain things. But in terms of realistically, people say how much does it cost to open a DPC? And it's in the thousands. It's not in the hundreds of thousands.

HF: Well, this is so interesting. And for our listeners, could you break down exactly what is a DPC and how it is different from a concierge practice?

MC: Absolutely. Typically, the main difference is that in a concierge medicine practice, insurance is still billed. There is still a third party payer involved in the decision between what happens from what the doctor recommends and what the patient actually gets at

the end of the day. In DPC, direct primary care, and I love that you said that specialists are realizing that this is for them as well. Direct primary care is a business model. It is not only for primary care model.

When I say that, that means that direct primary care typically is an insurance-free way of having members invest in you and your practice. And that membership can either be a monthly membership or an annual membership. And that patient, as a result, gets for their membership. And like you go to the gym and you get to use the gym equipment, you pay Netflix, you get your movies. In a DPC, what the member is paying into is the direct relationship and access to that physician who they have a relationship with.

And so that is something that, especially in rural America, is the number one reason why people have insurance and still pay for our services apart from their insurance. Because they're able to invest in a relationship directly with the physician who not only has the time to see them, but who also knows them. Because typically we have smaller patient panels. And when I say that insurance does not play a role, we actually have a backpacker swag for our clinic says that, that we do not allow insurance to dictate our healthcare.

This is a typical conversation. And again, DPC is a business model. So you could be a sleep medicine specialist and talking about the same types of things. If you need a sleep study, like us, what sleep center and what sleep physician are you going to see in rural America when there's 45 licensed medical doctors in our county who are board certified and licensed by the state of California? What sleep medicine physician exists here? None.

And so, a sleep medicine physician with a population who doesn't have access to a physician can say, “Hey, you know what? We can either do a cash pay virtual visit with a physician. We can do a home study where for a whole month, we can check your sleep every single night to see if you have apnea.” If you are working without insurance, you

can just say, this is the cost of these things. Just like you can a loaf of bread at the grocery store.

Take for example, imaging or labs. You can say to a patient, absolutely you can use your insurance, but I don't know if your insurance is going to cover anything. In 2024, sadly, that is the case. We could say to patients, "Hey, you know what? Your thyroid, your TSH to get checked is about $6. Do you want to use your insurance or do you want to pay cash? Your mammogram, 3D mammo is $200." If you go for your insurance covered, they may not cover a 3D, they might cover a 2D. And if you get a 3D, then it's "not covered" and then you risk having to pay more than $200. If you had just paid cash, you would have just known the price outright.

And so, where the direct primary care movement is providing autonomy to not only physicians, but also to patients to be able to decide transparently, "What am I going to do for my next healthcare decision? Am I going to use my insurance benefit and invest in certain types of insurance so that I get "coverage?" Or am I going to have insurance, whatever, however I determine that, as well as have a direct line to my physician who knows me?"

HF: No, it sounds like there is some contracting that you might be able to be doing to offer these lower prices for labs and imaging studies. Is that something that comes along with being involved in a consortium for our DPC providers?

MC: Yeah, that's a great question. Group purchasing organizations or GPOs is how we leverage independent practices into a way to negotiate prices. Because I don't have ties organizationally, fiscally with another DPC like down the hill in Modesto. However, if they use the same GPO as myself, then collectively all the practices within that GPO or the group purchasing organization can work with Quest, LabCorp, McKesson, Henry Schein. We can work with these companies collectively through our GPO to get prices negotiated.

Those definitely differ from region to region, GPO to GPO. But overall, I cannot find a lab price that's cheaper cash if an insurance company, or even if you look at the wholesale pricing for Quest or LabCorp, you're still not going to beat these prices that we are able to offer.

HF: Interesting. And just for the listeners, would it work if we use the term direct care just to cover DPC and direct specialty care practices since we're talking about both of them?

MC: Yeah, absolutely. I think for conversational purposes, because it is inclusive, absolutely. The reason I say direct primary care most of the time is because that is the legal term in the ACA. So it is written into the ACA, Obamacare, as direct primary care and in the state laws that are protected. And now, as of this recording, 34 states where direct primary care is the legal term protected by law.

HF: Oh, okay. Now, would you be able to give us a couple of examples of a physician? Maybe we could do a primary care physician and then a specialty care physician to illustrate a little bit about what their day and week might look like. And then we can also get a little bit into income.

MC: Absolutely. I laugh at this because really, there is no stamp done, next one stamp done. There is no repeatable thing in DPC in terms of no physician is expected to have the exact same, everything is the next physician doing DPC, which I love. And we have this phrase, if you've seen one DPC, you've seen one DPC. And again, that definitely applies. It applies to direct care as well.

But when it comes to how many patients you see, how many patients you take on in your practice, that absolutely depends on you. If you're a person who's like, “Hey I just had a baby and I really don't want to be in the clinic 08:00 to 05:00.” Great. You could do locums coverage for another DPC practice. You could do it completely virtually from home. You don't even have to have an office. You could set your hours.

If you have a smaller practice and I will say a typical "full" direct primary care, we see about 600 to 800 people on a person's panel. But if you are charging a higher rate, you could potentially see fewer and have the exact same income at the end of the day as somebody with 600 to 800 patients who is charging less like in, for example, Kansas. There's different ways to slice and dice DPC. But when it comes to the day-to-day, it really depends on what you want to do. Literally I've had examples in my own practice where I'm like, the school let me know two days before the performance of the season that I'm supposed to be at the auditorium. And I'm able to rearrange my schedule to say like, hey because my patients aren't stressed out that they can't see me for six months. These are people who are like, "Oh, you want to move me to the day before, fantastic." Or "I'll see you at the day after, no problem."

But just in terms of the overall general primary care office, again, a full practice, 600 to 800 people. But when you look at that, if you see 1% of patients per day, and that's typically what we tell people to ask. If they're looking at their fee-for-service job, if they think they need to, or they're going to take a fee-for-service job before DPC, asking around to say like, how many patients do you see per day? And if the number is 30, and 30 is 1% of the total population, that's a lot more than you would typically experience in DPC.

Because sometimes when you're at an interview at a fee-for-service job, it's like, we can give you seven years of your mortgage, and we can give you a million gazillion dollars, and all your 401(k) dreams come true. But as a result, you have to sell your soul to the devil and see so many people that you don't have your own soul at the end of the day.

And so, when it comes to the number of patients, you can see as many as you want to, and you can see as few as you want to. You can see them in person, you can see them virtually. And you can do a hybrid of those, because as of this podcast, we're about to lose telemedicine. And I hope that that changes for Medicare beneficiaries come January, but that's on the docket to be ending with the pandemic allowances that are

covered under Medicare. And unless it's changed, my rural people who are benefiting from telemedicine, they may, if we are considered rural and remain rural, maintain those benefits, but it's always on the chopping block.

In a specialty practice, I'll take, for example, Dr. Amina Moheyuddin. She's a pediatric dermatologist in Houston, Texas area. She has both people who are seeing her regularly. And then she also has people coming off for a one-off visit because I think she said there's, I don't know, it's like 400 total pediatric dermatologists or maybe I'm adding a zero or I shouldn't be. I apologize, I did not fact check myself there, but I know she said she's one of very few pediatric dermatologists.

And so, people from all over will be able to do virtual and in-person visits, as long as she's licensed in their state, for issues that they might not be able to have addressed or they're just really irritated with. And she talks about this in her podcast on My DPC Story.

The six months to get a five-minute visit and then you had to rearrange your whole schedule to be able to make that appointment, pay for the parking. And then you'd still have questions about what to do after your five minutes. And then you have to make another appointment three to six months and people are just like, “Or I can just pay for a dermatologist to see my kid right away.”

She's able income-wise, when you look at the number of patients and the number of visits, it's how you bill your patients. If it's for one-off visits and or membership, that's how you can calculate your income at the end of the day. Some people have side gigs, absolutely, especially common when you're opening a DPC. But I would say for the most part around 50 patients is typically where we see word of mouth in membership practices take off. Once the threshold of around 50 patients is there, the word of mouth, you have 50 people who are talking about your practice to other people. And those people are talking to other people about, hey my friend told me this. And then it just, it snowballs is what we typically see.

And so, thinking financially, like if you have, if you estimate what would 50 patients be, so to speak, and you financially float yourself to that amount until you get to that place, or if you have that from savings or whatnot, and then you plan out, like I want my income to be $250,000, $350,000. And then if you subtract, this came from Dr. Julie Gunther's book, Spark Start Fires, about 30% overhead. And that's overestimating, but it's safe. Then you can mathematically say especially if you have memberships, "I have this many patients paying this much a month. I can literally doctor from anywhere that has Wi-Fi. Fantastic. This is how much I can make."

And then you have taxes and you have vendors that you work with that you have to pay bills for fine. But this is where it's so much easier than the stress of, oh my God, what is CMS going to reimburse us for this visit and this code this year?

HF: Now, often when people think about this practice, they may get excited about the autonomy and taking care of patients the way they want. And then they think, "Uh-oh, if I am responsible for them and they have this access to me, does this mean that I'm eating dinner with my family and I get a page or I'm on call all the time, or can I go to Africa for a safari and who's going to take care of my patients?" How do you handle the logistics of coverage?

MC: Yeah, it's a very, very important question. And I'm glad you're asking it because this is what scares a lot of people from the get-go. They're like, oh, 24/7, 365. No, no, no, that's not for me. I go back to autonomy. If you have your practice and this is your practice, you literally can say Dr. Jade Norris is a great example. I work 08:00 to 05:00, period. From this hour to this hour, you can go ahead and contact me. Some people do have 24/7 on their website. And it literally is up to you to, one, not only establish those goals, but also to nourish those goals with the conversation and how you talk to your patients of "This is not an appropriate means of conversation. The appropriate way to converse with me is by doing this." If it's only portal messages, if it's calling this number after hours rather than texting.

And then also if you have patients who are really not following through with their part of the bargain in terms of they're abusing or they're encroaching on those barriers, and this hardly happens, but it's like, "Oh, I'm texting you at 02:00 A.M. because I need Tylenol. And yes, there is a Walmart that is open 24/7 , but I had to ask for Tylenol." That's a place to say, "Hey, you know what? This is my practice. I'm either going to say something, ask ChatGPT to help me with how to say something appropriately, or talk to another physician to be like, "Hey, how do I handle this? Have you ever had something like this?"

We have such a community where we can literally talk to each other because most of us do not have MBAs. But I will say that the 24/7, I do not recommend it because we don't have electricity sometimes. We don't have the ability to be available 24/7 if a tree falls on a power line. I do not use and or recommend that terminology. With our patients though, we say we have an acute line and our message says, if you do not hear back from us in 30 minutes, go to the emergency room. If you truly think you have an emergency, dial 911.

There's ways to craft your clinic so that it allows you to protect your time. And if you do not want to be on call and that's what your patients know transparently upfront you're offering, then that's what they're buying into. And if it doesn't fit for them, they can definitely find another doctor, but you as a doctor no longer have to say, "Oh, I have to take this call because I have to do anything." You don't have to do anything. Following evidence-based medicine is a good thing, but you don't have to take behavioral things that are not going to be in alignment with how you wish to practice.

HF: And do some DBCs cover each other? Do you have coverage so you go away from your practice?

MC: Yeah, that's a great question. That's why I mentioned earlier, if somebody wishes to only do coverage for DPC and they want to just get their toes wet in the water with different

EMRs, different ways of how people handle practice under a DPC model, they can do that. For our practice in particular, it's my husband and I, we will take call depending on where we're at. When we were at family reunion in Canada this summer, we told our patients that we are going to be on virtual visits only. And we told our patients we would be available at certain times. And then we would check our acute messages. But again, if you needed an acute visit, like stitches, we were not going to be available.

And we tell people up front, like we're married. We're not going to be in town 100% of the time. There might be times that you have to go to urgent care or the emergency room. But in terms of most of the things we can evaluate, send us a picture, let's take a call, do this and then text me how are you doing an hour later, if your blood pressure is an issue or whatever.

But there has been a time when I turned the practice over to another physician. That's something to definitely ask in a malpractice policy. What's your coverage for locums? Our coverage is 30 days. There's other policies out there with 60 days covered under your malpractice that you pay for. So, it's pretty amazing that you can take a whole two weeks off. You can take five weeks off if you want to, as long as you're transparent with your patients and they know the rules.

HF: That's really helpful because often we feel like we just have to not just meet expectations, but exceed them to have happy patients. I love all those different scenarios that you've given us. I'd love it, Maryal, if you could give us some more examples of the direct specialty positions. You mentioned the pediatric dermatologist. I'm sure people are wondering, "I'm a surgeon. Could I do this? I'm an endocrinologist. I'm an OB-GYN physician. Could this be for me?"

MC: Yeah, absolutely. There's so much happening in the healthcare space to fight for patient autotomy, and that absolutely includes surgical specialties. If you look at Wellbridge Surgical Center in Indiana, or if you look at the Surgery Center of Oklahoma, those are

places where they're great models for how are you building a practice, a surgical specialty practice into a community, and you're not dealing with insurance. Those are great models to look at.

When it comes to vascular surgery, the idea of a vascular surgeon doing ultrasound reviews definitely can be done remotely. You do not have to be in a particular hospital to be able to do that. I was saying before we started recording, I had spoken at the FlexMed Summit last year, or excuse me, it's 2024, it was earlier this year, and it was an entire room filled of mostly OB-GYNs, but also vascular surgery, hematology, oncology, and their mouths were dropping on my podcast. On the mapper, on mydpcstory.com, on my podcast website, you can search by specialty.

The specialty care doctors that I've had have been cardiology, endocrinology, neurology, hematology, oncology, gastroenterology, rheumatology, definitely gynecology. I've had obstetrics, but not, I have not had anyone still doing deliveries except for one who's an OB-GYN still doing deliveries. The others are doing mostly gynecology, but there are family practice doctors who are doing a C-section still.

There are ways to literally build what you're doing and what you love to do into your practice. Because the thing that really stuck with the physicians at the FlexMed Summit was that you don't have to have DPC as a full-time thing. You can have your DPC practice as another way of creating your medical career going into the future. Somebody like Dr. Maggie Abrahams, she's OB-GYN, she's still doing deliveries. She has a virtual gynecology practice for teenagers, heavily focused on teenagers and just understanding the cycle and ways to treat the cycle. But she doesn't do IUDs. If somebody needs an IUD, she can help coordinate that care. But she does do part of a person's healthcare journey virtually and personably.

You look at a person like Dr. Andy Burkowski, he's a quaternary sleep medicine physician and restless leg expert. He's the person that if Cleveland can't take care of him and Mayo

can't take care of him, they send them to him. And he's doing things completely virtually. Endocrinology, such a perfect specialty for membership-based care because it's endocrinology. Anyone who's a physician can understand that, no more details needed.

Dermatology, I have a patient who every four months and sometimes in between every four months, this patient is a basal cell, melanoma. And it's crazy that even a person like that, for example, in our area, "Oh, we won't see you in dermatology unless you have pathology but there's no one to cut anything out. So how am I supposed to get that pathology?" And I'm like, okay, well, good thing I'm trained as a rural family physician to take something out, even if it's on the face and get you to a most capable surgeon if needed or converse with them to acutely advocate for you to get an ASAP.

Like all of the different specialties that exist in medicine, there's definitely ways to incorporate a cash-based practice into your practice if you wish to, and if your contracts allow, that's a big thing for physicians to think about is in your contract, does it have a non-compete? Is your non-compete enforceable in your state? And is it negotiable? Those are three big things to think about, especially if you're about to sign or about to re-up a contract.

HF: When you look at the physicians who are specialists who go in this direction, how often are they starting everything from scratch and leaving their current job versus doing it on the side, maybe starting a virtual practice and then testing the waters that way?

MC: Yeah, and really fast, I will add infectious disease also. I've had infectious disease on the podcast. I would say the trend is that specialists tend to be a little bit more cautious about direct primary care because of the "Can I get members to buy into my practice part?" I would say that that envisionment of membership is a lot easier for a primary care practice. But when it comes to the trends in indirect specialty care, people are definitely, because specialty care that is not primary care focused is definitely more lucrative in a lot of cases compared to primary care reimbursements. And so we see a lot

of specialists who financially, they're solid to be able to make a decision. And so they go into this with less, "Oh boy, how am I going to make ends meet?"

I feel from the physicians I've spoken with so far compared to somebody who is either coming out from residency with the $45,000 to $52,000 a year that they make in residency. I think also though, they're embracing the fact that there's more and more specialty care doctors, there's a direct specialty care alliance, geared specifically for specialists, but they're embracing the community with more openness overall than skepticism.

I would see a lot more skepticism on the Facebook groups. And that sounds very, again, 16 year old of me to say, but when people are asking, "How could I do this as a, more so than I could never do that because I am a." Again, this is a great time to be in medicine because most likely there's somebody who has either thought it or done it and who has in both cases, learned from their thinking or their doing of opening a specialty care practice.

This is where I see people going into taking their leap of faith into the direct specialty care or the direct primary care movement with asking more, "What do I want in my practice?" You see a little bit of waxing and waning between what do I want and then going back to like, "Okay, but how do I make this amazing for my patients?" And there's got to be some of that because at the end of the day, your patients are investing in you. But I do like that there is the waxing and waning versus it's all about my patients. It's never about me anymore. So I hope that answers that question.

HF: Yeah, that is a great point. And it's sort of a mindset shift we often have to make when we've always heard the patient comes first and you just do what you have to do. Now I want to take a short break to share a resource and then when we come back in a little bit of time we have left, I want to talk about steps for a physician who might be interested in it to explore, to find out more. Okay, we'll be right back, don't go away.

All right, my dear listeners, as always, I like to try to find different ways to help you out. And I know often when you're at the crossroads and you're trying to figure out "What can I do?", there's that initial excitement of, "Oh, this sounds really great. I can maybe do a DPC or maybe I want to transition into a non-clinical job or how can I make my current situation better?"

And my favorite thing to do is to do these one-off consults where we get to spend an hour on Zoom and I really dive in to help you as much as possible during that time and I really find them often transformative.

If you have some questions, you feel like you're stuck, things aren't moving forward, you're more than welcome to reach out to us at team@doctorscrossing.com and I'm happy to help you. My assistant Kati will give you information about the consultation and we can meet and my goal is always to exceed your expectations and have you feel like, "Wow, I just got a lot of help and I feel hopeful." Again, if you're interested in a consultation, please reach us at team@doctorscrossing.com and I'll have that email in the show notes.

All right, we are back here now with our wonderful guest, Dr. Maryal Concepcion and we're going to talk now about steps that you can take to explore this area if you are interested. I know you have some great things for us, Maryal.

MC: Absolutely. This is a time where DPC resources are a plenty compared to when I started looking at DPC and compared to when the first DPC opened in Washington State. There are so many options, whether you're a podcaster, whether you like to read physical books or Kindle books, whether you like to network and attend things in person. There are conferences throughout the year. I list these resources on my podcast website. They're all just linked there. There's a pediatric DPC mastermind. There's a general summit for people who are interested in learning about DPC and really in those, trying to figure out if this is right for them, early planning stages.

And then there's a smaller masterminds. There is a conference that is specifically focused on building direct primary care into health plans. Self-funded health plans for employers who wish to bring a DPC doctor's practice to their employees. There's so many ways to learn about DPC. In the podcasting space, there's more than there used to be. There's one specifically for direct specialty care and my podcast is for all practicing direct primary care physicians and direct specialty care physicians.

And then you have books like the one I mentioned, “Spark Start Fires” by Dr. Julie Gunther. Another great one is by Dr. Douglas Farrago, “The Official Guide to Starting Your Own Direct Primary Care Clinic”. There's another one, Dr. Byron Jasper just released the “Byja Clinic” book.

But yes, there's so many resources. There's organizations out there like the DPC Alliance. They bring discounts and malpractice discounts specifically to physician members. There's a DPC coalition that talks specifically about direct primary care and where policy meets direct primary care. There are so many resources there. And also you have a ton of Facebook groups. There's even Facebook groups for direct care, endocrinologists, et cetera.

And one great source for you, wherever you are in the nation, is DPC Frontier. DPC Frontier has a mapper of practices. Now they're not all physician practices, but they will at least help narrow DPC practices within your state. And you can find people who might be a mile down the road from your office and you had no idea that they were there. My podcast page has a mapper of guests that I've spoken with.

But what I will say is that it definitely is a great idea to start with, are you happy in your career? You talk about this on your podcast all the time. You asked me, how does a person reevaluate if what they're doing is right for them? But when it comes to direct care, figuring out not only what are you wanting to do in the future, but also does your current career allow you to do that? And then if you are looking into DPC, start looking

for people either who went to residency with you and who are doing direct care now or somebody in your state, because the laws in California are going to be very different from the laws in Texas.

And then from there, it's very likely that you'll find a kindred spirit and you'll develop your community from there. And that community may share their own resources for your locale. But I definitely would say those are good general resources for whatever floats your boat in terms of if you want to learn on your own or if you want to learn as part of a group or a mixture of all of those.

HF: All right. Well, we often love homework. It sounds like you have a lot of resources where we can do our homework and learn about these things. Will you please repeat, and we'll put this in the show notes, your website and your podcast?

MC: Yeah, absolutely. My podcast is called My DPC Story for Direct Primary Care. And it's not my DPC story, it's the stories of every physician who has shared on the podcast. And the website is mydpcstory.com. It goes right along with the title there.

HF: Wonderful, and I think you told me earlier that you have a sheet, a resource sheet on your website, which has a lot of these resources on it that you mentioned.

MC: Yeah, absolutely. We have a resource page. It's basically like "Go here if you want to get started." And also we have a startup guide that's a free download for people to access not only resources, basically a checklist that allows a person to literally see what are the main things and physically check off a list if they want to print it out or use the PDF of typical things that you would need to do in a direct care practice. And then also we have podcast episodes that I recommend starting to listen to if you're really getting into "I want to know more about this whole direct primary care world."

HF: Well, I love your website. I also love that you can search by specialty. If you're an XYZ physician, you can find podcasts within your specialty. This is a wonderful, wonderful list of resources. There's no reason to feel intimidated and you can go to her website, check it out, listen to her great podcast. And I just want to thank you so much, Maryal for coming on the podcast and also for what you do. I know you're a game changer for so many other physicians trying to find their way.

MC: Thank you so much for having me and thank you for what you're doing as well. Again, a wonderful time to be in medicine because we are literally finding ourselves as we continue to be doctors.

HF: I love that and that's so important because we can't forget how much agency we have and people can't live without us. We're very, very important and valuable even if you're not getting that message from your employer.

All right, my dear friend, thank you again for listening. Please share the podcast. If you have a moment, just go and rate the podcast on Spotify or iTunes or wherever you listen. I really appreciate that. And if you do want a consultation, you feel like you've been thinking about this for a while, making some changes, but haven't had any success, I'd love to help you. Reach out to us at team@doctorscrossing.com. And as always, don't forget to carpe that diem and I'll see you in the next episode. Bye for now.

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Podcast details

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