Defining the Place of Direct Primary Care in a Value-Based Care System

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ABSTRACT

Introduction: Direct primary care, one of several retainer-based practice models, is a niche practice type that offers an alternative to the traditional fee-for-service and insurance-based practices most prevalent in US health care. In Wisconsin, the prevalence of direct primary care practices is higher than in most other states. The market for direct primary care practice may be growing along with the industry shift to value-based care and an increase in physicians' desire to reduce the increasing administrative work and regulations that detract from patient care and increase burnout. Many physicians are seeking ways to reduce these burdens so they have more time with patients. Some are transitioning their practice to a retainer-based model, such as direct primary care, in which they collect a retainer from patients in exchange for more time, freer communication, and less paperwork.

Objective: The objective of this review is to provide information about the direct primary care practice model, possible drivers to this model of care, and its advantages and drawbacks for physicians and patients. This discussion also aims to evaluate the care model's place in the shift to value-based care, and key positions and policy from leading organizations.

Methods: A literature review was conducted to collect and analyze current evidence about the prevalence of retainer-based practices, the average fees associated with such models, the contributors to physician burnout that may lead to a transition to the direct primary care model, and the relevant ethical and policy considerations associated with direct primary care.

Discussion: Eighty-two percent of Wisconsin physicians report some level of burnout. Estimates demonstrate an increase in the number of direct primary care practices, and that Wisconsin is among the top 3 states with the highest number of direct primary care practices. The literature suggests that since the early stages of modern retainer-based models, patient fees have decreased and the patient base for these practices has expanded. The practice model is relatively rare, although there are indicators that its presence has increased in recent years.

Conclusions: Physicians seeking strategies to reduce administrative burden, spend more time with patients, or simply streamline their practice may experience benefits in transitioning to a retainer practice such as direct primary care. There are foundational concepts about direct primary care, including advantages, drawbacks, and ethical considerations, to heed when transitioning to this model. There is a need for further research to quantify key data about direct primary care and its effects on patient outcomes and physician burnout and satisfaction.

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INTRODUCTION

Health care in the United States has transformed in recent years as influences throughout the system necessitate changes in the ways patient care is delivered and paid for. Physicians increasingly find themselves facing burdensome administrative work,[1] pressure to increase the quantity of patients,[2] and increased levels of burnout.[3] Recent research shows 82% of Wisconsin physicians report some level of professional burnout and over half feel their work environment is chaotic or hectic.[4] Insurers are navigating higher costs and regulatory changes, and patients contend with a lack of transparency about their care and higher out-of-pocket costs. Often patients are forced to mediate between their providers and insurance carriers to ensure their care is covered and avoid the potentially serious financial consequences of receiving noncovered treatment.

Managing this ever-changing assortment of influences has become burdensome and problematic for some physicians. An increasing number of physicians are seeking ways to reduce the time spent on tasks that take away from patients and spend more time on activities that contribute to professional satisfaction and better patient care.[2] For some, this has meant transitioning their practice to a retainer-based model in which many of the administrative tasks are eliminated and they are able to spend significantly more time with their patients. Little quantitative data exist about the prevalence or implications of this practice model. This review aims to provide a synopsis of direct primary care, clarify misconceptions about the retainer-based practices, and emphasize the need for clarity and more substantial data about physicians and patients participating in this type of care setting.

METHODS

A literature review was conducted to identify information about various practice models in which a retainer fee is paid in exchange for open access to a physician's care. Articles and statistical analyses reviewed included those that focused on direct primary care, concierge and, to a lesser extent, other types of retainer-based practices. Literature on the effects of administrative and regulatory burdens on physicians also was reviewed to identify if there exists a connection between increases in physician burnout and a desire to enter into a practice model that may reduce or eliminate those burdens. There was some inconsistency throughout the literature in the label used to identify the practice type—"concierge," "direct primary care," "cash practice," and "membership medicine" all were observed. As a result, this review required diligence in ensuring consistency in concepts and topics in the literature used for analysis.

DISCUSSION

Retainer-based practices exist in several forms, including what are known as "boutique medicine," "concierge medicine," "direct primary care," and "membership medicine." Retainer-based medical care has been a part of health care in the United States for at least a century.[5,6] The practice model in its current form, however, is relatively new. Modern concierge practices were introduced in the mid-1990s and other variations, including direct primary care, emerged later in the early 2000s.[7,8] There are distinctions to be drawn between the various practice types that fit in this model, however the following content provides a review of "direct primary care," so the information throughout may not necessarily reflect attributes found in other similar models.

The primary feature of this practice model is a recurring fee, paid by the patient directly to the physician, in exchange for virtually unlimited access to the physician. In its early form, fraternal organizations like lodge clubs or worker's unions paid a physician a regular retainer to provide for their members' health care needs. Decades later, in much different economic times, retainer-based practices were largely available only to the wealthy, since the fees were often tens of thousands of dollars per year. Over time the model has evolved to be more inclusive, and many physicians have made their practices more accessible and affordable to a larger array of patients by reducing the fees and opening their doors to people who do not have insurance.[8,9] The fee, paid on a monthly or annual basis, is often the only exchange of money between the patient and physician, since in most direct primary care practices patients are not charged additional fees for services rendered. The average monthly cost to patients in a direct primary care practice, according to a study published in the *Journal of the American Board of Family Medicine (JABFM)*, is $93.26. For those practices that also charge an additional one-time enrollment fee, the average cost for that fee is $78.39.[8]

Some physicians in this type of practice do not participate in insurance networks or transact with insurance companies, eliminating the need for claims and preauthorizations that can lead to delays in care, complicated paperwork, and interference with the physician-patient relationship.[10] Deviations from this structure exist, as some physicians charge additional fees for certain procedures, and some accept Medicare and other types of third-party reimbursement. Seventy-five percent of physicians in this type of practice arrangement still accept third-party reimbursement,[11] and patients in these settings still may carry some insurance to help cover services the primary physician cannot or will not provide.

Accurately quantifying how many direct primary care practices are in operation is difficult since there is no federal registry or national database listing all physicians in this type of practice. Estimates from industry organizations are based on voluntary self-reported data from various surveyed audiences, so estimates differ across the board. For example, in 2017 the American Academy of Family Physicians (AAFP) estimated nearly 3% of family physicians operated in direct primary care practices.[12] The Medscape Physician Compensation Report 2017, a study of responses from 19,000 physicians in 27 specialties, estimated cash-only practices accounted for 6% of practices in the United States, an increase from 3% five years prior.[13] Additionally, in a 2016 Physicians Foundation survey of 17,236 physicians, 6.6% of respondents indicated they currently practice in a retainer-based setting, and another 8.8% indicated they plan to switch to a cash-based practice within the next 3 years.[14] A study published in the *JABFM* found that Wisconsin, with 21 identifiable direct primary care practices, is among the top 3 states with the highest number of direct primary care practices.[8] The *Direct Primary Care Journal* estimates there are currently 500 to 600 direct primary care practices in operation in the United States, and Philip Eskew, MD, a leading expert in direct primary care, similarly estimates 620.[15,16] These figures suggest the overall market penetration of direct primary care practices is low, although some reports indicate their prevalence has increased in recent years and will continue to do so for the near future. The growth projections vary, however, depending on the analyst's definition of what qualifies as direct primary care. For instance, The Heritage Foundation reported in 2014 that approximately 4,400 direct primary care physicians were in practice, compared to 756 four years prior.[17] Using a different set of criteria, DPC Frontier estimates that by 2020, 2,000 direct primary care practice locations will be in operation.[16]

The literature reviewed demonstrates a variety of potential contributors to physician entry or transition into a direct primary care practice model. Demand for health care services has increased in recent years as a result of growth in the insured population and other factors. Increased demand in care has not been met with increased physician supply, however, resulting in more patient visits to fit into the clinic day, which is a known contributor to phy-

Box 1. Potential Benefits and Drawbacks of the Direct Primary Care Model

Possible Advantages for Physicians	Potential Drawbacks for Physicians
More time with patients	Possible lower income at start
Reduction in administrative work	Risk of feeling isolated
Improved professional satisfaction	Fewer patients
Decreased interaction with payers	May overburden other, non-retainer-based practices
Improved work-life balance	Difficult to recruit and build patient base
Fewer patients	Insurers may not cover services
Lower overhead costs, fewer staff	
Possible Advantages for Patients	**Potential Drawbacks for Patients**
More time with physician during visits	Does not eliminate requirement to carry insurance
Increased access to physician after hours	Additional monthly payment
Improved quality, personalization of care	
Possible lower out-of-pocket costs	
Ease of communication with physician via email, text, or telephone	
Increased price transparency	

sician dissatisfaction.[18] Physicians also face a significant amount of administrative work in complying with payer demands and regulatory requirements.[19] Over half of physicians report symptoms of burnout, and the percentage of physicians who are satisfied with their work-life balance has decreased to just 40%.[3] Considered together, these factors are likely contributors to the attraction to a model of care that eliminates many of these burdens.[10,20,21]

Retainer practices as a whole currently are not heavily regulated. A clause in the Patient Protection and Affordable Care Act requires that the insurance exchanges include direct primary care with another wraparound policy to ensure adequate coverage.[22] States have largely been left to choose if and how to regulate the practice model, and, to date, many have enacted laws exempting direct primary care practices from insurance regulations. Wisconsin is currently among the states with no existing laws.[23]

Retainer-Based Practices in Value-Based Health Care

The shift to value-based care in the US health care system is driven by a need to improve patient outcomes and reduce costs for patients, as well as health care spending overall. Both physicians and payers have been driving forces behind this pursuit of higher quality care at a lower cost.

One of the primary advantages to practicing in the direct care model is the ability to spend more time with patients, providing more thorough and personalized care.[17,20] Physicians at Solstice Health, a direct primary care clinic in Wisconsin, experience this effect in practice. Compared to a national average of 7 minutes spent with a patient during a visit, Solstice Health physicians spend an average of 60 minutes with their patients.[24] For some physicians, another advantage of direct primary care is the elimination of the need to interact with payers, thereby reducing administrative functions such as documentation requirements, prior authorization, and electronic health record and desk work which are known to contribute to burnout,[1] as well as potential costs that would otherwise get passed on to the patient. Patients at Solstice Health work only with their physician, while in traditional models other clinicians and payers may have a role in deciding a course of treatment. Another direct primary care practice in Wisconsin, ReforMedicine, asserts that its practice model saves patients up to 50% on costs compared to traditional insurance-based practices.[25]

For patients, the increased attention and more open, personal, and regular access to the physician may strengthen their relationship with their physician, which can improve the patient health care experience and enable better outcomes and lower costs.[26] Accenture consumer research shows prior knowledge of out-of-pocket health care costs is important to 91% of patients,[27] suggesting that increased price transparency provided in direct primary care models could improve the patient experience. Possible drawbacks for patients are that the recurring fee is an additional cost, and receiving care from a direct primary care physician does not preclude the requirement for carrying health insurance. See Box 1 for potential benefits and drawbacks for both physicians and patients.

Ethical Considerations

Critics of the retainer-based medical practice model cite ethical concerns about access, quality, and continuity of care that arise in the fundamental concept of limiting the volume of, and thus access to, one's health care practice. For example, AAFP reports that the average patient panel of a direct primary care physician is between 600 and 800, compared to a panel of 2,000 to 2,500 for a physician in a traditional fee-for-service setting.[28] There could be perceived ethical concerns about the limitations of access to care that would result from reducing a patient panel at this rate. Proponents of direct primary care assert that it is their obligation to provide competent and ethical patient care that makes retainer practices a well-suited model of care.[29]

Also of note are the implications for the physician workforce. The United States is facing an increase in physician demand projected to leave the nation with a shortfall of 40,000 to 100,000 doctors by 2030.[30] Reasons for the anticipated shortage include an aging senior population, retiring physicians, and a growing total population. Physician burnout is also a significant threat to the physician workforce,[31] as it can drive physicians to reduce their work hours, see fewer

patients, or retire from practice altogether.[32] There are concerns that if physicians move to practice models that inherently reduce their patient panel, it will exacerbate the physician shortage, leaving patients without access to care, and that many patients will be priced out of the practice, potentially leaving them without a physician. Limiting the patient base to only those in certain geographical areas or those who can afford the annual fee can be perceived as intentional restriction of access to care for underserved or low to middle income populations—a "social injustice" that some believe is an outcome that physicians are obligated to diminish.[29] To help mitigate this, physicians who transition to a direct primary care practice can make an effort to help patients who do not want to participate in the new arrangement find another provider.

The American Medical Association (AMA) Code of Medical Ethics recognizes that regardless of the model in which they practice, physicians must uphold their primary professional obligation of fidelity and their responsibility to treat all patients with courtesy and respect for patients' rights and dignity.[33] Physicians should also ensure that all patients in the physician's practice receive the same quality of medical care, regardless of contractual arrangements for special, non-medical services and amenities.

Box 2. Common Myths and Truths About Retainer-Based Practices

Myth	Truth
Retainer-based practices are only available and affordable for wealthy and elite patients.	While concierge or boutique medical practices started out as a type of practice catered only to the wealthy, in recent years other types of retainer practices, like direct primary care, have emerged. These models typically have lower monthly fees,[8] which allows patients of a wider variety of socioeconomic statuses to have access to this type of care. Average annual fees range from $1,200 to $3,000 nationally,[38] and the average monthly fee is $93.26.[8]
Direct primary care practices do not accept insurance.	It is true some direct primary care practices do not accept reimbursement from insurance payers, but many do. The decision to accept insurance is at the sole discretion of the physician, but consideration should be given to the health care market in the area, patient pool, type of specialty/services provided, and willingness to accommodate the administrative requirements of submitting claims to and receiving payment from insurers.
Patients do not need insurance if their physician practices in direct primary care.	Retainer-based medical practices are not insurance. Current federal law mandates that every individual maintain health insurance coverage, and going without will result in a tax penalty. Some patients may choose to forego comprehensive health insurance, but having basic, prescription, or catastrophic coverage can help provide payment for services that may not be covered by the retainer paid to the physician. Medicare-eligible patients also may benefit from seeing a physician who accepts Medicare payment in addition to the retainer.
Retainer-based practices such as direct primary care make a significant amount of money quickly.	While the eventual income can be very rewarding, the upfront costs of opening a new practice can be high. Additionally, like any business startup, a new retainer-based practice takes time to develop and grow. Building a strong patient base and steady income can take years.

Organized Medicine

Many physician and health care focused organizations recognize the potential for a surge in direct primary care practices, and have issued policy, guidelines or principles to assist physicians in making decisions about their practice. The AMA, for example, supports physician choice of practice and the inclusion of direct primary care as a qualified medical expense for IRS tax deductions. Additionally, the AMA adopted principles for operating a cash-based practice that include guidance on how to transition to such a model.[34-36]

The AAFP recognizes direct primary care as a sensible solution to the issues that physicians face in practice today. Approximately 3% of its membership practices in this setting.[12] The AAFP has actively endorsed legislation that expands access to these types of practices and supports the model as a true alternative to fee-for-service payment models. The AAFP also draws a distinction between direct primary care and concierge medical practices, describing the lower retainer fees of direct primary care as the key difference.

The American College of Physicians (ACP) issued a policy position paper on direct patient contracting practices that assesses the effects on access, cost, and quality of care, and discusses ethical principles that should apply to all practice types.[37] While the ACP supports physician and patient choice of practice and delivery models, its primary concern with the practice model is the potential for limiting access to care for low-income populations, patients with chronic disease, or underserved populations. Other concerns are its effects on physician workforce and the unknown effects on overall costs of care.

The Future of Direct Primary Care

Given the relative newness of the practice model in its modern form, there is a lack of evidence to demonstrate the long-term effects on patients and physicians of participating in direct primary care. Additionally, while the recent growth in the market has stirred up more attention, it also has instigated confusion and misinformation about the practice type. See Box 2 for a description of common myths and truths about retainer-based practices, including direct primary care.

Widespread adoption of direct primary care practices has been slow, and while its presence in Wisconsin is larger than in most states, direct primary care practices remain only a small portion of the physician practices at the state and national levels. As changes in federal and state insurance regulations and advancements in health information technology continue to influence the practice of medicine, physicians increasingly may transition or enter into

direct primary care in an effort to reduce administrative costs and improve the quality of patient care. In addition to dispelling myths about the practice model, further research should be pursued to gain a deeper understanding of direct primary care, its implications for physicians and patients, practicality and sustainability, and its effects on the costs of health care and health outcomes. The need for outcomes analysis and the development of best practices will become increasingly important as the number of physicians transitioning to this practice model grows.

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REFERENCES

1. Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. *Sources of Physician Satisfaction and Dissatisfaction and Review of Administrative Tasks in Ambulatory Practice: A Qualitative Analysis of Physician and Staff Interviews.* Chicago, IL: American Medical Association; 2016.

2. Friedberg MW, Chen PG, Van Busum KR, et al. *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* Santa Monica, CA: RAND Corporation; 2013.

3. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc.* 2015;90(12):1600-1613. doi:10.1016/j.mayocp.2015.08.023.

4. Coleman M, Dexter D, Nankivil N. Factors affecting physician satisfaction and Wisconsin Medical Society strategies to drive change. *WMJ.* 2015;114(4):135-142.

5. Koplin AN. Retainer payment for physicians' services. *Am J Public Health Nations Health.* 1967:57(8):1363-1373.

6. Miller P, Klein D. *Physician and Hospital Reimbursement: From "Lodge Medicine" to MIPS.* Dallas, TX: Staff Care; 2015. White Paper Series.

7. Alexander CG, Kurlander J, Wynia MK. Physicians in retainer ("concierge") practice: a national survey of physician, patient, and practice characteristics. *J Gen Intern Med.* 2005;20(12):1079-1083. doi:10.1111/j.1525-1497.2005.0233.x.

8. Eskew PM, Klink K. Direct primary care: practice distribution and cost across the nation. *J Am Board Fam Med.* 2015;28(6):793-801. doi:10.3122/jabfm.2015.06.140337.

9. Johnson SR. Expanding VIP care: new concierge doc models focus on employers, with some offering specialists. *Modern Healthcare.* September 19, 2015. http://www.modernhealthcare.com/article/20150919/MAGAZINE/309199980. Accessed August 24, 2018.

10. Erickson SM, Rockwern B, Koltov M, McLean RM; Medical Practice and Quality Committee of the American College of Physicians. Putting patients first by reducing administrative tasks in health care: a position paper of the American College of Physicians. *Ann Intern Med.* 2017;166(9):659-661. doi:10.7326/M16-2697.

11. Page L. The rise and further rise of concierge medicine. *BMJ.* 2013;347:f6465. doi:10.1136/bmj.f6465.

12. AAFP applauds bill to ease direct primary care payment. *AAFP News.* January 24, 2017. https://www.aafp.org/news/government-medicine/20170124dpcbill.html. Accessed August 25, 2018.

13. Grisham S. Medscape physician compensation report 2017. WebMD LLC. https://www.medscape.com/slideshow/compensation-2017-overview-6008547. Published April 5, 2017. Accessed August 25, 2018.

14. 2016 survey of America's physicians: practical patterns and perspectives. The Physicians Foundation. https://physiciansfoundation.org/wp-content/uploads/2018/01/Biennial_Physician_Survey_2016.pdf. Published 2016. Accessed August 25, 2018.

15. Infographic & insight, 2017: the differences between DPC and concierge medicine. *Direct Primary Care Journal.* March 25, 2017. https://directprimarycare.com/2017/03/25/infographic-insight-2017-the-differences-between-dpc-and-concierge-medicine/. Accessed August 25, 2018.

16. Eskew PM. The future legal and regulatory landscape of direct care. Presented at: Hint Summit; April 28, 2017; San Francisco, CA. https://summit.hint.com/talks/2017/keynote-phil-eskew. Accessed August 25, 2018.

17. McCorry D. Direct primary care: an innovative alternative to conventional health insurance. Health Care Reform. August 6, 2014. https://www.heritage.org/health-care-reform/report/direct-primary-care-innovative-alternative-conventional-health-insurance. Accessed August 25, 2018.

18. Friedberg MW, Chen PG, Van Busum KR, et al. Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. *Rand Health Q.* 2014;3(4):1.

19. Arndt BG, Beasley JW, Watkinson MD. Tethered to the EHR: primary care physician workload assessment using EHR event log data and time-motion observations. Ann Fam Med. 2017;15(5):419-426. doi:10.1370/afm.2121.

20. Lagasse J. Hybrid models give concierge medicine a boost for physicians, patients. *Healthcare Finance News.* March 8, 2017. https://www.healthcarefinancenews.com/news/hybrid-models-give-concierge-medicine-boost-physicians-patients. Accessed August 25, 2018.

21. Restrepo K. Direct primary care: saving doctors from physician burnout. Forbes. https://www.forbes.com/sites/katherinerestrepo/2017/11/03/direct-primary-care-saving-doctors-from-burnout/#3955dd2837b6. Published November 3, 2017. Accessed August 25, 2018.

22. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

23. Eskew PM. DPC legal potpourri with a Florida focus. Presented at: Direct Primary Care Conference; 2017; Orlando, FL.

24. Direct primary care. Solstice Health. http://www.solsticewi.com/direct-primary-care/. Accessed December 4, 2017.

25. ReforMedicine website. http://www.reformedicine.com/. Accessed December 4, 2017.

26. Sullivan EE, Ellner A. Strong patient-provider relationships drive healthier outcomes. *Harvard Business Review.* October 9, 2015. https://hbr.org/2015/10/strong-patient-provider-relationships-drive-healthier-outcomes. Accessed August 25, 2018.

27. Sinha S, Sessions D, Saratsiotis M-L. Show me the money: why price transparency for patients is good for providers, too. Accenture. https://www.accenture.com/us-en/insight-show-me-the-money. Accessed August 25, 2018.

28. Direct primary care: an alternative practice model to the fee-for-service framework. American Academy of Family Physicians. https://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf. Published April 2014. Accessed August 25, 2018.

29. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. *Ann Intern Med.* 2011:155(9):633-635. doi:10.7326/0003-4819-155-9-201111010-00013.

30. Dall T, Chakrabarti R, Iacobucci W, Hansari A, West T. *The Complexities of Physician Supply and Demand 2017 Update: Projections from 2015 to 2030.* Washington, DC: Association of American Colleges; 2017.

31. Shanafelt TD, Dyrbye LN, West CP, Sinsky CA. Potential impact of burnout on the US physician workforce. *Mayo Clin Proc.* 2016;91(11):1667-1668. doi:10.1016/j.mayocp.2016.08.016.

32. Shanafelt TD, Mungo M, Schmitgen J, et al. Longitudinal study evaluating the association between physician burnout and changes in professional work effort. *Mayo Clin Proc.* 2016;91(4):422-431. doi:10.1016/j.mayocp.2016.02.001.

33. Retainer practices. Code of Medical Ethics Opinion 11.2.5. American Medical Association Code of Medical Ethics. https://www.ama-assn.org/delivering-care/retainer-practices. Accessed August 25, 2018.

34. American Medical Association. The role of cash payments in all physician practices. https://www.ama-assn.org/sites/default/files/media-browser/public/cms/cms-report-3-a08.pdf. CMS Report 3-A-08. Published 2008. Accessed August 25, 2018.

35. American Medical Association. Direct primary care. https://policysearch.ama-assn.org/policyfinder/detail/AMA%20Policy%20H-385.912?uri=%2FAMADoc%2FHOD-385.912.xml. AMA Policy H-385.912. Last Modified 2018. Accessed August 25, 2018.

36. American Medical Association. Physician choice of practice. https://policysearch.ama-assn.org/policyfinder/detail/AMA%20Policy%20H-385.926?uri=%2FAMADoc%2FHOD.xml-0-3245.xml. AMA Policy H-385.926. Last Modified 2017. Accessed August 25, 2018.

37. Doherty RP; Medical Practice and Quality Committee of the American College of Physicians. Assessing the patient care implications of "concierge" and other direct patient contracting practices: a policy position paper from the American College of Physicians. *Ann Intern Med.* 2015;163(12):949-952. doi:10.7326/M15-0366.

38. Traits & trends: business anatomy of a typical concierge medicine office. Concierge Medicine Today. https://conciergemedicinetoday.org/2017/04/01/traits-trends-business-anatomy-of-a-typical-concierge-medicine-office/. Published 2017. Accessed August 25, 2018.

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