



A PUBLICATION FOR THE
DPC COMMUNITY

THE

TOOLKIT

2026 BATTLE OF THE SUPPORT STACK

131 VOTES. NINE CATEGORIES. THE TOOLS DPC ACTUALLY TRUSTS

2026

SUMMER ISSUE

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the 10-minute healthcare decision guide

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— GOT FIVE MINUTES

- [05](#) **Your Next Step in DPC** THE STANDING FEATURE
free tools matched to your stage, the page this publication is built around
- [30](#) **Lean Startup Business Plan, Your Turn** WORKSHEET
- [26](#) **10 DPC Podcasts We Can't Get Enough Of** LISTENING LIST
- [31](#) **The First Year Dashboard** FREE TOOL
fourteen free pages for your first twelve months
- [62](#) **My DPC Story Notes** YOURS

— GOT A COFFEE BREAK

- [16](#) **Choosing Tools That Serve You** EDUCATION
- [27](#) **A Business Plan Is Not Just for Day One** EDUCATION
- [21](#) **Building Your Practice Support Stack** EDUCATION
help can start at four hours a week
- [24](#) **The Practice You Built Should Not Live Only in Your Head** SYSTEMS
- [36](#) **Why Every State Deserves Its Own DPC Summit** COMMUNITY
a column from Maryal
- [19](#) **The Women the System Misses** COMMUNITY
two physicians, one New Orleans evening, July 17
- [23](#) **When the Patient Brings the Whole Story** CLINICAL

— SETTLE IN

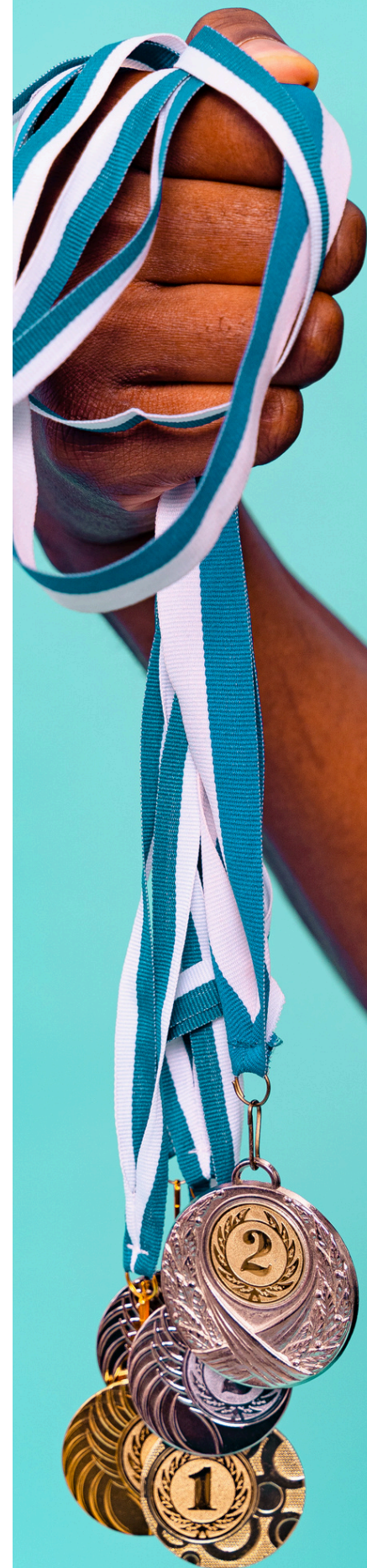
- [06](#) **THE 2026 BATTLE OF THE SUPPORT STACK** THE COVER STORY
131 votes across nine categories, and the most surprising winner costs nothing
- [59](#) **The Practice She Left Corporate Medicine to Build** A PHYSICIAN'S STORY
Dr. Dedra Beckles

— FOR YOUR PATIENTS

- [44](#) **The Insurance Question, Answered For You** WHY THIS EXISTS
- [45](#) **How to Choose Your Healthcare** PATIENT HANDOUT
the ten-minute decision guide, free printable on page 51

— THE ECOSYSTEM

- [51](#) **My DPC Story: State by State with Dr. Phil Eskew** NEW SERIES
- [52](#) **The DPC Directory** FIND A PARTNER, GET LISTED FREE
- [53](#) **DPC Doctor: Dr. Deepti Mundkur** SPOTLIGHT
- [64](#) **Before You Put This Down** THE SEND-OFF (Back Cover)
where to go on your journey next!



A LETTER TO THE PHYSICIAN ON THEIR DPC JOURNEY

Maryal Concepcion, MD FAAFP



I do not know exactly where you are standing as you read this. Maybe you are still thinking about Direct Primary Care, turning it over at night, wondering if you could really do it. Maybe you are mid leap, one foot out of employed medicine and one foot into something you are building yourself. Or maybe you already opened your doors and you are seeing patients the way you always believed medicine should be practiced. Wherever you are on this road, I want you to know something first. You belong here, and you are not doing this alone.

I have practiced Direct Primary Care since 2021, and I have listened to hundreds of physicians tell their stories on My DPC Story. What I have learned is that the fear looks the same at every stage. It just wears different clothes.

If you are still deciding, the fear is usually money. Walking away from a predictable paycheck is the hardest mental hurdle there is. Physicians solve it in different ways. Some pick up urgent care or telehealth shifts while their panel grows. Some build a runway of savings and treat those months like a budget to protect. Some open with a small founding group before they fully let go. There is no single right answer, only the version that lets you sleep at night.

If you are already open, the fear changes shape. Now it is about knowing your numbers, steadying your foundation, and wondering whether the thing holding your practice together is simply you, carrying all of it in your head. That feeling is not a sign you did something wrong. It is a sign you are ready to build real systems instead of running on improvisation.

At every stage, the emotional weight is real. Leaving a job is leaving an identity and a team. Running a practice alone can get lonely in a way no one warns you about. The physicians who thrive do not white-knuckle through it by themselves.

They reach for community before they need it. A mentor a few years ahead. A peer group. The colleagues at a summit who nod because they have felt it too. Hearing another physician say "I felt that too" changes everything.

And no matter where you are, the work that matters most is closing your open loops. Every task living only in your memory is a tax on your attention. When you write your workflows down, build simple SOPs, and let your team run them, you get yourself back. A practice that only functions when you are in the room is a job. A practice that runs on systems is a business you can actually grow.

That is the whole shift. Build a foundation you can thrive on, then grow from there. You do not have to feel completely ready. You just have to start with a plan, a cushion, a community, and tools that keep the loops from piling up.

This is exactly why I built the **My DPC Story library**. Everything in it comes from real practices solving real problems, mine included. **The DPC Starter Guide** and the **First Year Dashboard** help you plan ahead so nothing falls through the cracks. The **Physician Owner's Planner** gets the whole business out of your head and into a system you can run month after month. I built these tools because I needed them, and I want you to have them too.

Wherever you are on this road, take a breath. You are further along than you think. I am cheering for you.

- Maryal



MEET THE TEAM



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YOUR NEXT STEP IN DPC

My DPC Story exists because we believe every physician deserves to know there is a different and better way to practice medicine. Wherever you are on that path, this page is for you.

READY TO PLAN

You have decided. Now you need the roadmap. The 90-Day DPC Startup Checklist walks you from decision to open doors, one week at a time, with the podcast episodes to match every milestone.



**BUILD YOUR
LAUNCH PLAN**

*finish the
checklist
and the
Dashboard
is waiting
for you*

NEWLY OPEN

The doors are open and the real learning begins. The First Year Dashboard gives you the tracking pages, monthly rhythms, and decision checkpoints that carry you from opening day through month twelve.



**GROW
WITH US**

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Curious whether DPC could work for you? Start with the DPC Starter Guide.



START HERE

OPEN FOR YEARS

Refine it, scale it, or reimagine it. Take the Growth Audit.



GO DEEPER

**EVERY RESOURCE ON THIS PAGE IS FREE.
IT IS OUR WAY OF KEEPING THE PROMISE THIS PODCAST WAS BUILT ON.**



BATTLE OF THE SUPPORT STACK 2026

Every "best software" roundup in medicine has the same problem: it treats a 900-bed hospital and a solo DPC practice as the same buyer. They are not. In Direct Primary Care, the tools that run the practice are chosen by the physician who also answers the phones, sets the pricing, and covers after-hours messages. The stakes are personal and the budget is real.

So this year the Battle moved past the Electronic Health Record (EHR). **The 2025 Battle of the EHR issue** ranked the systems physicians chart in. The 2026 Battle asks a harder question:

once the EHR is decided, what fills in the *rest of the stack*? Billing, scheduling, patient communication, telemedicine, labs, HR, AI, patient education, and the day-to-day operations layer. Nine categories, one for each major job a DPC practice has to solve.

The rules were simple and they did not bend. Only practicing DPC physicians could vote. No vendor paid for placement, weighted a ballot, or saw a result before print. The winners on the following pages were chosen by the people.

WHO VOTED?

131 survey participants in the DPC space completed the ballot between the launch and the July 1 close. The field looks like DPC itself:

- **69% ARE SOLO PHYSICIAN PRACTICES; ANOTHER 25% PRACTICE IN TWO- OR THREE-PHYSICIAN GROUPS.**
- **46% HAVE BEEN IN DPC TWO YEARS OR LESS; 28% HAVE BEEN AT IT SIX YEARS OR MORE. NEW BUILDERS AND SEASONED OPERATORS, SIDE BY SIDE.**
- **PANEL SIZES RUN THE FULL RANGE, FROM PRACTICES UNDER 100 MEMBERS TO ESTABLISHED PANELS OVER 600.**
- **40 STATES ARE REPRESENTED. CALIFORNIA LED PARTICIPATION, FOLLOWED BY TEXAS, FLORIDA, AND THE CAROLINAS.**
- **MOST PHYSICIANS FOUND THE BATTLE THROUGH THE MY DPC STORY NEWSLETTER AND PODCAST.**



HOW THE WINNERS WERE CHOSEN

Each category winner is the tool named by the most votes in that category. Alongside the vote, tools were rated on ease of use, value for the price, and whether the voter would recommend it to another DPC physician. Many left written comments explaining their choice. Those comments are the source of every quote in this issue.

ON TIES

Where two tools drew the same number of votes, the tie was broken by the secondary ratings: ease of use, value, and recommendation score, in that order. This happened once, in Telemedicine, and the tie-break is noted plainly where it occurs. No result was decided by anything other than the numbers on this page.

ON CATEGORIES WHERE THE WINNER WAS NOT A PRODUCT

In one category, Scheduling, the most common answer was not a named tool at all. It is reported honestly as what it is, with the top named product recognized alongside it.

WHY THIS ISN'T PAY-TO-PLAY

The Battle is built to reflect what the DPC community actually uses and trusts, not who spends the most on visibility. That distinction matters enough to spell out.

Our DPC community decides the winners. Only practicing DPC physicians and community members vote. Vendors, sponsors, and partners do not vote and do not shape the outcome.

Sponsorship is not a win. Sponsorship buys visibility and alignment with the DPC community, nothing more. Sponsors appear as part of the ecosystem, never as default winners. Past Battle champions were not sponsors at all, and this year's slate was decided the same way.

Every eligible tool gets the same ballot. Tools within a category are listed without weighting, ranking, or paid placement. No brand receives priority positioning.

The tally is the whole story. Results rest on three things and only three: total number of votes, category-specific counts, and the optional written comments voters left behind. Rankings, endorsements, and awards are not for sale.

The editorial is independent. Everything written in The Toolkit is developed by the My DPC Story team. Sponsors may run adjacent to the content. They never control it.

DPC runs on trust: between a physician and a patient, between a practice and its community, and between a practice and the tools it leans on every day. Pay-to-play would corrode all three. The point of the Battle was never to crown the loudest brand. It was to surface the tools that genuinely hold up a sustainable, relationship-based practice.

Hold on to this issue. It may double as a shopping list for the year ahead!

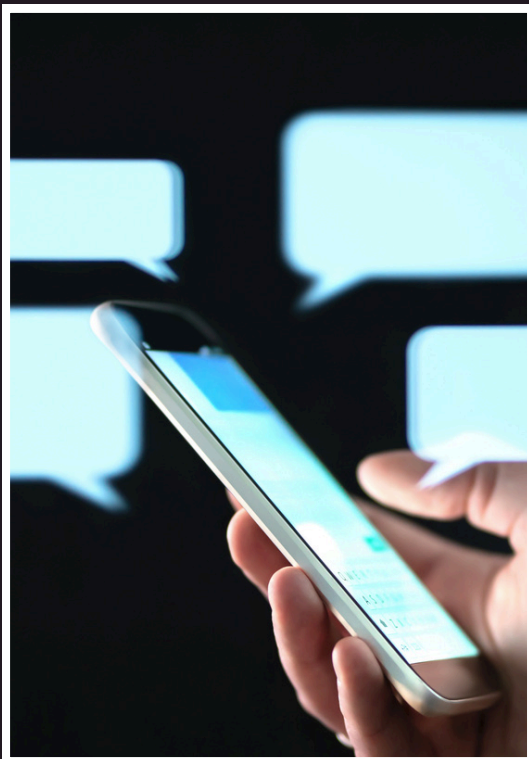


THE 2026 BATTLE OF THE SUPPORT STACK: NINE CATEGORY CHAMPIONS

DPC physicians make real purchasing decisions without a procurement department behind them. What follows is nine categories of hard-won consensus, category by category, with the runner-up named in each because the field is rarely settled.



PATIENT COMMUNICATION



SPRUCE HEALTH, 49 VOTES.

RUNNER-UP: HINT HEALTH (22)

The most decisive win of the entire Battle. Spruce took Patient Communication by more than two to one, and the reasons physicians gave were consistent: texting patients love, an after-hours auto-reply that sets boundaries without going silent, and EHR integration that means the conversation only gets documented once. One physician summed up the appeal of the auto-reply plainly: it tells patients how to reach the practice in an emergency and when to expect a reply if it is not one. Another pointed to the team side, where staff can monitor messages, respond, set reminders, and create tasks from the same thread.

"Other staff can easily monitor messages, respond and create tasks. Also easy to set reminders and future messages to staff or patients." ~ Battle quote about Spruce Health

MEMBERSHIP BILLING & PAYMENTS

The clearest incumbent in the survey. Hint won billing on the strength of one comment voters kept using: all-in-one. Memberships, packages, recurring charges, late notifications, reprocessing, and a native payment processor, handled all in one place. Several physicians described the relief of taking billing off their own plate. The honest note, in their words too, is cost: more than one flagged fees that have grown over the years and said they are watching alternatives. The win is real, and so is the pressure on price.

"I can setup multiple memberships and all of the billing is done through HINT including late notifications and re-processing. I feel like this takes a lot off of my plate." ~ Battle quote about Hint Health

SCHEDULING & ACCESS

The most common answer in Scheduling & Access was not a product you can buy. It was **"the tool already built into my EHR."** That is a finding worth stating plainly: for a large share of the DPC community, scheduling is not a separate purchase, it is a feature they expect their core system to cover.

Among named, standalone products, Hint Health led at 30, close behind the native-tool total.

The takeaway for the category is less about a champion and more about a signal to vendors: the DPC community is not eager to bolt on a second system for something their EHR should already do well.

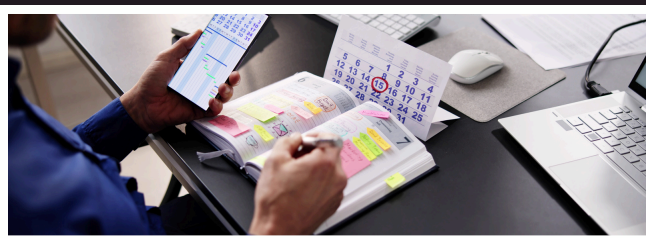
HINT HEALTH, 63 VOTES

RUNNER-UP: ATLASMD (29)



THE FINDING: MOST PHYSICIANS SCHEDULE INSIDE THEIR EHR NATIVE EHR TOOL, 36 VOTES.

TOP NAMED PRODUCT: HINT HEALTH (30)

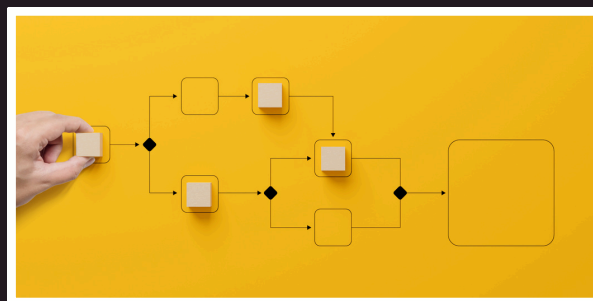


AI & AUTOMATION (NON-EHR)

HEIDI HEALTH, 19 VOTES.

RUNNER-UP: OPENEVIDENCE (12), THEN FREED (11)

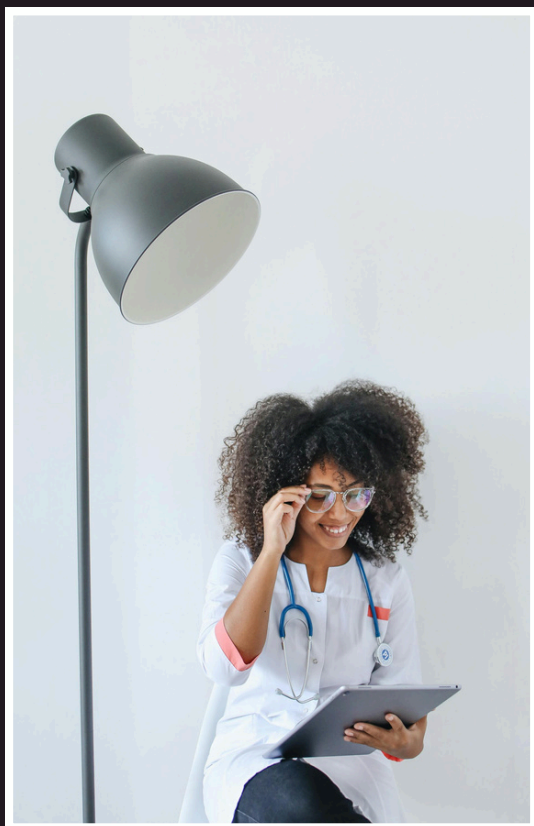
The most crowded category in the Battle, and the newest. Heidi took the AI scribe title in a tight three-way field. Voters praised its accuracy and the way it learns an individual documentation style, and several noted the free tier carried them when they were starting out. The wish list was equally clear: native EHR integration, named again and again. One physician called Heidi the most accurate AI scribe they had used, with a single caveat, that



it does not yet write straight back into their EHR on its own.

"It's the best, most accurate AI scribe I've ever used. I just wish it integrated with my EMR automatically." ~Battle quote about Heidi Health

TELEMEDICINE & VIRTUAL CARE



SPRUCE HEALTH TIE AT 20 VOTES WITH GOOGLE MEET.

BASED ON SECONDARY RATINGS, SPRUCE CAME OUT ON TOP AS THE WINNER.

This category ended in a dead tie: Spruce Health and Google Meet, 20 votes each. Under the stated tie-break rule, Spruce took the category on higher secondary scores (ease of use 4.75 vs 4.45, value 4.75 vs 4.45, with every Spruce rater scoring it 4 or 5 out of 5).

The honest story behind the numbers is worth telling. Voters do not pick Spruce for telemedicine because it is the flashiest product. They pick it because it is already their communication hub, and the visit lives where the rest of the patient conversation already does. In their own words: ***"I use Spruce anyway so I continue it, plus it integrates with my EMR so much easier to transfer over data."***

A few were candid that for pure video they sometimes reach for Zoom or a phone call instead. Spruce wins here on continuity, not on cinematics, and for a solo practice that is often the point.

PRACTICE OPERATIONS & ADMIN

The everyday operations layer went to the tool many voters already live in. Google Workspace won on being cheap, familiar, and enough: email, docs, calendar, and shared files that keep a small team connected without ceremony.

Physicians noted it does the job for a solo practice while admitting they would look elsewhere for stronger task management, and a few raised HIPAA considerations for anything patient-facing.

A practical winner for the back office.

"Provides structure and connectivity between team members without being obtrusive." ~Battle quote about Google Workspace

GOOGLE WORKSPACE, 51 VOTES

RUNNER-UP: HINT HEALTH (36)



HR, PAYROLL & TEAM MANAGEMENT

Once a DPC practice hires its first employee, payroll becomes real, and Gusto is where most physicians handle it. It won on being affordable and approachable, with an interface physicians actually liked. As with any workhorse tool, the reviews were not uniform, some found setup clunky, others called it simply "the best." The consensus: it does the job at a fair price, which is exactly what a lean practice needs from payroll.

"Affordable and straightforward to use with a lovely interface." ~Battle quote about Gusto

GUSTO, 38 VOTES

RUNNER-UP: QUICKBOOKS PAYROLL (28)



LABS, IMAGING & DIAGNOSTICS

LABCORP, 54 VOTES

RUNNER-UP: QUEST LABORATORIES (47)

The closest two-way race in the Battle. Labcorp edged Quest by seven votes, and the deciding factor voters named again and again was human, not technical: the local rep. A good rep and a reliable courier turned a commodity service into a relationship. Several voters said they had used both and stayed with Labcorp because a specific person answered when something went wrong. Cash pricing and a broad client-billing lab list came up as well.



The lesson for this category is old-fashioned: in labs, service is the product.

"Having a good representative really helps. I had more problems with Quest locally, so I stayed with LabCorp." ~Battle quote about Labcorp

PATIENT EDUCATION & ENGAGEMENT

OPENEVIDENCE, 48 VOTES

RUNNER-UP: UPTODATE (26)



OpenEvidence won patient education by nearly two to one over the incumbent it is quietly displacing. Voters praised clearly spelled-out references, accuracy, and a price that is hard to argue with: **FREE**.

More than one framed it directly against the paid standard they used to rely on. This result is the seed of its own article, which follows.

"It's free, and pretty transparent, and references are spelled out clearly."
~Battle quote about OpenEvidence

Three tools, three different definitions of essential: the one that gets you paid, the one that answers the clinical question, and the one that keeps you talking to your patients. When the choice was forced, the conversation won.



THE ONE TOOL DPC PHYSICIANS WOULD KEEP

If you could keep only one tool, what would it be?

At the end of the ballot, physicians faced a deliberately tough question. Strip the stack down to a single tool, everything else goes. Only one survives. The answers cut past preference and into what a DPC practice cannot physically run without.

One tool pulled clear of the field.

Spruce Health (20 votes) was the tool DPC voters would keep, ahead of **Hint Health (16)** and **OpenEvidence (13)**.

That result is worth sitting with, because Spruce is not the tool that takes the payment or holds the chart. It is the tool that carries the conversation. And when physicians were forced to choose, communication is what they refused to give up. The reasons were specific and often personal. One physician described the before and after in plain terms: the practice had been using a basic phone line and drowning in missed calls and messages, and Spruce was the thing that finally got them organized. Another was answering the survey from vacation, without a laptop, and said the whole team was still reachable through one app,

patients included. The word that came up most was not a feature. It was "easy."

"It's so easy to use. I'm on vacation right now and don't need my computer. My entire team can communicate on it. The patients love the texting feature."

The runners-up tell you why they lost this particular question, and it is not for lack of importance.

Voters who would keep Hint were blunt that it is the tool they cannot get paid without, the billing and membership engine underneath everything. One estimated 90% of patient care and office administration runs through it.

OpenEvidence drew a different kind of loyalty, from voters who valued getting cutting-edge clinical answers, patient handouts, and note help in one free place, and said it saves them real time on complex patients.

THE MOST SURPRISING WINNER IN THE BATTLE COSTS NOTHING CLINICAL REFERENCE, ALL IN ONE PLACE.

The most surprising winner in the Battle costs nothing. Every other champion in this issue is a paid product, or close to it.: billing platforms, payroll systems, lab networks, communication suites. These tools cost money because running a practice costs money, and practices pay it because the tools earn their keep.

Then there is OpenEvidence.

It won Patient Education and Engagement by nearly two to one, 48 votes to UpToDate's 26. It placed third in the desert-island question, the only free tool standing among the essentials physicians said they could not practice without. And it did all of this against UpToDate, the paid clinical reference that has been the default in medicine for a generation. Those who voted for it did not bury the reason. They led with it.

"Open evidence blows UpToDate out of the water."

What makes the result more than a price story is why voters trust it. The praise was not "it's free, so it's good enough." It was the opposite: voters said the references are spelled out clearly, the answers have been accurate, and they have not missed the tool they used to pay for.

One described a full workflow built around it, pulling clinical information and then running it through other tools to generate patient handouts to reuse later. Another named the exact jobs it now covers, prior-auth notes, referral notes, patient education, quick clinical reference, all in one place.



This is not a free tool being tolerated. It is a free tool being preferred, on the merits, by voters who have used the expensive alternative. There is a pattern underneath it, and it runs through the whole Battle. Free and low-cost tools kept showing up in the winner's circle and just behind it. Heidi's free scribe tier carried many practices through their early days in the AI category. Google Meet tied for the top telemedicine slot. Google Workspace won the operations layer outright on being cheap and sufficient.

...physicians said the references are spelled out clearly, the answers have been accurate, and they have not missed the tool they used to pay for.

The DPC community is not chasing the most expensive stack. Practices are building the leanest tech stack that works, and increasingly the tools that fit that instinct are free, doctor-built, or both.

The surprise is not that a free tool won a category. It is that when voters were asked to name what actually helps them care for patients, one of the answers cost nothing at all, and they said so without a hint of apology.

FANS OF MY DPC STORY! USE MARYAL'S REFERRAL CODES FOR DISCOUNTS ON SPRUCE, HEIDI, GUSTO AND MORE! GO TO [TOOLKIT.MYDPCSTORY.COM](https://www.toolkit.mydpcstory.com)



Choosing Tools That Serve You

How a West Michigan DPC physician built a tech stack that grows with the practice instead of boxing it in



Before Dr. Angela Andrews practiced medicine, she designed software. User interfaces, systems, the logic of how one piece connects to the next. That training never left her. "Nothing in the body happens in isolation," she tells patients, and she runs her practice the same way: as a set of interlocking parts, each one chosen on purpose.

For a long time, the system she worked inside did not return the favor. Employed in a fee-for-service model, she felt her range narrowing. The work was not just tiring. It was smaller than she was. Within six months of leaving for direct primary care, her husband noticed the difference before she did. "Who are you?" he asked her. "You have come alive."

Andrews describes her path in three layers. First she made the change for herself. Then she made it for her patients. Now she is making it for the movement, mentoring other doctors and teaching at Michigan State, where she serves on faculty.

The practice grew alongside her. It started as Seeds of Health Direct Primary Care. After buying the practice of her mentor, Dr. Bailen Amat, one of West Michigan's earliest DPC physicians, Andrews rebranded to Direct Primary Care of West Michigan, a name meant to point past her own clinic toward something larger. The rebrand was never only cosmetic. It

was a reason to align every tool around the practice she actually wanted. An EMR she had watched from the sidelines for months. A phone system. The small daily mechanics that either give time back or quietly take it. In January she moved to Hint Clinical, and it became the backbone of everything she wrapped around it.

What sold her was visibility. Andrews is a visual thinker, and she wanted a platform where the numbers that run a practice (enrollment, who is past due, who is new) surface the moment she opens it, without hunting. One example she calls small but telling: the system reads her Google Calendar and blocks time automatically, color-coded so she can see at a glance which slots are acute visits, which are physicals, which are new patients. "Every extra manual task you have to do takes away from something else," she says. "It's also mental energy."

The piece that changed how she grows the practice is the Hint Marketplace, which she describes as an app store for the EMR: curated apps, integrations, and partner solutions that connect to the platform. She treats it the way an engineer treats a backlog. Roughly every quarter she audits her workflows for the task eating the most time, then checks whether a solution already exists. Several now do. Fullscript sits inside the patient chart

for supplements and for labs patients cannot get through the usual networks. Spin gave her practice manager, who started as a phlebotomist and now handles purchasing, a budgeted card and the ability to buy supplies directly in Hint, rolling straight into inventory. "That has saved us both so much time," she says. Vivlio Health pulls outside records into the chart. Spruce handles the phones and QuickBooks catches the accounting, both flowing in without a second login.

The pediatric side of her panel tests tools differently. Med-peds work runs into platforms built almost entirely for adults, and Andrews has felt it: printing growth charts by hand, chasing milestone questionnaires. Some of that has eased. Hint Clinical's growth charts recently added BMI percentiles, a small change that makes well-child visits noticeably smoother. She now sends M-CHATs, ASQs, and other forms ahead of visits through the platform, tied directly to the chart. "If it's on paper, it's going to get misplaced," she says. She would rather it live where she will actually see it.

None of this came without fear. Most physicians who trained inside hospital systems have survived an EMR migration and remember the cost. Andrews made the leap only when the cumulative benefit clearly outweighed it, what she calls the juice being worth the squeeze.

For doctors weighing the same move, her advice is concrete. Get your charts current before you start, notes finished and payment information confirmed. Tell patients three to six months out, because this is not a decision you make today and execute tomorrow. Divide the chart prep with your team. And build a short intake form for after the switch, to catch the details that never transfer cleanly.

What she found on the other side was more than software. "It's a whole ecosystem," she says. "You get a community within that." She is now a cohort mentor in Hint's launch boot camp, which puts her back where she started, helping the next physician build something that fits.



hint.com/emr

This article is sponsored by Hint Health. Hint Clinical is an all-in-one direct primary care platform that combines membership management with a clinical EMR, plus a Marketplace of apps, integrations, and partner solutions built for DPC. Learn more at hint.com/clinical.



Hint is the all-in-one platform powering the future of Direct Primary Care.

From a modern, purpose-built EMR and membership management to automated billing, practice operations, and patient engagement, Hint provides everything DPC practices need to launch, grow, and scale. Trusted by startups and established DPC practices alike, Hint supports thousands of providers nationwide in delivering better care outside the traditional fee-for-service system. As Dr. Wendy Stevens shared: "Very intuitive, quick learning curve."

Why DPC Practices Choose Hint: An integrated platform combining a modern EMR, membership management, billing, and patient engagement tools—plus the Hint Marketplace to keep systems in sync, Hint Community for peer collaboration, and Hint Connect, the nation's largest network of independent DPC practices.



The DPC platform built
for the way you practice



Features Include

- Intuitive charting
- AI scribe and assistant
- Custom packages and memberships
- Billing and Invoice management
- In-app phone/text & eFax
- Self-scheduling
- Patient onboarding
- ePrescribe & dispense
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- Bi-directional lab ordering
- Clinical team task management
- Integrated Google calendar
- Marketplace to keep all of your tools in sync
- The fastest growing DPC Community to help you succeed



Hint has everything a Direct Primary Care Practice needs to run smoothly, allowing clinicians to take their attention off the computer screen and focus on what truly matters - their patients.

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THE WOMEN THE SYSTEM MISSES

Two physicians, one mission, and a New Orleans evening built around closing the maternal health gap.

In the most recent CDC data, Black mothers die from pregnancy-related causes at 44.8 per 100,000 births, against 14.2 for white mothers. About three times the risk. Much of that gap is not biology. It is access: who can get early prenatal care, who can reach a doctor who knows them, who gets real attention instead of two rushed minutes. Two physicians on the My DPC Story podcast have built their practices squarely inside that gap, and this July they share a stage in New Orleans.

Dr. Emily Holt runs Poppy Direct Care in Uptown New Orleans, a year past opening and grown on almost nothing but word of mouth. About a third of her patients are uninsured: the bartenders, carpenters, artists, and caregivers she calls the cultural backbone of the city, people who earn too much for Medicaid and too little for a usable marketplace plan. When premiums spiked in early 2026, some members left because they could no longer carry insurance and her fee both. Others joined her for the same reason, having given up on insurance entirely.

The last year narrowed their options sharply. Every Planned Parenthood in Louisiana closed, so Holt opened a free clinic on Tuesday nights, staffed by Tulane undergraduate volunteers, offering birth control consults and rapid STI testing at no cost. When the state moved to require clinics to buy their own testing supplies, roughly forty-five dollars a patient

against a one-dollar reimbursement, she chose to keep the clinic open and restructure rather than close it. "This is my community service," she says. One practical thing stands between her and more of the care her patients need: an autoclave, so she can offer procedures like IUD placement without disposable kits her patients cannot afford. A fundraiser for it is underway.

What independence gave her, she says, is the freedom to say so out loud. "Being a DPC doctor and my own boss has been so liberating because I can stand up for evidence-based medicine without anyone telling me not to." She describes patients who had not seen a doctor in years arriving because they finally trusted they would be heard. They know, she says, "they can trust me to trust them."



In Texas, Dr. Esther Khatibi is working the same gap from the other direction. A family physician who practices surgical obstetrics, she nearly sank her own DPC caring for pregnant patients who could not pay, women who would otherwise drive three and four hours for a single visit. Her answer was My DOC, a nonprofit delivering obstetric care on the direct primary care model to women who are uninsured, underinsured, or high-risk. The visits, the labs, and the ultrasounds are free.

What kept it sustainable was not working harder. It was a coalition: volunteer physicians she vets carefully, a board that believed in her before she had proof, a sonographer, grant writers, and donors. The model is built to travel. "We know you guys have the heart. You want to do it. You have the skillset," she says of DPC doctors, offering a way to practice obstetrics without an academic department or a punishing call schedule. Her mission, in her words, is care for all women "regardless of their social, religious, ethnic, or economic background," because, as she puts it, "these are moms, these are sisters, these are our mothers, these are our kids."

On July 17, My DPC Story brings the two of them together for a fireside evening in New Orleans. Two doctors, no slides, on what real access looks like and how a model like this travels. It is also a fundraiser, for My DOC's obstetric care and for Poppy's free clinic and the autoclave that would expand it. The gap is wide, and it falls hardest on the mothers the system has failed longest. This is an evening about narrowing it.

An Evening for Women's Healthcare Access. July 17, 2026, 7:00 to 9:00 PM, [Poppy Direct Care](#). Hosted by Dr. Emily Holt and Dr. Esther Khatibi and produced by My DPC Story. Seats are limited. Reserve a seat, back Poppy's free-clinic fund, or donate to My DOC at [mydoc.org](#). Tickets and details at [mydpcstory.com/nola](#).

Tickets and sponsorships support Poppy Direct Care and the evening. Donations to My DOC, a separate nonprofit, go directly through My DOC at [mydoc.org](#).

Disclosure: My DPC Story founder Dr. Maryal Concepcion serves on the board of My DOC.

DPC PHYSICIANS FOCUSED ON QUALITY WOMEN'S HEALTHCARE ACCESS



In Uptown New Orleans, Dr. Emily Holt opened a free Tuesday-night clinic at her DPC, [Poppy Direct Care](#), with Tulane student volunteers, offering birth control consultations and rapid STI testing after local reproductive options closed. About a third of her patients are uninsured. She is raising funds for an autoclave so the clinic can do even more.



Dr. Esther Khatibi is a board-certified family medicine, obstetrics, and women's health physician. She founded [My DOC](#), a 501(c)(3) nonprofit that brings obstetric care to uninsured, underinsured, and high-risk women on the Direct Primary Care model, with no separate delivery fee. Her mission is to reduce illness and death in pregnancy, especially for African American mothers, with an all-volunteer team of physicians.

BUILDING YOUR PRACTICE SUPPORT STACK

When to hire what, and why waiting is the expensive option



WHAT PROBLEM AM I REALLY TRYING TO SOLVE?

It is 8:40 on a Tuesday night. The last patient left hours ago. You are at the kitchen table with a laptop and four charts still open, a voicemail light blinking on a phone you could not answer during the day, and a vague guilt about an Instagram account you have not touched since March. The medicine was the easy part. Everything around the medicine is what is keeping you up.

Most DPC physicians know this feeling. The model works. The relationships are real. But the work that surrounds the visit (documentation, intake, billing follow-up, the practice's online presence) does not shrink just because the panel is small. It quietly expands to fill every hour you give it.

The fix is rarely more hours. It is the right help, added at the right time. Here is a simple way to think about which support to bring on, and when.

STAGE 1: BEFORE YOU OPEN THE DOORS

Pre-launch, the temptation is to do everything yourself to save money. Some of it makes sense. But a practice with no website, no booking flow, and no findable presence is invisible to the patients it wants. This is the stage where a clean website and a basic brand presence pay for themselves fastest, because they work while you sleep. Doing it yourself is the default. It is rarely the best use of the months before launch.

STAGE 2: THE FIRST HIRE QUESTION

Once patients are coming in, the question becomes which job is breaking you first. Two

answers are most common. If you are charting at night, the answer is a scribe. A medical scribe documents during the visit so you finish the note when the patient leaves, not at 9pm. If instead the problem is the front of the house (a phone you cannot answer mid-visit, new patients who never get a callback, scheduling that slips), the answer is a virtual receptionist who covers intake and patient communication while you are with someone else.

The test is simple: where does your day fall apart first? Start there. One good hire that solves the actual bottleneck beats three that solve problems you do not have yet.

A useful gut check: track one ordinary week. Note the tasks you do after the last patient leaves and the ones you keep meaning to get to but never do. The category that shows up most is your first hire. For many solo practices it is documentation. For many growing ones it is the phone.

STAGE 3:

WHEN THE BACK OFFICE OUTGROWS YOU

As the panel grows, a second category of work appears: the operational layer. Records requests, referral coordination, the message-center inbox, vendor and renewal tracking, the small administrative tasks that individually take four minutes and collectively take your evenings. This is the point for an administrative assistant, and the case for adding one before you hit the wall, not after. Practices that wait until burnout forces the decision tend to make it badly and in a hurry. This is also the stage where visibility becomes a growth lever rather than a nice-to-have. A practice

doing average work that shows up consistently. Social media support keeps the practice present without costing you a minute you do not have.

STAGE 4: THE MATURE STACK

Established practices settle into a rhythm of what stays in-house and what stays outsourced for good. The physician holds the clinical work and the relationships. Nearly everything else (documentation, front desk, admin, content) can run on trained support. The goal is not to delegate everything. It is to make sure the only work landing on the physician's desk is work that genuinely requires the physician.

THE PRINCIPLE UNDERNEATH ALL OF IT

Across every stage, one pattern holds: the practices that outsource a little earlier than feels comfortable grow faster than the ones

that wait for a crisis. Help is not a reward you earn once you are overwhelmed. It is the thing that keeps you from getting there.



This article is sponsored by Cool Blue VA, which provides HIPAA-trained healthcare virtual assistants for DPC practices, trained on Hint, Spruce, Sigma.md, and Elation, with no contracts and rates starting at \$9.95 per hour. Not sure which kind of support fits your practice right now? Take the two-minute quiz at sponsor.mydpcstory.com/coolblueva-quiz, then start a free two-week trial at coolblueva.com/dpcgrow.



FIND OUT WHERE YOUR DPC SYSTEMS MAY NEED SUPPORT.

Running a DPC practice means seeing patients plus running a business at the same time, often alone. Harmony Ops gives DPC physicians the systems to capture patient leads before they disappear, follow up without lifting a finger, and stay easy to find online, even as a solo doc. The result is a practice that keeps growing even when you're with patients, on a call, or just trying to have a day off.

Harmony Ops was founded by Anne Gonzalez, MD, a DPC doctor who uses it in her own practice. She knows what it's like to be the physician, secretary, front desk, and marketing department all at once. So she priced and built Harmony Ops for new and smaller DPC practices, with setup support and calls included from the start.

When you're ready to stop doing it all manually, find out where to start at

<https://quiz.harmonyopsfordpc.com>.



HARMONY OPS FOR DPC

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When the Patient Brings the WHOLE STORY

Why patient-controlled health history changes what a preventive visit can start from

Direct Primary Care is built on prevention, and prevention runs on complete information. Yet most patients arrive with their health scattered across memory, manila folders, and a handful of portals they can no longer log into. The history that matters most is often the history the patient cannot fully assemble on the spot, and no amount of time in the exam room fixes a record that was never gathered in the first place.

Vivid Vault works on the patient's side of that gap. It is a patient-controlled health navigation platform where people organize their own records, medications, appointments, and family caregiving in one secure place, and decide who is allowed to see it. The patient owns the vault. The physician is granted a view, not the other way around.

That ownership is the point. Because the information lives with the patient and their family, where the history actually originates, it can be assembled before a visit rather than reconstructed during one. The platform helps patients prepare with appointment summaries and track how they are doing over time through validated assessments, so they walk in with a picture instead of a shoebox.

For a DPC practice, the payoff shows up in the visit itself. When a patient arrives already organized, less time goes to chasing records and rebuilding timelines, and more goes to interpretation, conversation, and the kind of preventive guidance that lands as a logical next step. Family patterns worth watching, the ones that span generations and rarely surface in a single rushed history, are easier to see when a family has laid them out themselves. Organized history does not replace clinical judgment. It gives that judgment more to work with.

“The history that matters most is often the history the patient cannot fully assemble on the spot”

For DPC practices, that organization is worth formalizing. Through a practice partnership, Vivid Vault connects the clinic to what patients are already tracking on their own: validated PROMIS assessments across the panel, a prepared summary ahead of each visit, and a clinic-wide view of how care plans are holding. None of it adds data entry to the practice. The patient still enters and controls

the record. The partnership simply opens a window onto the picture the patient has chosen to share, and patient adoption is an easy ask, since Vivid Vault is HIPAA-compliant and eligible for HSA and FSA spending.

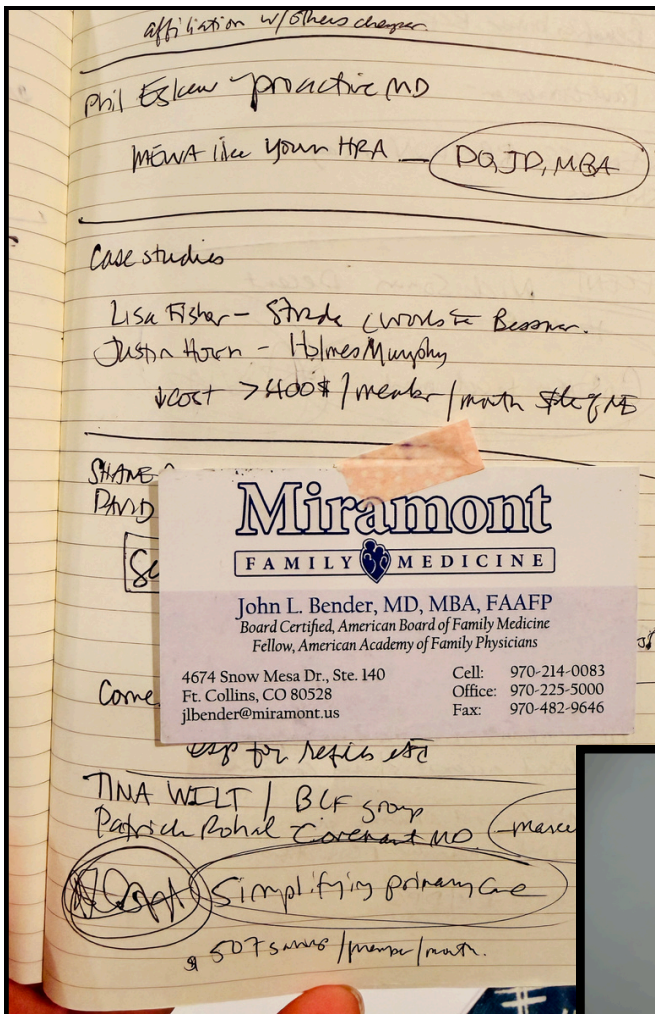
For a practice built on prevention, that is the missing piece. Not another system to run, but a connection to information the patient finally has in one place.

This article is sponsored by **Vivid Vault Health Solutions**, a patient-controlled, HIPAA-compliant health navigation platform. Patients and families organize their records, medications, and care in one secure place, and DPC practices can connect through a partnership for a shared clinical view. Explore a practice partnership at vividvaulthealth.org/concierge.



The Practice You Built Should Not Live Only in Your Head

By Maryal Conception, MD



Here's where I fell asleep from info overload!

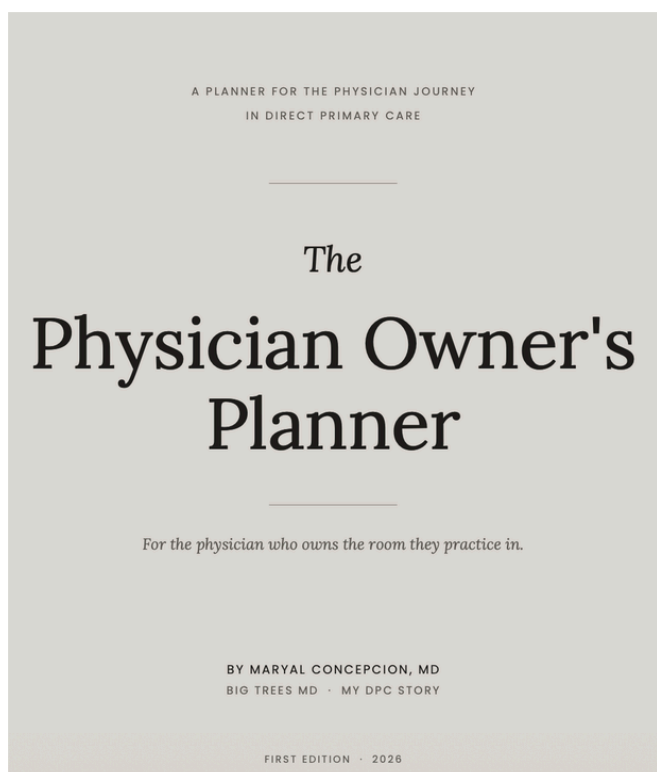


I did not start with a binder. I started in 2019 with taping business cards with washi tape next to notes I was writing on things like the back of the practice brochure of Santa Cruz DPC, scribbling what this non-MBA physician was learning about the business of medicine. Then I had too many days to count where I could not remember why I signed a certain contract, or when I reviewed an SOP last, or which login opened the account I needed at nine at night. ACK!

Here is what I learned the hard way. Anything that lives only in your memory is a single point of failure. Getting organized is not about becoming a different kind of physician. It is about getting the practice out of your head and onto a page your

team can actually read, and this has significantly reduced my practice anxiety!

That is the whole reason I built the **Physician Owner's Planner**. It does not ask you to overhaul your life. Nobody's got time for that even though it is something I have desired to do at times. It asks you to fill in a few rows at a time. The software and login inventory can help you save two hours and a panic on the worst possible day. The vendor and contract log that sets a renewal reminder so you stop hunting through email at midnight. The decision log that remembers your big calls so your tired brain does not have to. The one number, your break-even, that turns money from a report card into a map.



The quarterly rhythm that lets you plan ninety days at a time instead of carrying the whole year on your back.

No page asks for more than three inputs. The whitespace is not you falling behind. It is room to breathe.

It comes with an audio companion now too, fourteen short episodes where I walk each section with you in plain language. Think of it as me in the passenger seat while you drive to the clinic. You do not have to take notes. You listen, then you open the one page that fits the season you are in.

I am bringing a limited number of planner and audio bundles to the My DPC Story booth at the Summit. Come find me at our table, flip through a copy, and take one home. If you would rather not wait, order yours today or grab the digital version and start tonight.

You own the room you practice in. I hope this tool can help you run it!

Order your planner today at payhip.com/mydpcstory





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A Business Plan Is Not Just for Day One

There is a quiet myth in the DPC world that a business plan is something you write once, before you open, to convince a bank or to calm your own nerves, and then never look at again. That myth costs practices real money and clear direction. A business plan is not a hoop you jump through to launch. It is a working document, and it stays useful long after your doors are open.

So what is it, plainly? A business plan is the written answer to a handful of honest questions. What is this practice, and who is it for? How does it make money, and what does it cost to run? How many patients do you need, at what membership price, to cover your expenses and pay yourself a real wage? Where is the practice headed over the next year, and what would have to be true to get there? Put those answers on paper and you stop guessing. You can see your breakeven and your panel math laid out in front of you, instead of carrying the numbers as a vague worry in the back of your mind. If you are still planning for day one, this is where you find out whether the numbers

work before you sign a lease. You can test your pricing and map your real startup costs on paper, where mistakes are cheap.

If you are already open, the business plan earns its keep just as much. The questions simply change. Do you add a second physician, or hold your panel where it is? Is it time to bring labs or a new service line in house? Should you raise your rates, or take on a contract with your county? Growth that happens on purpose almost always starts as a plan on paper. Growth that happens by accident is just drift with a busy calendar.

That is why we have included a business plan example and template you can use either way in the following pages. Use it before you launch and let it pressure-test your idea. Open it three years in and let it map your next move. Fill it in, then come back to it whenever a real decision is on the table. A business plan is not proof that you are a beginner. It is proof that you are running a business on purpose.



Lean Startup Business Plan (Example)

PROBLEM01	SOLUTION05
- List a frustration your target market has. - ACME Clinic is too hard to access because they have 3000 patients per doctor. - ACME Clinic has a non-physician model for care. Existing Alternatives - List a potential competitor or similar business and their offering. Wildfire Aesthetics has a trendier marketing approach that appeals to all demographics Front Porch DPC has a "for students" community college agreement	- List how your business can solve a customer's problem. - Offer innovative healthcare at a friendlier price. - Appeal to a larger and growing demographic who want a relationship with their doctor.
UNIQUE VALUE PROPOSITION02	KEY METRICS06
- Write about what makes your product (you ARE the product!) special so you can convince a stranger to become your customer. High-Level Concept - Provide a short, catchy, easy-to-remember description of your product	- List a metric by which you measure the success of your business. 10% profit increase by our third year - Increased customer retention rate at the end of each year
CUSTOMER SEGMENTS03	UNFAIR ADVANTAGE07
- List personas of the people that you expect to use your product. - Students - Professionals EARLY ADOPTERS - List specific characteristics of your early adopters. - Students who see having access by text as a break from the stress of having to make an appointment in person to review labs. - Professionals who appreciate cost-savings through transparent lab and image pricing.	- List what sets you apart from competitors. - All-In-One services. - New features that patients are looking for.
	CHANNELS - List the ways you plan to reach your audience. - Physical space - Social media
COST STRUCTURE04	REVENUE STREAMS08
What are the fixed and variable costs to launch your product or service? Consider the cost at each stage from setting up a website, hiring employees, production, marketing, and bringing them to patients.	How will you generate income? Show a pricing model of your product or service and include other revenue sources, such as sales and subscription fees.

Find More Resources at mydpcstory.com





Lean Startup Business Plan (Your Turn!)

PROBLEM01	SOLUTION05
UNIQUE VALUE PROPOSITION02	KEY METRICS06
CUSTOMER SEGMENTS03	UNFAIR ADVANTAGE07
	CHANNELS
COST STRUCTURE04	REVENUE STREAMS08

[Find More Resources at mydpcstory.com](https://mydpcstory.com)



FREE FROM MY DPC STORY

Opening Day Is The Easy Part

Everyone prepares you for opening. What if you were also prepared for month three?



GET IT FREE

You just worked through a business plan!

Now, here is the truth about what comes after it: the plan gets you to opening day, and *then* the questions change. Am I growing fast enough? What should I be tracking? When do I raise prices, hire help, or say no?

The First Year Dashboard is fourteen pages pulled straight from the Physician Owner's Planner and built for exactly that stretch.

Monthly panel and revenue tracking. The year-one decision checkpoints. A quarterly reflection page so the practice you are building does not quietly consume the physician who built it.

Each section pairs with My DPC Story episodes where physicians look back at their own first year and tell you what they wish someone had said out loud.

No page asks for more than three inputs. The whitespace is not you falling behind. It is room to breathe.

*The Dashboard is free. When you are ready for the full year-round system, the complete **Physician Owner's Planner** and its audio companion are at payhip.com/mydpcstory.*

Turning New Hires Into High Performing Staff

From the Practice Management and Human Resources Experts at the Cooperative of American Physicians (CAP)

Training new employees in healthcare is an opportunity to shape how your team functions, communicates, and cares for patients. With staffing shortages, heavy workloads, and constant changes, getting a new employee up to speed can feel like a full-time job. A well-structured training approach can empower new hires, enhance teamwork, and improve patient care.

Whether you are managing a practice, overseeing operations as an administrator, or leading a team of back office or front office staff, strategic approaches to training can become an engaging and effective process.



Build a Thoughtful Onboarding Experience

First impressions set the tone for success. A strong onboarding program ensures employees feel supported from day one and are prepared for long-term growth.

- **Map out clear milestones:** Laying out the first 30, 60, and 90 days with defined milestones helps new hires feel confident and purposeful.
- **Create role-specific training modules:** Tailor your trainings to the specific responsibilities of clinical, administrative, and support staff.
- **Implement compliance and policy education:** Ensure that all staff are trained on current regulations, such as HIPAA, OSHA, Sexual Harassment Avoidance, Workplace Violence and CMS standards. Annual updates and assessments help maintain compliance.
- **Encouragement or ship assignments:** Find your practice stars and pair new hires with experienced staff to encourage knowledge transfer and foster connection.



Train With Purpose and Relevance

We learn best when training is practical, problem-centered, and relevant to everyday roles.

- **Incorporate scenario-based learning:** Use real-life patient cases or workflow challenges to make lessons practical.
- **Encourage shadowing and cross-training:** Encourage employees to observe and engage with experienced staff members to gain firsthand insights.
- **Facilitate open feedback:** Frequent check-ins keep training aligned with actual needs, making it more impactful.



Utilize Technology to Enhance Learning

We all thrive when a good system makes life easier. But technology should support training and not replace human connection.

- Adopt a learning management system for self-paced learning, assessments, and tracking progress.
- Create quick-access guides or short on-demand videos for common tasks like submitting referrals or running reports.
- Implement virtual walkthroughs and simulations for complex processes that benefit from visualization.



Make Learning a Part of the Culture

Training should not end after onboarding. Create an environment where learning is continuous and valued.

- ▶ Host monthly refreshers on new technologies and best practices.
- ▶ Offer growth paths, such as leadership tracks, certifications, or even in-house “train-the-trainer” programs to show that you are invested in your employees' development.
- ▶ Recognize and celebrate progress when employees master new skills, mentor others, or contribute innovative ideas.



Provide Regular Feedback and Performance Evaluations

A successful training program must be measurable. Assessments and feedback loops ensure continuous improvement.

- ▶ Track performance metrics to look at how new staff are doing after 30, 60, and 90 days. Are they making fewer mistakes? Managing more patients? Getting valuable feedback? Creating a higher level of patient satisfaction?

- ▶ Gather direct feedback on what worked well and what could be improved upon for future training rounds.
- ▶ Ensure consistency across locations and departments through policies and procedures, audits, and quality checks.



Support Leadership in Training Execution

Training is not just the responsibility of HR or department heads—leaders at every level should actively shape the experience.

- ▶ Develop leadership coaching programs to ensure managers know how to train effectively, give constructive feedback, and inspire growth.
- ▶ Clarify expectations for team leads. They are not just managing people: they are shaping workplace culture.
- ▶ Give leaders room to support new hires by adjusting their workload temporarily so they can dedicate time to mentoring.

Training new employees is not about teaching them the basics—it is about building a team that works well together and feels confident in what they do. In healthcare, great training leads to better patient outcomes, stronger collaboration, and a more efficient practice. Invest in your team, and you will see the returns in excellence and morale.

This article is provided by the practice management and human resources experts at the Cooperative of American Physicians (CAP). Since 1975, CAP has delivered exceptional medical malpractice coverage to California physicians. Today, CAP serves more than 13,000 physicians with trusted and reliable coverage, and much more.

At no additional cost, CAP members have access to a comprehensive suite of benefits designed to help independent physicians stay ahead, including:

- Human resources support and customizable HR manuals for employees and managers
- Practice management consulting for expert guidance to optimize operations

- Risk management services to reduce liability and improve patient safety
- Personal insurance benefits, like up to \$500,000 in life insurance, guaranteed*
- Unparalleled claims and legal defense for trusted support when you need it most
- And much more!

To learn more about becoming a CAP member, please call **800-356-5672** or email **MD@CAPphysicians.com**.

*Exclusions Apply.

Medical professional liability coverage is provided to CAP members through the Mutual Protection Trust (MPT), an unincorporated interindemnity arrangement organized under Section 1280.7 of the California Insurance Code. Members pay assessments, based on risk classifications, for the amount necessary to pay claims and administrative costs. No assurance can be given as to the amount or frequency of assessments. Members also make an Initial Trust Deposit, which is refundable according to the terms of the MPT Agreement.



COOPERATIVE OF
AMERICAN PHYSICIANS



Freedom to Practice Medicine on Your Terms

“When it comes to exceptional patient care and meaningful medical careers, physician independence matters. That’s one of the reasons why CAP supports direct primary care providers with reliable medical malpractice coverage and practice and risk management services tailored to the clinical and professional realities of medicine today. Our promise will always be to protect what physicians have worked hard to build and to support their ability to remain independent.”

Sarah E. Scher, JD
Chief Executive Officer
Cooperative of American Physicians

Physician founded in 1975, the Cooperative of American Physicians (CAP) is a leading provider of medical malpractice coverage in California. More than 13,000 physicians rely on CAP to protect their practices every day.

Learn how CAP can help you succeed.

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Medical professional liability coverage is provided to CAP members through the Mutual Protection Trust (MPT), an unincorporated interindemnity arrangement organized under Section 1280.7 of the California Insurance Code.

MORE THAN A BOOKKEEPER

WHEN THE BUSINESS SIDE OF A GROWING DPC
BECOMES ITS OWN KIND OF BURNOUT



The clinical side is the part physicians trained for. Years of it. The business side is the part no one taught them, and it has a way of becoming its own kind of burnout, quietly, as the practice grows.

It often starts with a small act of confidence. "I can learn QuickBooks in a weekend," the thinking goes, and maybe that holds at launch, when the only expenses are rent and insurance and the panel is small. But a DPC practice changes seasons. What worked at the start does not keep working at scale, and the financial admin that took an hour a week starts taking an afternoon.

Tom Squire has watched that curve from both sides. Before founding Osprey CFO in 2024, he spent his career in banking and private equity, and the two problems he sees most often in DPC practices have nothing to do with medicine. The first is time. Physicians end up running payroll, paying bills, and reconciling accounts, none of which is the highest and best use of a

doctor's hours. The second is quieter and harder to name: a lack of confidence.

"People sometimes feel like they're not necessarily in control of what's going on in the financial piece of their business," Squire says. They have an accountant. They receive financials. They do not always know how to read them, and they have no budget or plan to measure against.

This is the line that matters, and it is the one most DPC owners miss. A bookkeeper records what already happened. A financial strategist helps you decide what to do next. Many physicians describe the same early experience: a bookkeeper hands over a summary with no explanation, no read on whether the practice is actually sustainable, no space to ask the questions that keep them up at night. Squire's clients, he says, increasingly want a partner rather than a record-keeper. "Every single client of ours is an advisory client," he says, whether Osprey is doing quarterly books or running the entire back office.

Paying yourself is often first, and it is one of Squire's favorite problems to solve. Most new practices cannot draw a salary on day one. There may be a few months of cash burn, and the point is to plan for it rather than be surprised by it: no salary for the first three months because personal savings can cover it, then a draw beginning at month three or month six, contingent on hitting revenue and expense targets. The harder truth sits underneath. A for-profit practice that never turns a profit cannot keep its doors open. Squire remembers a Louisiana practice doing real good for its community while running unprofitably, and the math is unforgiving. As Concepcion frames a lesson she learned early in training, if you cannot take care of yourself, you cannot take care of others. A clinic that closes serves no one.

Pricing is usually next, and it is where small changes move the most money. Squire describes a client who hit every patient goal last year, grew the panel to the size they wanted, and still came up light on revenue. The fix was not more patients. It was a five-dollar adjustment to the membership price. Across a full panel, that is meaningful money landing directly on the bottom line, and the handful of patients sensitive to five dollars is almost always a small share of the whole.

Expenses are the third lever. Rather than rolling last year's numbers forward, Squire favors building the budget back up from zero and questioning each category. Some costs are fixed, like a multi-year lease. Others are not: insurance that jumped more than expected can go back out to bid, and the fourteen magazine subscriptions in the lobby can probably become seven.

Each cut is small. Over twelve months they compound, and every dollar saved is a dollar to the bottom line.

Underneath all of it is one question Squire considers the most important he asks. What is the goal? A doctor who wants to grow aggressively gets one plan. A doctor who wants to be out of the office by four and home with family gets another. Both are valid. Both need a plan to get there, and neither happens by managing a bank account.



Which returns to the objection that stops most physicians from outsourcing at all: it costs money. Squire frames it as a two-sided coin. Yes, there is a dollar cost. But there is also the opportunity cost of a physician spending evenings on a profit-and-loss statement instead of seeing patients or building the practice. There is a human cost, too. Osprey CFO gives every client a direct line and a real person who knows the tools, so a PTO-policy question that would otherwise eat five hours inside a payroll platform becomes a single email. And there is the cost of holding on too long. As one physician put it, the spreadsheet becomes a favorite toy you refuse to hand over, right up until you let it go and remember what you would rather be doing instead.



*This article is sponsored by **Osprey CFO**, a fractional CFO and managed accounting firm built for direct primary care. Founded in 2024, Osprey brings a banking and private equity background to DPC back offices, charges a flat monthly rate with no end-of-month surprises, and is openly invested in keeping the model independent rather than absorbed by private equity. Osprey and My DPC Story put together a free decision guide that walks owners through what to outsource and when. Download it at mydpcstory.com/library, or book a call at ospreycfo.com.*

WHY EVERY STATE DESERVES ITS OWN DPC SUMMIT

BY MARYAL CONCEPCION, HOST OF MY DPC STORY

This June, 80 physicians gathered in Newport Beach for three days of the second annual California DPC Summit. On Friday, people walked in carrying weight. You could see it in their faces. By Sunday, that weight had lifted. That shift is the whole point, and it is by design.



The My DPC Story team produced this gathering with a focus on building community and not just another conference. The weekend opened with a small group immersive experience, where small attendee groups rotated through expert stations instead of sitting through lectures. Friday's debrief sessions made room for myth-busting with no prepared remarks, and everyone went home with one word, one thing that shifted, and (at least!) one action put into motion.

The content was wide on purpose. Physicians worked through the financial reality of DPC and how to fund the transition. We talked through an update on national policy and California's specific legal landscape. Dr. Esther Khatibi opened up women's health and OB care in DPC, while a Sunday block covered aesthetics, lifestyle medicine, integrative family medicine and more. We made space for sharing stories with each other, had intentional time for asking questions, as well as diving into topics like business pearls from tools we use to how we onboard patients.

Every part of this event was envisioned and designed around the DPC doctor at **every stage** and not just those starting out.

California is not Illinois. Illinois is not Tennessee. Every state has different laws, nuances, needs, and a different insurance landscape, and every state has its own community of physicians who need to find each other. That is why I believe each state deserves the chance to build a DPC summit of its own.

Our next stop is the **Illinois DPC Summit** (limited to 40 attendees, hosted by Dr. Clodagh Ryan and Paula Tomczyk of Cara Direct Care) this October, just before our virtual women's summit later that same month, with a **Tennessee DPC Summit** hosted by Dr. Matthew Hitchcock on the horizon for next year.

If you are looking for LIVE events like a State DPC Summit near you or you would like the My DPC Story team to help bring a DPC Summit to your state, write to us at mydpcstory.com/contact

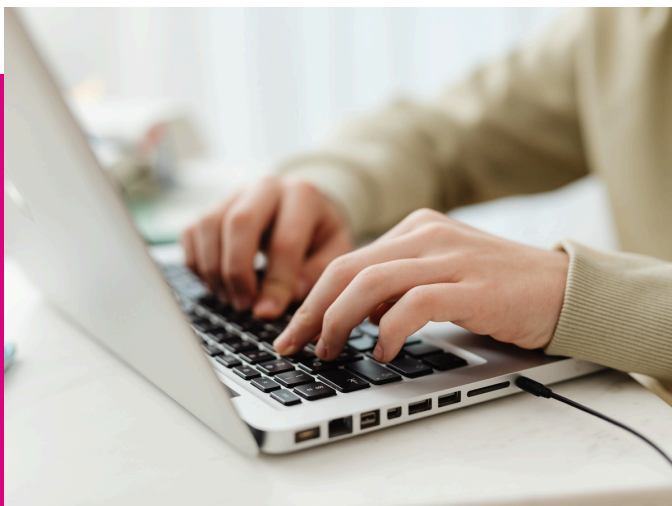


The Smallest Marketing Stack That Works

DPC physicians don't need a marketing department. They need five tools they'll actually use.

Every tool in the Battle of the Support Stack earns its place once a patient walks through the door. This is about the stack that gets them there. The billing platform, the scheduler, the EHR, the AI scribe, all of it assumes someone has already found you. But the best support stack in direct primary care cannot fill a panel that nobody knows exists.

That is the job of a marketing stack. The good news is that you do not need a content agency or fifteen subscriptions, just the smallest set of tools you will actually reach for every week. In marketing, showing up regularly beats being the practice with the most aesthetic feed. A fancy stack you abandon in 2 months does nothing for you, while a modest one you keep using all year quietly builds a practice.



Here is the full stack, organized by the job each tool does.

- Start with the camera you already own. The phone in your pocket shoots photos and video good enough for everything you will post this year. The quality is not what is holding your practice back. A gear upgrade is just the easiest thing to buy when posting starts to feel hard.
- Reach for one tool to make things look intentional. Canva builds your graphics, layouts, and reusable templates, and CapCut cuts short video if you decide to do reels, both on free tiers that carry you well past the start. You are not trying to look like an agency made it. You are trying to look like you put thought into it.
- Use a scheduler so you are not opening the app to post in real time. For a solo practice, Meta Business Suite runs free and covers Instagram and Facebook, which is where your local patients already are, so you can batch a week of posts in one sitting and let them go out on their own. Skip the enterprise platforms until you have genuinely outgrown the free one, which takes a lot longer than the sales pages promise.
- Claim the asset that works without posting at all: your Google Business Profile. It costs nothing, and for a local practice it might pull more weight than anything else on this list, because most patients search before they ever scroll. A complete profile, with your hours, location, services, and a few real photos, quietly markets for you in the gaps between posts.

- Close it out with one link and one way to track it. A link-in-bio page hands every platform a single front door, and a shortener like Bitly shows you which posts actually drive people toward membership signup. Without tracking, you are guessing. With it, you learn what your community responds to and do more of exactly that.

Five jobs, mostly free, and you can stand the whole thing up in an afternoon.

One thing to get right before you start: aim at the people you actually want to reach. If your target is employers or other physicians, that happens on LinkedIn.

Patients who will join your practice directly will likely be on Instagram, Facebook, and Google. Pick the room your patients are in, not the platform you use the most yourself or the one other DPC docs told you to be on. Good content pointed at the wrong audience mostly just goes quiet.

The tools are the easy part. The hard part is showing up after the novelty wears off, and the only reason this stack stays this small is so that showing up stays possible. Build it light, and the only thing left between you and a full panel is the work itself.

From AlignedMD: **The Aligned Circle** hands DPC physicians new marketing assets every month, so consistency does not depend on motivation. The first 20 founding members get the full Marketing Without the Lck course included while they're in, and first-month proceeds support the free clinic at Poppy Direct Care. alignedmd.agency/circle.



NATHALIA HYLAND
Founder, AlignedMD Marketing

THE CONSUMER HEALTH BAR IS HIGH. HERE'S HOW FORWARD-THINKING DPC PRACTICES ARE MEETING IT.

In Direct Primary Care, patients don't stop thinking about their health when they leave the office. As of 2023, over half of US patients were already using wearables for daily tracking, yet only 11 percent of physicians reported integrating that data into their practice by 2024. In membership-based models where patients self-select for this kind of engagement, those numbers are likely much higher.

By the morning after the appointment, patients may have checked sleep scores, reviewed lab results with an LLM, and logged symptoms, blood pressure, or glucose. Health information accumulates continuously, thus changing expectations: care becomes something patients experience continuously through their devices, not only during appointments. That shift doesn't just create more data; it raises expectations for how care should feel between visits.

So, in an era when patients can generate personalized health protocols at the drop of a hat, how do DPC physicians deliver an experience that meets the bar set so high by consumer health tech?

Unlimited visits and direct access still matter, but they're no longer enough to differentiate the experience within the world of DPC. The answer starts with a well-known tenet of the tech space: people notice user experience most when it fails. Patients aren't thinking about integrations, EHR choices, or clinical workflows, but they do notice when it feels disorganized. They notice when they get stuck in feedback loops while looking for their records, when they have to re-explain their health history for the twentieth time, or when blood pressure readings they've been instructed to log go completely



unaddressed. Just as health occurs between visits, so does a patient's perception of their physician. Trust builds through small interactions over months. This could be a lab result accompanied by personalized context rather than standing alone in a portal, a physician who's already aware of what changed since the last visit, or a timely answer that prevents uncertainty from becoming frustration. Supporting those moments requires infrastructure that many clinical tools lack.

That's where Guava fits; it connects a practice's existing data, tools, and communications into an experience that works for both sides of the relationship.

The Next Evolution of the DPC Stack

As consumer health advances and clinical workflows expand, matching a top-tier patient experience has become increasingly complex. Most DPC practices rely on entire ecosystems: EHRs, secure messaging, wearables, outside lab reports, specialist records, and patient-reported health data. As the stack grows, prep time increases because before the clinical work can start, someone has to find everything.



"I've got the biometric data and the 'Ask Guava AI' functionality, so I can have it give me the three-month summary of everything going on with this client and help me get prepared for a call."

~ Mike Stone, MD, founder of Pillars Health

For physicians, the value shows up first in preparation. Mike Stone, MD, founder of Pillars Health, described his workflow this way:

"I go to Guava easily as often as I go to Elation for client prep and review before I meet with somebody. I've got all of my notes and all the labs that have already come over from Elation. Plus, I've got the biometric data and the 'Ask Guava AI' functionality, so I can have it give me the three-month summary of everything going on with this client and help me get prepared for a call."

That preparation shapes the visit before the conversation even starts. Guava connects data across systems: EHR data from Elation, Cerbo, Athena, Hint, and external patient portals sits alongside messages from Spruce. It integrates this with wearable data, symptom tracking, uploaded documents, and AI-generated clinical summaries. Clinical highlights are automatically surfaced, and physicians get a single longitudinal view of each patient. That matters not only for clinical efficiency, but for the patient experience on the other side of the visit.

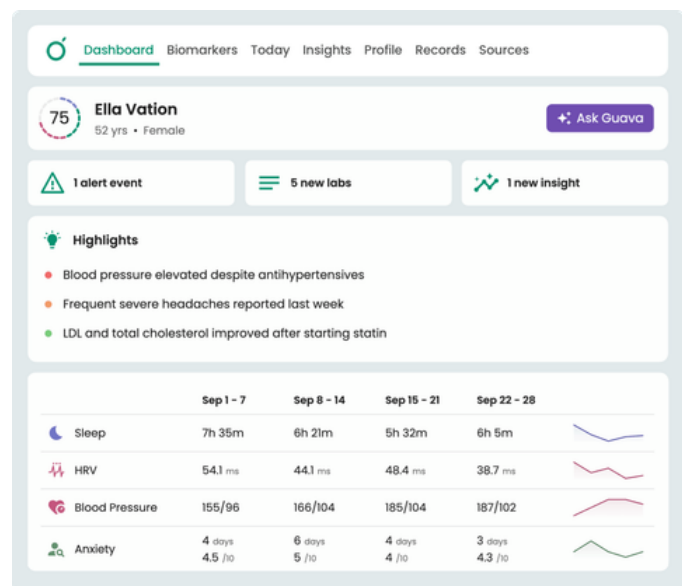
Designing an Experience Patients Notice

With Guava, patients access records, wearable data, labs, and health insights in one place. Their experience can now exceed expectations set by consumer wearables—and it's hand-delivered by their physician.

This differentiation extends to personalization as well. Clinicians can customize reference ranges for individuals, provide cohort-specific explanations alongside lab results, and build health scores that reinforce preventive care

plans between visits. The experience with the practice is clinically informed in ways no consumer wearable can replicate on its own. One patient who got Guava through her provider put it simply:

"No other app makes tracking symptoms easier, and in the same space, I have access to all of my medical records! The design is seamless and easy to use...I wish every medical provider used this platform."



Relationships Need Infrastructure

Technology can't create trust on its own, but it can remove the small sources of friction that gradually erode it. It can help physicians arrive better prepared, give patients clearer visibility into their health, and keep conversations moving forward between appointments.

For practices built around long-term relationships, those details become part of the

care itself. The consumer health bar is high. Guava helps independent practices meet it. Learn more at guavahealth.com/provider-dashboard.



Sources:

1. Venn RA, Wasfy JH, Atlas SJ, et al. Characteristics and attitudes of wearable device users and nonusers in a healthcare system. J Am Heart Assoc. 2024;13:e032126. doi:10.1161/JAHA.123.032126
2. Sermo. Wearable health devices: Examples & 2026 technology transforming patient care. Published April 25, 2025. <https://www.sermo.com/resources/wearable-devices-for-healthcare/>



LedgerHealth

YOUR PRACTICE DESERVES MORE THAN BASIC BOOKKEEPING

Independent physicians need more than categorized transactions and year-end reports. They need financial clarity, reliable numbers, and a partner who understands the business realities of medical practice ownership.

LedgerHealth is a physician-owned bookkeeping company created for independent practices, including Direct Primary Care and medical entrepreneurs. Our exclusive LedgerHealth membership helps physicians understand their numbers, improve cash flow, coordinate with tax professionals, and make better business decisions throughout the year.

LedgerHealth membership is built for physicians who want ongoing financial support, education, and accountability as they grow and protect their practices. For those who are not ready for full membership or who are not physicians, we also offer a non-member track for bookkeeping and financial support services.

Whether you are launching, stabilizing, or scaling your practice, LedgerHealth turns financial chaos into clarity.

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PRESERVE. PROMOTE. PROLIFERATE.

Learn more at LedgerHealth.com.

Guava

the platform for personalized care

Scan to see how Guava
fits into your practice



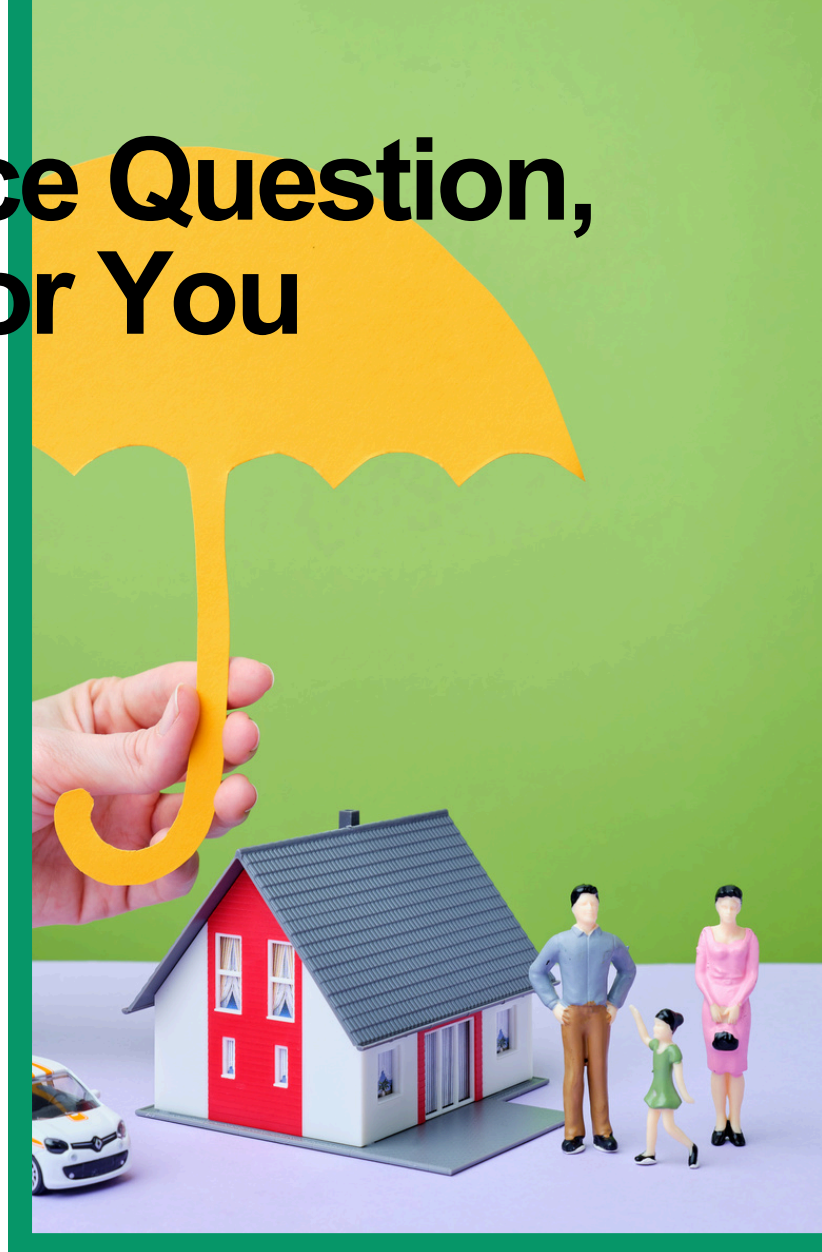
The Insurance Question, Answered For You

Every DPC doctor knows the question. A patient sits across from you at a meet and greet, genuinely interested in your practice, and then asks some version of "but what do I do about insurance?" You are a physician, not a benefits broker, and yet that question may land in your lap several times a week. The How to CHOOSE Your Healthcare handout was built to help answer it for you.

This handout is a plain-language decision guide that walks a patient through a choice most of them were never taught to make, and it does it in about ten minutes. It starts where care actually starts, with their own health needs. From there it walks them through whether they are likely to need specialty care and whether a catastrophic plan fits, then lands on the coverage pathway that matches their life. It lays out four real options, from DPC paired with a catastrophic plan to traditional insurance, a HealthShare, or cash-pay, and it closes with a checklist so the patient can confirm they have chosen well and stayed compliant with their state and employer rules.

What makes it useful in a DPC clinic is what it refuses to do. It does not pit your membership against insurance. It shows patients how DPC fits inside a coverage strategy, which is an honest answer and the one that builds trust. When a prospective member understands that you are not asking them to drop their safety net, the "why do I need you if I have insurance" worry can dissolve on its own.

So use it. Print a stack and leave it in your waiting room where people can pick it up while they wait. Tuck it into your meet and greet folder, put a copy on your website. Hand it to the patient who is interested but nervous, and to the one whose employer open enrollment is around the corner. Pass it to the HR contact



**"You are a physician,
not a benefits broker"**

who keeps sending you questions. You do not have to deliver a benefits lecture. Let the handout help carry that load and keep your visit focused on the patient in front of you.

A digital copy lives on the toolkit.mydpcstory.com/resources page as well, and you are welcome to point patients there. But this one was made to be printed. There is something about a piece of paper a patient can hold, mark up, and carry home that a screen does not match. The last page says it plainly: **You Are Not Alone In This.** *Put it somewhere your patients can find it.*



How to CHOOSE Your Healthcare

A HELPFUL HANDOUT EXPLAINING HEALTHCARE COVERAGE.



How to CHOOSE Your Healthcare

A Step-by-Step Decision Guide for Choosing Coverage

In Just **10** Minutes

First Questions to Ask:

What do I want and need from healthcare?

- Preventative care
- Chronic disease management
- Pregnancy care
- Cancer/Complex care
- Procedures/Surgeries

Who will be my primary physician/provider?

- Traditional Insurance
- Direct Primary Care
- Concierge Care
- Community-based clinic

How will I access medications, labs, imaging?

- Access to affordable generic medications
- Coverage for expensive medications
- Cash vs. insurance for medical tests



STEP 1: Understand Your Health Needs

Which best represents you +/- your family?



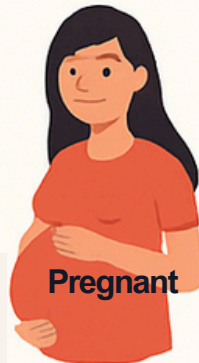
Baby/Child

- Wellness visits, vaccines, acute care
- Coverage required by parents



Young Healthy Adult

- Preventive + injury protection
- Low medical use
- Mandate penalty only in select states



Pregnant

- Prenatal, imaging
- Must have maternity benefits including delivery coverage



Young Adult w/ Chronic Disease

- Chronic care + labs + meds
- Benefit from stable primary care



Older Adult

- Specialists, imaging, hospital care
- Medicare or ACA Gold recommended

STEP 2: Will You Need Specialty Care?

Examples: Dermatology, Rheumatology, Orthopaedics, General Surgery, Oncology, Cardiology, Endocrinology etc.

The answer is likely YES if:

- You already see a specialist
- You have a diagnosed condition like cancer, a heart condition or mental health condition
- You anticipate a medical procedure or surgery
- You take expensive or specialty medications



STEP 3: Eligibility Check for Catastrophic Insurance

Are you under 30 or do you have a hardship-exemption?

Catastrophic coverage may be a good thing IF these are the case:

- You are generally healthy
- You rarely see specialists
- You don't need maternity coverage
- You don't take expensive medications
- You can afford a large bill if something happens
- You have a primary care plan (like DPC)

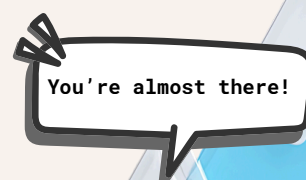


STEP 4: Choose Your Coverage Pathway

THIS is where the REAL FUN starts...



Seriously. keep going.



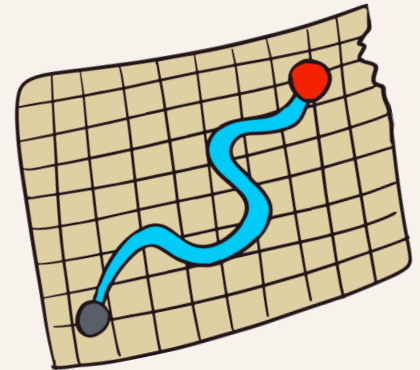
Which Seems Right For You?

Path 1 - Direct Primary Care + Catastrophic Plan

- Low cost, strong primary care, emergency protection
- For: healthy adults, families, chronic disease, self-employed

Path 2 - Traditional Insurance (Bronze/Silver/Gold) +/- DPC

- For: pregnancy, cancer, surgery, expensive meds



Path 3 - HealthShare + DPC

- Low cost, community-based coverage
- For: healthy adults, families, chronic disease, self-employed

Path 4 - Cash-Pay + DPC Only

- For: very low medical use, must have savings, consider coverage for when accidents happen!

Final Questions to Ask Yourself!

(After Completing This Healthcare Decision Algorithm)

Use this checklist to confirm you've chosen the right path and remain compliant with state and employer requirements.

1. Am I required to carry insurance in my state?

Check if you live in a mandate state (CA, MA, NJ, RI, DC). If yes → Make sure your choice counts as qualifying coverage.

2. Does my employer offer options I should compare? Questions to ask:

What plans are available? Can I decline group insurance without penalty? Are HSA or FSA options available? Can I pair their plan with a Direct Primary Care membership?

3. Do I have the right level of protection for big medical events?

Emergency care, Hospitalization, Surgeries, Cancer treatment, Pregnancy and delivery. If not → Reassess your Major Medical option.

4. Did I choose a primary care model that matches my needs?

Relationship-based care (DPC), Convenience-based care (like telemedicine), Insurance-based clinic, Pediatric or Obstetric needs.

5. Where will I get labs, imaging, and medications?

Confirm: Pricing, Coverage, Network requirements, access for chronic meds or expensive drugs.

6. If choosing DPC, do I understand what's included and what's not?

Unlimited visits? Labs or imaging included or discounted? After-hours care? Procedures?

7. If choosing a HealthShare, do I understand the rules?

Waiting periods, Eligible vs Ineligible expenses, Incident vs Illness-based sharing, Caps, or Limits?

8. Do I need to update any documents?

Insurance cards, Employer waivers, State compliance forms, Contact information for your new Primary Care Physician/Provider.

9. Do I have a plan for re-evaluating my needs each year?

Open enrollment (marketplace or employer), DPC membership renewal
Changes in health status (pregnancy, diagnosis, aging parents, etc.).

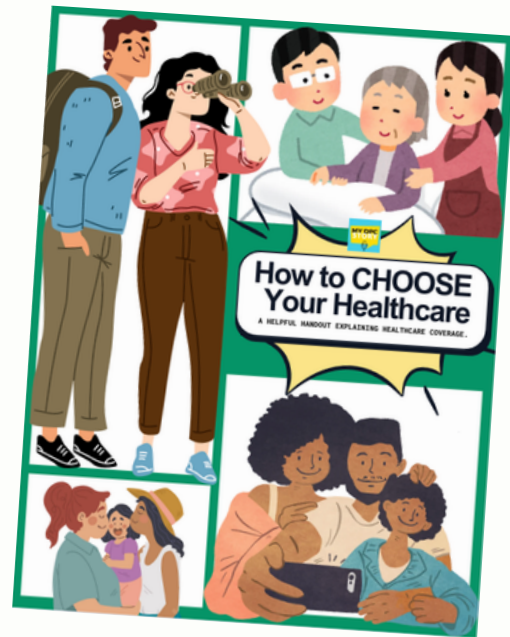
10. Do I feel confident, protected, and well supported?

If not → Talk to your employer's HR, primary care doctor, and/or benefits advisors (familiar with DPC and alternative coverage models).

You Are Not Alone In This!

FOR PATIENTS

THE HOW TO CHOOSE YOUR HEALTHCARE HANDOUT



PHYSICIANS: HAND THIS GUIDE TO YOUR PATIENTS.

Get the free printable version of the following pages for your clinic website, your exam room and (not-for-waiting) waiting area, plus a shareable link for your patient newsletter. Your patients get clarity. You get one less conversation to repeat.

A POWERFUL NEW ASSET FOR DPC CLINICS

EXPLAIN DPC WITH CONFIDENCE.

Help Patients Understand.
Build Trust. Grow Your Practice.



White-Labelled Patient Education Video
Professionally produced and ready to use.



100% Your Brand
Your colors. Your logo. Your clinic details.



Built to Build Understanding & Trust
Clearly explain Direct Primary Care in a way that resonates with patients.

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One video. Endless impact.

The easiest way to explain the DPC model, answer key questions, and help more patients say "yes" to care.



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**MY DPC
STORY**

SHARE YOUR WHY.
GROW YOUR IMPACT.

INTRODUCING MY DPC STORY: STATE BY STATE WITH DR. PHIL ESKEW



If you have ever wondered whether your state's insurance commissioner could shut you down, if your DPC is covered under HIPAA, or even if your state has a law protecting DPC, this one is for you.

My DPC Story is launching a new spin-off, State by State with Dr. Phil Eskew. Dr. Eskew wears both hats, physician and attorney (and MBA, too), and he has spent more than a decade tracking how DPC law actually plays out across all fifty states.

Each episode, real physicians bring their real questions and Dr. Eskew answers them in plain language, the kind of answer you can act on Monday morning.

We have already covered the ones that keep owners up at night. How to hang your shingle without looking like a limited service HMO. What opting out of Medicare really means, and how it changes nursing home and hospice access. W2 versus 1099 when you bring on a nurse or rent a room to an esthetician. Dispensing rules that flip the moment you cross a state line. The HSA changes that came with HR1.

HERE IS HOW TO GET IN ON IT!

Call the My DPC Story voicemail line and leave your state question (link and QR code below). As we cover each state, listen to hear your question answered.

Then join us at patreon.com/mydpcstoryfan so you know the moment a new episode drops and when you can join in for the LIVE recordings when they happen! The law moves state by state, and this is how you stay ahead of it.

Bring your hardest legal questions. Let this show work on getting you an answer.

**Note: Information in State by State with Dr. Phil Eskew is for educational purposes and does not serve as legal advice. Funds raised from Patreon for these episodes go to support the work of both DPC Frontier and My DPC Story.*



[SPEAKPIPE.COM/MYDPCSTORY](https://speakpipe.com/mydpcstory)

THE DPC DIRECTORY



GET LISTED TODAY

FIND WHAT YOU NEED FOR YOUR DPC JOURNEY

CONNECT
TODAY

GET
LISTED!

Who will you meet next?

Created by Maryal Concepcion, The DPC Directory is a place to connect with others in the DPC ecosystem. From finding help with marketing, business management consulting and more, the DPC Directory is a place to find help, offer your own services and build a better future together!



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my
happy
doctor

DEEPTI MUNDKUR MD

DPC
DOCTOR



Ask Dr. Deepti Mundkur what makes Direct Primary Care different, and the answer starts before you ever reach her patients. It starts with how she thinks. The name of her practice, myhappydoctor.com, is a philosophy. Dr. Mundkur believes a physician's mindset shapes everything downstream, from the exam room to the community to the life she gets to build outside of medicine. And what a life it is. When she is not caring for patients, you might find Dr. Mundkur on the pickleball court, chasing that particular joy of a good rally and an even better laugh. You will find her teaching in her community, sharing what she knows and lifting up the people around her. Ask her how DPC feels, and she will tell you it feels like being on vacation every single day.

Not because the work is easy, but because she designed a practice that gives her room to breathe, to show up fully, and to love what she does.

That same spirit shows up in her art. Dr. Mundkur created an original watercolor (pictured here) for the silent auction at Dr. Emily Holt's event, see pg. 19, with proceeds going to expand women's healthcare access. It is a beautiful reminder that the DPC community shows up for each other, and for the patients who need us most. Mindset is not a soft skill. It is the foundation. Dr. Mundkur is proof that when a physician builds a practice around joy, purpose, and freedom, everyone benefits: the doctor, the patients, and the community she serves.

Want more of that energy in your own practice? **Follow and connect with Dr. Mundkur at dpcmindset.com.**





How DPC Doctors Can Help Their Patients Avoid Financial Disaster



Direct Primary Care brings back what matters: access, time, and real relationships.

But even patients who love their DPC practice eventually ask the question that keeps them up at night: "What if something big happens to me?"

That's where most feel exposed and where Zion HealthShare enters the picture. We exist for this exact scenario.

Zion HealthShare is a nonprofit medical cost-sharing community, not insurance. Members simply contribute monthly to share in the eligible medical expenses of other members.

When a large eligible medical need occurs, the member is first responsible for their chosen Initial Unsharable Amount (IUA).

This is the amount the member is responsible for before the rest of the eligible expenses are shared by the community.

There are no provider networks, no enrollment windows, and unlike most healthshares, no lifestyle or religious requirements to join.

Where DPC Ends & Protection Begins

For DPC physicians, this creates a clean separation of roles. You continue to provide direct, routine, and preventative care exactly as you always have.

Zion HealthShare steps in only when patients face major medical expenses like hospitalizations, surgeries, advanced imaging, maternity, and other high-cost events.

DPC remains the front door of care. Health sharing becomes the financial safety net for everything beyond it.

Many DPC doctors choose Zion HealthShare for themselves and their staff. As independent practice owners, traditional group insurance often feels expensive, restrictive, and philosophically misaligned.



ZION HEALTHSHARE

is built to fit the DPC Model

Health sharing offers a corporate benefit that actually aligns with DPC values of simplicity, transparency, and freedom from insurance interference.

Practices can offer Essential Membership at a fraction of health insurance costs while avoiding the administrative burden entirely. Both physicians and their teams receive real protection from major medical costs while remaining fully self-pay for routine care.

Most importantly, Zion HealthShare gives DPC physicians a clear, ethical answer for uninsured patients who trust you but live one diagnosis away from financial collapse.

These are the patients who stretch labs, skip imaging, and quietly hope nothing big happens.

You've seen the relief on their faces when they

finally have protection that doesn't compromise the care model they chose.

A simple referral to Zion HealthShare gives them that peace of mind. A \$50,000 becomes manageable instead of devastating, while preserving the self-pay relationship you built your practice on.

When patients can combine direct care with community health sharing, they stop choosing between access and financial protection. They can finally get both.

If you believe healthcare should be personal and transparent, Zion HealthShare is built for your practice, your staff, and the patients you serve.

Your practice already delivers the care patients deserve. ZionHealthShare ensures they can afford what happens next.

Three Ways to Get Started with Zion HealthShare

- For you: Get a personal membership quote.
- For your team: Explore staff benefit options.
- For your patients: Become a referring practice.

Call us at (888) 920-9466 or email us at sales@zionhealthshare.org to get started.



Get Started Now

Scan to schedule a 15-minute call with our DPC partnership team and get started today.

ZION HEALTHSHARE & DPC

Works Together



Expanding What Your Practice Can Do For Patients

Direct Primary Care has already transformed how patients access healthcare. You provide affordable, relationship based care without the interference of insurance. At Zion HealthShare, we share your commitment to patient centered healthcare and we step in where your care ends.

Our nonprofit health sharing community helps with larger, unexpected medical expenses such as hospital stays, surgeries, and emergencies. When paired with your practice, patients can rely on you for everyday care while turning to Zion HealthShare for major medical needs. Together, this creates a complete and cost effective solution that keeps patients engaged with you while protecting them from high healthcare costs.

We want to help your practice thrive. DPC practices can be listed on our national DPC map so Zion HealthShare members can find and join your practice. We also provide

brochures and posters you can use in your office to introduce Zion HealthShare to patients who need support beyond routine care.

By working together, we can strengthen independent practices, and give patients peace of mind at a fraction of the cost of traditional insurance.

Our DPC Partners



To be added to our DPC map call
(888) 920-9466 or email
affiliate@zionhealthshare.org.



A FULL EKG, *WITHOUT* THE REFERRAL

HOW A PORTABLE 12-LEAD AND ON-DEMAND CARDIOLOGY REVIEW KEEP
CARDIAC CARE INSIDE THE PRIMARY CARE RELATIONSHIP

In most of medicine, the words "let's get an EKG" set a referral in motion. The patient is sent to another office, waits for an appointment, waits again for results, and the thread of the relationship frays a little at every handoff. Direct primary care is built to avoid exactly that. The question for a DPC physician is not whether cardiac insight matters. It is whether it has to leave the practice to happen.

A portable 12-lead changes the answer. With a device that captures a full reading in the exam room and a network of cardiologists available to review it on demand, a physician can do the cardiac workup in primary care and still have a specialist's eyes on the tracing, without writing a referral or losing the patient to the system.

The distinction starts with the tracing itself. Patients now arrive with rhythm strips from watches and consumer monitors, and those have their place, but they answer a narrow question. "A true EKG has twelve leads," says Dr. Robert Beto, a cardiologist. That's how you get a full picture of the heart, not just a rhythm strip." A portable, FDA-cleared 12-lead delivers that full picture in about thirty seconds, in the room, during the same visit.

What makes it workable for primary care is the read that comes with it. Preliminary interpretations are available around the clock, and a board-certified cardiologist can return a

full reading within roughly half an hour. That changes the calculus of offering EKGs in-house. The physician is not practicing beyond scope or guessing alone. The specialist backup is built in, and it arrives without the weeks-long detour a referral usually means. "If it crosses your mind to ask for a cardiology over-read," Beto says, "that's usually reason enough to do it." Here, asking is a single step, not a separate appointment.

That is the part that fits DPC most naturally. With time, continuity, and context, an EKG stops being a scare tactic or a referral reflex and becomes a baseline, a trend tool, a conversation. "Direct Primary Care really makes health care accessible," says Dr. Maryal Concepcion. "When we have tools that make our jobs even more valuable to our patients, we're able to give health care the way it should be delivered, no matter someone's ZIP code or income." The payoff, she says, is timing: "We're able to identify things before they manifest into emergency visits or delayed care. That's the power of access."

For physicians who make house calls, the same capability travels. A homebound or recently discharged patient can have a real 12-lead captured at the kitchen table, read remotely, and folded into the visit, instead of facing a trip to an outpatient lab they may never make. The device is light, pairs with a phone, and needs no shaving, gel, or adhesives, so the home setting costs nothing in quality.

None of this is a case for recording an EKG on everyone because the equipment is close at hand. The decision still rests on indication, risk, and shared decision-making, and a portable EKG never substitutes for emergency evaluation when a patient needs it. "An EKG doesn't replace judgment," says Dr. Jake Mutch, "but it sharpens it." Used that way, even a baseline pays off later. "Having a baseline matters," Mutch says. "It gives you something to compare to instead of guessing later."

The throughline is simple. DPC keeps care inside a relationship the patient already trusts. A full EKG that can be captured in the practice, and reviewed by a cardiologist without a referral, keeps the cardiac part of that care there too.

This article is sponsored by SmartHeart, an FDA-cleared, portable, hospital-grade 12-lead EKG from SHL Telemedicine. It captures a full reading in about 30 seconds and pairs with a phone or tablet, with preliminary reads available around the clock and full interpretations from board-certified cardiologists. Learn more at smartheartpro.com.



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The Practice She Left Corporate Medicine to Build

Dr. Dedra Beckles

Divinely Restored Health & Wellness, Long Beach, CA

Four years ago, Dr. Dedra Beckles walked away from corporate medicine. She called it a leap of faith, and she built the thing she left to find: a practice rooted in lasting relationships and real healing rather than volume.

That practice is Divinely Restored Health & Wellness in Long Beach, which she co-founded with clinical psychologist Dr. Adriana Westby-Trent. Dr. Beckles, a board-certified family physician with more than twenty years of experience, runs the medical side. Dr. Westby-Trent runs the behavioral health side. Together, they care for the patient most systems split into parts: body, mind, and spirit, under one roof.

Divinely Restored set out to change the story of who gets good care, and to shift what value-based care looks like for a community long treated as an afterthought. Dr. Beckles built it to serve whole communities, not only individual patients, reaching families across Orange and Los Angeles counties. The practice cares for patients across every stage of life, from young families to seniors. The work is openly faith-driven and openly about equity: a culturally safe space where every patient gets a fair chance at their best health, free from the fear of racism or discrimination. She describes her work simply, as healing, the way God meant it.

Inside the practice, that mission shows up as time. Direct Primary Care gave Dr. Beckles the room a packed insurance panel never allowed: longer visits, real access, and the freedom to treat physical and mental health as one conversation rather than two referrals.

“Patients describe a space that feels calm and welcoming, and first visits that begin with being met where they are, oftentimes with a hug.”

Because medicine and therapy sit side by side, a patient's stress and their lab work are read as parts of the same picture. Patients describe a space that feels calm and welcoming, and first visits that begin with being met where they are, oftentimes with a hug. They describe a physician who explains how the pieces connect, who helps



a patient see how hormones move A1c and cholesterol, and who makes them feel seen without judgment. Some of these relationships go back several decades from her time practicing in corporate medicine. Others belong to patients who searched for years to find a physician who looked like them and listened the way she does.

Year four has been a season of alignment. The practice transitioned to a Direct Primary Care model which has allowed Dr. Beckles to provide even deeper levels of healing with more time and greater coordination of care.

Through its foundation, the practice has participated in numerous community wellness events, an extension of the same conviction that healing is communal, not individual. The aim was never only to treat patients. It was to serve a community, and to restore something a fragmented system tends to strip away: dignity.

A line from Alice Walker runs through the practice: healing begins where the wound was made. Four years in, Divinely Restored is still building from exactly there.

Community driven. Doctor approved.

Visit her website! **WATCH HER PATIENT VIDEO!** at divinelyrestoredhealth.com



Hear Dr. Beckles on My DPC Story!



QuickTakes from Our Sponsors

Here's a rapid-fire look at the innovators backing this year's Battle of the Support Stack. These companies are helping DPC practices thrive with tools that actually work for doctors.



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