REIMAGINING Private Practice

Here are some lessons learned from direct care.

BY GRACE TORRES-HODGES, DPM

I am often asked how I got into direct care and what led me down this path in podiatry. When I opened my private practice in 2001, daily life looked much like it did for most of my colleagues at the time. These were the days before EMRs and eRx—when SOAP notes were handwritten, prescriptions were scribbled on pads, and the rhythm of practice felt straightforward and personal.

But as time went on, the practice of medicine started to change. Our profession was introduced to a wave of new requirements that, in retrospect, had little to do with the clinical care of patients: quality metrics, coding compliance, and the constant need to follow the rules to avoid penalties and maximize reimbursement. What once felt like the normal routine of practice slowly became dominated by administrative demands and insurance-related tasks.

With time, the writing on the wall was becoming clearer: declining reimbursements, mounting paperwork, and a system that made it increasingly difficult to focus on what mattered most: patient care. Like most, I found myself thinking, "There has to be a better way."

Like other doctors at the time who were becoming frustrated, I followed an old quote by Pavlov, which paraphrased basically said, *"If you want to find a new idea, read an old book."* I started to look at how medicine was practiced and delivered before third-party payors took center stage and realized that returning to those roots might offer a solution. The transition to a direct care model wasn't a leap of faith; it was a calculated decision, grounded in careful analysis and a willingness to accept some risk.

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When I first shared my plans with colleagues, I was met with plenty of surprised looks, and most doubted it would work. I had researched anything I could about cash-only practices and dropping insurance, including opting out of Medicare. Direct care in podiatry was not the norm, and the conventional wisdom was to stick with the familiar insurance path.

However, by 2013, I was feeling the effects of burnout—caught between declining reimbursements and mounting administrative demands. But even then, I saw an opportunity to return to a more transpar-

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THE *PM* FORUM

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ent, patient-centered way of practicing. Today, I don't contract with any third-party payor and have opted out of Medicare. There is now a growing number of podiatrists doing this, and our next generation of physicians are starting earlier to learn about it too. It's not about working harder; I'm working smarter. That's why I'm sharing my perspective here—not to claim there's only one path forward, but to offer an alternative to the conventional model that many of us were trained to follow.

If you're like me, you've probably checked out the annual *Podiatry Management (PM)* survey results and felt a mix of curiosity and concern. What has changed? What has stayed the same? And most importantly—where do we go from here?

As someone who's always appreciated numbers and data, I've been reading *PM* since my medical student days. I'm grateful to Dr. Barry Block and all the contributing doctors who have shared not only practice advice but also the kind of data-driven insights that help us make sense of where our profession is headed. The magazine consistently fosters a healthy exchange of ideas and encourages us to look beyond anecdotes to real trends.

With this in mind, let's see how a careful analysis of the numbers—whether it's annual survey data on patient volume, practice expenses, or changing demographics—can inspire us to rethink our approach. By learning from these trends and the lessons of direct care, we can discover new strategies to adapt, innovate, and ensure that podiatry continues to thrive in an ever-evolving healthcare landscape.

Stagnant Growth and Diminishing Returns

Despite our best efforts, the numbers just aren't moving in our favor. The 2013 *PM* survey revealed that solo DPMs saw a median net income decrease of 9 percent, with a notable drop in the average number of patients treated per week—down to 85.6 from 94.3 the previous year. Even though we invested more in equipment, staff, and technology, and boosted staff pension contributions, the return on investment remained flat or even declined. Fast forward to the 2024 survey, and the story hasn't changed. Growth is still stagnant when you factor in rising overhead and administrative costs. We're spending more—on EMRs, compliance, and new equipment—yet our take-home pay and satisfaction haven't kept pace.

Who Really Holds the Power?

It's not just us feeling the pinch. Our patients are facing higher deductibles, narrower networks, and increasingly complex bills. But when you step back and look at the system, it becomes clear why so many of us feel boxed in. The third-party payor sits at the center, dictating not only what services can be provided and at what price, but also who can access them and under what circumstances. In effect, the same entity is setting the terms for both the "buyer" (our patients) and the "seller" (those providing care, including us). That's a far cry from a true free market, where value and choice are determined by open exchange. Instead, we often find ourselves navigating a landscape where autonomy is limited and the rules can change overnight—rarely in our favor.

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Rethinking Private Practice: Five Points to Consider

1) Take Inventory and Define Your Vision

Start by looking closely at your patient base and practice patterns. Are your insured patients opting to pay cash for some services? Are you seeing more diabetic or elderly patients (as the surveys show is trending up)? Are you spending more on technology and staff just to keep up?

I remember running a financial audit and realizing that, despite the majority of my patients having insurance, their out-of-pocket deductibles and co-pays were increasing annually and many were choosing to pay out-of-pocket for their foot and ankle care. That realization was a turning point because it was a starting point for understanding what patients were willing to pay; it helped me envision a practice truly aligned with my community's needs. At the same time, the increasing influence of quality metrics and the incentives and penalties dictated by Medicare and commercial carriers led to a growing list of non-covered services.

This wasn't unique to my practice; it became a common experience with many of our routine procedures. We found ourselves having more conversations with patients about what their insurance wouldn't cover—discussing ABNs, explaining out-of-pocket costs, and navigating the awkward territory of non-covered care. These changes didn't just add administrative hassle; they fundamentally shifted the doctor-patient dynamic and made it clear that the traditional model was no longer serving either side as well as it could.

2) Communicate Change and Build Trust

As podiatrists, we have a unique advantage sitting right in front of us: our patients are a captive audience while we're working on their feet. This is an opportunity for real conversation—not just about their health, but about the frustrations they face with the healthcare system.

I made it a point to use this time to talk honestly with patients about their experiences and needs. We discussed the health insurance process once the claim was sent in. I reviewed the revenue cycle and delays experienced by not just our office but every office op-

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erating in that system. I found that many patients didn't actually know how the system worked, and walking them through the process—explaining how claims are submitted, how long reimbursement can take, and the uncertainty involved—gave them a new clarity. It wasn't hard for them to understand why I and others were looking for alternative ways to deliver care. And once explained, they saw it and could not unsee it anymore. It enlightened them and made them better consumers. This transparency made it much easier for patients to understand my position and, in many cases, even to this day, they are my biggest supporters and advocates.

3) Create Flexible, Transparent Pricing, and Navigate Procedures

Patients are tired of surprise bills and confusing statements. The surveys show they're willing to pay for clarity and predictability. Working outside of insurance restraints allowed me not only to be fully transparent about costs, but also to be flexible—bundling services, offering packages, and creating payment plans tailored to patient needs. I created a simple, transparent fee schedule for my most common services, and displaying prices in the office and online made a huge difference—patients valued knowing exactly what to expect, and the flexibility made care more accessible.

A common question I get is about surgeries. Many wonder if surgical practices can continue, and the answer is yes—I continue to do surgeries in my office, at ambulatory surgery centers, and at the hospital. You learn how to negotiate and advocate on behalf of your patient, often directly with facilities, other providers, and vendors. It's worth noting that there are now several tools with reference-based pricing in today's practice market to help you navigate and succeed in these negotiations.

4) Streamline Overhead and Reinvest for Patient Care

Revenue generated in a healthy practice should be reinvested back into the business—to improve technology, expand services, and enhance patient care. However, what I noticed (and what the *PM* surveys confirm) is that when overhead expenses—especially non-human overhead like equipment, EMR systems, and compliance costs—start to overshadow the resources devoted to patient care, there's a real disconnect.

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Even with the previously mentioned drop in median net income and patient numbers in *PM's* 2013 survey, many of us actually spent increasingly more on overhead. This included increased investments in new equipment, digital x-rays, EMR systems, and computer technology—costs that were often necessary for compliance or to keep up with technological standards, but did not directly generate revenue. Fast forward to 2024, and the trend has only accelerated, with practices facing even higher costs for EMR subscriptions, cybersecurity, compliance software, and required hardware upgrades. Many of these expenses were essential, but they continue to not bring in a dollar on their own.

In my insurance-based days, I watched as more and more of my revenue was funneled into administrative and operational overhead. There were days when it felt like the bulk of our resources went to chasing down claims, maintaining compliance, and keeping up with technology mandates—rather than to patient care or staff development. The administrative and technological drag was palpable, and it was demoralizing to see resources that could have gone toward patient care or innovation instead were being swallowed by bureaucracy and non-productive costs.

Transitioning to direct care changed that equation. My staff could return to dedicating their time and efforts back to the patients in our clinic: greeting them, educating them, and ensuring their experience was as smooth and supportive as possible. The energy in the office shifted from frustration to collaboration, and I could finally reinvest in technology and services that directly benefited my patients, not just the insurance companies or software vendors.

5) Monitor, Adjust, and Engage with Your Patients

No transition is perfect from day one. The key is to stay flexible and responsive. While I don't rely on formal metrics to track patient satisfaction, I do look at trends. I pay close attention to the number of referrals I receive—especially those that come directly from existing patients. In my experience, patients who aren't satisfied simply don't return or refer others, so a steady stream of word-of-mouth referrals is a true barometer of the care I provide. Financially, I look at the percentage of revenue return per charge—which is close to 100 percent—apart from convenience fees for card use or when I choose to provide charity care. This is a stark contrast to the insurance model, where delays, denials, and write-offs were the norm, and overhead expenses—often non-revenue-generating, like technology upgrades and compliance costs—continued to climb.

I also monitor my patient volume and have noticed that, while the number of encounters has decreased, my revenue has remained steady. That means more time per patient, but it's not just about longer visits—it's about the quality of time spent with each patient, and far less time wasted on charting, coding, and compliance. Perhaps most importantly, I've observed that patients genuinely value this model. When people have "skin in the game," there's a natural sense of accountability—they're more likely to keep appointments, follow through with treatment plans, and take ownership of their

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health. This leads to better outcomes and healthier patients overall.

Over time, I found a rhythm that worked for both my patients and my practice. The result? A sustainable, fulfilling practice where I can focus on what matters most: high quality, patient-centered care, delivered efficiently and with genuine connection.

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Lessons Learned

Direct care isn't a one-size-fits-all solution, and it may not be right for everyone. But if you're feeling weighed down administrative overload or a loss of work-life balance, I hope sharing my experience and the lessons I've learned from analyzing the data offers a fresh perspective—or simply lets you know that this model is out there. For me, reimagining private practice through direct care has brought renewed purpose and balance, and I believe it's an option worth considering for anyone looking to adapt and thrive in today's evolving healthcare environment.

Podiatry is uniquely suited for the direct care model. Our specialty serves a remarkably diverse patient population and offers a wide range of services—from preventive care and wound management to orthotics and surgical procedures—which allows for multiple avenues of revenue. Patients recognize the value of our time and expertise, and many are actively seeking a better, more straightforward approach to their care—just as we are striving to provide it. **PM**

Data sources: Podiatry Management 30th Annual Survey (2013) and Podiatry Management 42nd Annual Survey (2024)

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