Primary Care Cures

Episode 59: Dr. Brian Forrest

Ron: You know, most problems in healthcare are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high-deductible insurance that squeezes the docs and is totally inaccessible to most of the employees.

The big squeeze is always on for docs. It's the acceleration of costs, and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with host Ron Barshop, CEO of Beacon Clinics. That's me.

Ron: So direct primary care by the numbers is so impressive. We know that through Qliance data, which was a couple of years ago, 80% of surgeries are lessened because of a direct primary care relationship. 66% of radiology ordered drops and we lose 62% of specialist visits because of the upstream visits with primary care. 59% of ER visits drop, 30% of hospital stays less and we have an increase of 115% primary care visits when care is free paid by the employers. Direct primary care works, the average savings at Qliance was $1,486 per member savings, which more than pays for the cost of the member.

Ron: Expedia eliminated 20% of their overall spend with other data we have from other companies. Union Hospital, 16.6% year one 25% year two. Digital Globe saved the cost of the Next Era Health via the monthly membership fee. Digital Globe, saved $99 per member, which is more than the cost of the Next Era health membership fee and the city of Arvada 22 to 28% according to Paladena Health.

Ron: We could go on and on like this and a lot of physicians are calling for, let's do some peer based reviews of this cost to see if it's real or if it's fake. And the reality is at Harvard Business School, you're going to see case studies at Harvard Medical School, you're going to see peer reviewed studies. They're the same thing folks. In business, they're widely accepted as case studies. And in healthcare we widely accept peer reviewed studies. They're the same thing in America just from two different perspectives. Look, the bottom line about direct primary care is costs drop when care is friction free, that means copays and deductibles and factory medicine vibes and complex medications and premiums disappear. And you have a team approach case management system, which is what our guest has today, who he has trained over the last 13 or 14 years.

Ron: You have cornfield maze navigation and getting through this transaction care that we've created in America with direct primary care. And you have truth-based

answers in your clinical visit with your doctor versus misinformation you're getting from the internet. And finally you have engaging doctors and nurses who are no longer burned out. Direct primary care conferences are the happiest in the medical America and most importantly and I think where direct primary care is going to be going in the next 10 years, is to give a customer experience, give them back the power and knowing what to do next for the 99% of their life that they're not with their care team.

Ron: Today we have a pioneer of 13 years history with direct primary care, Dr. Brian Forrest, who is not only an associate professor at UNC Chapel Hill School Of Medicine, go Tar Heels, and he's also a CEO and founder of Access Healthcare Direct, which has been empowering physicians across the country in 34 states since 2007, consulting with hundreds of physicians on how to get into the business. He's won a ton of awards, but the one that sounded really interesting was in 2018 you won the Change Maker In Medicine awarded by Medical Economics Magazine a couple of years ago. Welcome to the show Brian Forrest.

Brian: Thanks a bunch for having me on. I appreciate you guys have me on the show. I will correct one thing. I'm actually older than you made it sound. I have been doing direct primary care now for almost 20 years. We didn't start teaching people about it until probably around 2007. But we actually founded the company in 2001 so we are going on our 20th year here very, very shortly.

Ron: You've had a unique viewpoint in 20 years then to see models that have risen and failed, models that have risen and morphed into something else. I think of IOR Health. Models that have sort of been blends of other maybe fee for service plus DPC, which just sounds like a terrible idea for a doctor. What have you seen that actually works? Is it rural care that DPC works best in? Is it the staying away from the cities and the rich neighborhoods? What ... I've seen you blog about different things that you think actually are. What makes DPC work in America?

Brian: Well, the truth is that a direct primary care is flexible. So it's a flexible model. So it will work in most areas. I've seen it be very successful in really, really rural parts of the country. I've seen it be very successful in suburban areas. I've seen it be successful in urban areas. Interestingly, I think one of the big differences between a direct primary care and concierge medicine is that concierge medicine is something that can be successful in a really, really affluent area. You could have a concierge medicine practice in Beverly Hills, whereas direct primary care really doesn't fly as well there.

Brian: So if I always think of it as concierge medicine is like a Ferrari. Most people can't afford it and don't necessarily need it. Direct primary care is like a late model Honda. Everybody can afford it and everybody needs reliable transportation. And so we're sort of like that quality care with that access at a price that most people can tolerate. So, the interesting thing is probably the least likely place for direct primary care to succeed is a super affluent community. Most everywhere else in

America, as long as there's patients around in a community, even if it's rural, it can be very successful.

Ron: Why has it not been universally successful? Were people charging too little? Were are they going after the wrong markets? We've had a lot of risen and failure eagles, that just sort of flew brightly in the sun for a year or two and then disappeared. What do you think is going on with the models that don't work?

Brian: I think there's been a couple of common denominators for the failures and the biggest one, if you wanted to boil it all down to one thing, it's when people pollute the model. It's a very simple model if you execute it that way. And what I would give you the example of is, it's a low overhead practice model. So you have, typically a good DPC practice is going to have lower than 20% overhead. The monthly fee is a almost always going to be under a hundred dollars a month. You're also going to have a fairly tight staff. Usually a one-to-one ratio with staff and providers and you typically don't file any insurance at all. And if you look at the failures, most of the failures have been people that either tried to hybridize their practice where they kept some insurance and they tried to be direct primary care for the other part of their practice.

Brian: Because what happens when you do that is that you still have the overhead associated with a normal insurance practice. You still have to have that four additional full time employees if you're filing and submitting codes. Whereas in DPC you don't and your revenue, if you try to hybridize, your overall revenue is lower yet you're maintaining that high overhead. So when we look at corporate models, Qliance was very successful with businesses when they took on 40,000 Medicaid patients and tried to bend the model. And I know the folks there quite well, who started that, they did not want to do some of the things that Medicaid, wanted them to do like, basically code even though they weren't billing Medicaid per visit, they wanted them to start having things like ghost claims where you're basically doing all the paperwork and all the bureaucracy even though you're not filing the claim.

Brian: And so, whenever any of these models try to look too much like a regular insurance practice, that's when they're unsuccessful. When they keep their overhead low, keep their pricing structure fairly simple, then they're very successful. And you've made the point earlier about employers. My personal practice, we've worked with employers where I've had 500 patients from one employer. But nationally in terms of our network, we've helped these practices develop over the years in all these different states. And one of the things we do now is help the employers find these local areas of direct primary care they can directly contract with. In fact, just yesterday we were discussing with an employer in the Charlotte area in North Carolina. This is a multi-state employer and they're going to work with about eight of our practices in the Charlotte area and each of those practices is probably going to get roughly a hundred patients where the employers pay in the monthly fee.

Brian: It's a self funded employer so their price comes down dramatically and a lot of times those guys can save 60 to 70% on their healthcare spend. Now you have to be careful because some people have the idea that with direct primary care, the employers directly contracting with the practice is the largest part of the practice and generally speaking it's not. So for direct primary care in general, usually the employer patient base represents about 10% of the patients, which means 90% of those patients are grassroots, organic customers that came from the community around the practice. It's not usually built totally from employer-based patients.

Ron: So somebody's coming to you ... Well first of all, how large is your network? You have several hundred?

Brian: Yeah, several hundred. Don't keep an exact count because it seems like it changes every day, but it's like 34 states. Some states may have as many as 25 or 30 practices. Other states may only have one or two. But it's really come together. We're a nice group of folks that we sort of collegically work together to try to do what's best for patients and keep our overhead down and that type thing.

Ron: If I wanted to look for Access Healthcare's network, how would I find it? Do I just go to my a DPC map in Houston, Texas and see how many of ...Are they called Access Healthcare in Houston, Texas?

Brian: Yes. That's a great question. So we're not a franchise. Although, back in 2005 I'll never forget, there were lots of people after we wrote our first article about the model and people started learning about it, people said, "You should franchise that." And I really didn't want it to be a franchise because the beauty of it is it allows doctors to be independent and, practicing medicine is not a cookie cutter art. So we didn't want everybody's waiting room to have the same colors and look the same. So rather than being a franchise, we encourage people to have different names. So there are some practices in our network that took on similar names like Access Medicine or things like that. But most of them came up with their own names. They're totally independent. We don't set any pricing structure.

Brian: We have guidelines of what we suggest will be successful. But everybody has their own individual business policies and practices and that type of thing. There's a lot of commonality, but it's definitely individuals within the network.

Brian: So you asked about a site where people could find that. There's a few different ones. Probably the easiest one that we have is if they go to AccessHealthcaredirect.com. At that site there's actually a mapper. It says find a DPC doc and you can click on that. We also have some apps as well that are in the iTunes store and Google that help you find a doc. But probably for right now that website would be the easiest place to find doctors in our network who are accepting new patients. So that's meant for a patient goes and they say, "Hey, I like direct primary care, I want to find a doctor like that." If they go to

AccessHealthcaredirect.com, they look for that, find a doctor, they're going to find doctors on there who are taking new patients who are working in this model.

Ron: Very nice. And then what I, it seems you have the training or a class that you'll do and you're going to give them access to your malpractice insurance company and you have access to your purchasing your supplies from, whether it's Office Depot or Amazon and they're getting the same discount you're getting. So you're passing on almost like a purchasing organization. Your benefits that you're getting into as a network to your new members that are joining the network. Is that about how it works?

Brian: That's exactly right. And we never intended to do that. This grew up very grassroots. The first year those articles started coming out, we would get like 200 emails a day from doctors saying, "Can I come spend a day with you at your practice?" And so we said, "Sure." And so people started flying in and they would spend the day here. We didn't charge a fee or anything for like a year and then realized that it was taking 20% of my time training doctors. So we still figured, okay, we're going to charge a fee, but we're going to add some services. So we hired a legal team of experts with Medicare compliance and contracting and things like that to help out practices. We started writing up business plans for them and strategic plans for how they would open their practice, helping them, consulting on their website design and everything else.

Brian: But you're right, we also realized there was a need for keeping the overhead low. So since we already had contracts with national labs, national medical suppliers and things like that, we essentially created a group purchasing organization for the network so that all of those practices that were in the network could join in those savings. And it's really been useful. Like the most recent thing we did was we got a national discount on a malpractice insurance.

Brian: Up until a year or two ago, if you were a direct primary care physician, the actuarial data says you're much less likely to get sued for malpractice in this model. However, the malpractice companies were charging the same thing. So I approached a some malpractice companies and said, "Hey, we're DPC docs. We spend more time with patients, we're less burned out, we're less likely to make mistakes according to actuarial data anyway, we're less likely to get sued. So what do you guys think about a discount?" So they agreed to that. And so now nationally, anybody in the network, all they have to do, even if it's their existing company, they go and they basically tell them they're part of this program and they instantly get hundreds of dollars off of their malpractice premium just because they're part of the network. So we've sort of added services over the years based on what people requested and what we thought would be useful for people to help them be successful.

Ron: Well on your website, and I'm confused about something Brian, it's, join the network membership is free. I don't see your economic model here other than

you're like a great guy that dropped from heaven. I'm trying to figure this thing out.

Brian: So yes, our network model is that we try to keep the cost as low as possible for anybody that's interested in resources we provide. So existing direct primary care practices that want to join the network, it is free for them to join. And the reason for that is that we take the fees from employers that are interested in contracting directly with practices and we use that to pay for our overhead costs now. We did used to charge a monthly membership fee and we had to do that to staff up and have the lawyers and things that we have on staff. And the other thing we charge for as a network is the bootcamp fee for direct primary care bootcamp.

Brian: For the first year we didn't charge anything for that, but we just felt like we had to do something. We were taking 12 hours or so of time and we were putting together business plans and strategic plans for practices. So we charge $2,500 for that bootcamp, which is an all day training session. We train the staff for the practice as well if they have medical assistants and that kind of thing. But yeah, if you're already an existing practice or if you feel like you don't need any mentorship or one-on-one training, you can join the network absolutely for free, as long as you're willing to see patients from employers. And generally all DPC docs want patients. So that's easy for them.

Ron: Oh, I'm confused about something that you said and maybe I misunderstood you, that employers are paying the $2,500 fee.

Brian: No, no, no, no.

Ron: Okay.

Brian: Yeah, no, no, no, no.

Brian: No, not for bootcamp. Well, that has happened. Again, it's been, we've been doing this a long time. So, we have had employers that have paid for doctor's bootcamp fee. Usually that's been a hospital systems that were healthcare systems that they wanted to start a direct primary care practice within their healthcare system and they would pay for the bootcamp fee. But typically the employers pay the network fee for people who just want to join the network. So let's say somebody says, "I'd like to join the network. If you've got employers who want to send us patients, I'd be glad to see them." Well, the employers say, "Look, for anybody that we send to one of those practices, we'll pay the network a very small fee." And that helps offset the cost that we have for sort of administration of the network.

Ron: Okay. All right, well I appreciate that a lot better than the first thing I misunderstood. So if we're talking about 1200 practices in America, which is what the map says, roughly 2000 doctors is my guess because many of the clinics have more than one doc or a nurse involved or a PA involved. I'm thinking to

myself, well that's not even moving the dial on the percentages of doctors, even though it looks like two or 3%. 20 years to get to two or 3% is not like a gigantic earthquake of a change. What is it going to take to get DPC to really become a major player in primary care? And is it a model that's out there that we know of today?

Brian: That's a great question. So people ask me all the time, they say, "well, why isn't everybody doing this?" Well, the truth is the growth rate is a lot faster than you think. Because remember, 20 years ago it was just me and almost nobody knew anything about it until around 2005. In 2005 there were still only about five practices nationally. In 2007 into the 2009 range, we wrote a lot of articles and there was a one in particular called Breaking Even On Four Patients A Day that came out in Family Practice Management. And ever since then the number of practices has doubled each year. You know, we were roughly at 600 practices total in the country, 18 months ago. That mapper may show 1200, but the truth is there's more than that because those are just ones that have been identified. There's pretty good evidence that it's doubling about every year.

Brian: And if you look at adoption of electronic health records, as an example, 20 years ago nobody was using an electronic health record and now 99% do. But if you look at the growth rate of direct primary care among independent doctors since 2009, it is a faster growth rate than EHR adoption. So I do think we're seeing a trend that for independent doctors I think you are going to see a lot of people doing it. I think it is the right model for that. It's hard for somebody in an institution who's employed to do it. It's hard for institutions since they take insurance, they have insurance contracts to make it work. I think what you're going to see is as more doctors leave the hospital systems and the institutions, that want to go out and do independent practice and new residents out of training order to do practice, you're going to see the model continue to grow and I think it's honestly going to be the dominant model in our independent physician workforce nationally.

Ron: From your mouth to God's ears as my rabbi would say. Hey, I talked to Tom Banning who is the executive director of the Texas Association Of Family Physicians and we had lunch about a couple of weeks ago and he is speaking pretty much to all of the family practice residents that are getting ready to get into the workforce. And guess what model they're most interested in.

Brian: I would assume direct primary care.

Ron: How did you know that? That's amazing. 80%.

Brian: How about that? What's interesting is I actually know Tom and have spoken at events he's been at before and he told me a couple of years ago that Texas was one of the fastest growing markets for direct primary care. Here's an interesting statistic for you. We've done polls for residents that have gone into primary care

to family medicine, and if you ask them why they decided to go into primary care, fully 10% of those residents said the only reason they chose primary care was because of the DPC model.

Brian: So for those critics who say that this may hurt the workforce because we have smaller patient panels, well that's not really true because we're bringing in more workforce of enthusiastic primary caregivers and we're also keeping people in the workforce. Because very often somebody will come up to me and say, "I was about ready to retire early and then I found the direct primary care model and I decided to stay in it and now I love practicing and I'm never going to retire."

Brian: So if we're bringing people into the workforce and we're keeping them from exiting early due to burnout, I think that's really going to help overall. You mentioned burnout earlier. Just so you know, we've been collecting data on practices over the last five years and we're getting ready to publish several studies. But one of those deals with burnout, and just as a teaser, compared to a traditional family physicians, the burnout rate is about 80% less in direct primary care practices. And we know that physicians that are less burned out provide better care with fewer medical mistakes. So I think that's one of the arguments we made to the malpractice company about getting discounts.

Ron: When you're ready to come out with those studies, we're going to do a show just devoted to those studies. When you're ready to do that, we'll put it on this show. We have a lot of people interested in this subject. So let's talk about, Paul Thomas is the guy that woke me up to the numbers issue that you just brought up with Plum Health. He went straight out of residency into DPCs. He's one of the young men you're talking about. Gave a Ted Talk, just beautiful speaker, beautiful representative for the movement. But I also then from him was led to Kirk Umbear and they both said the same thing about this numbers problem that is the biggest criticism, which is population health is going suffer because 600 people doesn't work. The math doesn't work. Well, Paul said there's two issues to think about.

Ron: Number one is how many PCPs are in the market. And I named a number and he goes, "No, no. What about the mid levels as well? The extenders." And I went, "Oh well, of course, now we're talking about 500,000." He said, "What's 500,000 times 600 in a cohort? That's America." He got me there. The math works and the other thing that Kirk Umbear brought it to my attention, we don't have a math problem. We have an efficiency problem. When you're studying your EHR more than you're studying your patient for a 30 minute visit or really a 15 minute visits more accurately, and half of that time you're typing away. You're not doing the job efficiently basically. So because you're seeing how many patients a day, maybe five or six a day?

Brian: Well, again, direct primary care is a flexible model. So I typically see 12 per day. Full patient panel for me is about a thousand to 1200. There are models where you

have 600 patients. Typically, I would say the average nationally, it's more like 800 to a thousand at least in our network. And that makes the manpower issue even less. But again, I think that's a good point that it is an efficiency problem and when you're able to spend 45 minutes with a patient instead of seven or eight, you can optimize their care. You can make sure they're getting their prescriptions filled, can make sure they're getting the lowest cost on anything that you refer them to so they can actually afford to get it done. And that keeps people out of the hospital and it keeps them out of the emergency room.

Ron: Let's disavow anybody going into DPC have any romantic notions. Let's talk about your fees that you charge for mom, wife and the kids. And then let's talk about, I'm sorry dad, wife and the kids or it could be a mom, wife, the kids too. Of course we're living in America, God bless America. But we're also talking about the hours. Are you instead of watching binge TV, having to answer texts all night long?

Brian: No. In fact, typically I would say that we get about one after hours call per month. And part of the reason for that is that patients know that we are accessible to them. And so, instead of having to wait a month to get in for an appointment, typically they know they can show up and we'll have room for them on the schedule the next morning so they don't have to call at midnight the night before. They're like, "Well I'll just go in there in the morning 'cause I know they'll get me in and see me." And so we really don't have a problem. People don't abuse the access. I think that's one of the big myths that scare a lot of doctors about DPC is they think, "Oh my goodness, if I go into a high service model like this, patients are going to expect they can call me all weekend long and they're going to bug me after hours."

Brian: And that just not true. It doesn't happen. And honestly, the patients that do call after hours, typically it's somebody I wanted to hear from. A lot of the telemedicine visits that I do after hours, I'm actually the one that scheduled them. A good example. I had a 72 year old man who had a cellulitis on his leg and we were going into the weekend and I didn't want him to go all weekend and me not take a look at his leg. So again, most people think a 72 year old guy's not going to do a telemedicine visit. But he was thrilled to death. He introduced me to his two dogs. His wife pointed the camera and showed me his rash and I'm the one who initiated that after hours engagement rather than the patient. So we really don't find that patients abuse it.

Ron: I guess you've trained your bootcamp attendees to blow a foghorn in the phone after 5:00 PM.

Brian: That's right.

Ron: Hey, so you have ... Rashes is an interesting question. You have a consultative approach if you see a rash, you don't understand. You can call somebody that has

maybe a stronger dermatological background or somebody who has a stronger hypertension background. If you have an interesting case or a stronger diabetes background, I mean I know you're actually a hypertension specialist so they'd probably go to you for that. But isn't that nice to have a network of people you can go to when you have an interesting problem and you want to put it out there?

Brian: Yeah, I mean it's very collaborative and in a system where we truly are being medical colleagues instead of worrying about what institution we're with or what health care network we're we're in terms of insurance and that kind of thing. People are collegial and they also have, the time to talk. It's interesting, I've had patients tell me before that, especially the ones that have gone to multiple specialists, that they've never had a doctor actually take the time to talk with all their specialists and make sure everybody was on the same page 'cause their doctor in the past never had time to do that. They only had that seven minutes instead of 45 to an hour. And I've even had times where I'd have patients in the room and I'd say, "You know what? Let me go call the specialist and we'll talk to them together on the phone." And there's just no time to do things like that, that's really good collaborative medicine in the fee for service, rushed model.

Ron: I have a theory about value based care. One of the people I respect in Texas told me that VBC, value based care is really at the top of the food chain for where primary care is going and then DPC, direct primary care is second in line and then all the rest follows, fee for service.

Ron: But I challenged him and I said, "VBC is on a capitation model that means, in fancy words, they're getting X per member X per patient and that has been a road to disaster. If you look at MRIs or basically anything in America, the capitation model is just, we'll lower it next year, month and we'll lower it next month and we'll lower it next year and we'll lower it next year. And it's just basically a hammering that's a slow death." Do you agree that the capitation models are essentially giving the power to the insurance companies and the federal government?

Brian: Yeah, I think that that's exactly the problem is that in any of the models where basically somebody else tells you what you're going to charge or somebody else tells you about how the relationship with your patients is going to be and you don't have any control over that, they're going to continually sort of exploit it. Fee for service or value based care, insurance companies are always going to try to push that number down every year. With the accountable care organization model, I told people from the beginning, I'm like, "Look, they're going to pay you more if you get under the limbo bar a little bit this year. But guess what? Every year that limbo bar gets lower and lower and at some point you're flat on the ground and when they can't give you those bonus payments for, quote unquote, value based care, then you're back where you were or behind."

Brian: Because what they've done is they've decreased your fee for service payments while they were giving you those value-based bonuses. And once you can't achieve the metrics for the value based bonuses anymore, they've got you right where they want you. They've got you at a much lower fee for service rate. So, I think truly direct primary care is a value based model. It's the real value based care because it's the value that patients and employers put on the relationship between the patient and the physician, which is where we get most of the clinical care done, not at the administrator's office or at the insurance company.

Ron: I have a question about COVID-19. This is so much in the news and we want to put this out there as soon as we do this interview. So this will be out there today or tomorrow, but we're in the middle of March right now. And the President was just on TV and well-respected epidemiologists and public health experts are basically saying, "This is a public disaster." We already know it's an economic disaster in the making. Tell us what you're seeing in North Carolina from your perspective of as a primary care physician and the master of the universe of a much larger network. What are you seeing that we need to be aware of and, and the primary care world?

Brian: Well, it's been really interesting. There's been a lot of changes even in the last week. A week ago, we were not where we are now. We've had a outbreak here in the county where my practice is. So things have changed a lot. First I would say that I think a lot of primary care practices are going to be pushed towards wanting to do virtual visits. They're going to want to make contact with people without having to see them face to face in the office because that may actually increase the risk of contagion, especially to older adults. I mean, the last thing I want is for my hypertensive, high cholesterol, diabetic patient who's 70 years old, to come in and see me for a followup appointment in a practice where coronavirus could have been hanging in the air for three hours. So we're currently working on policies and things that we're going to send out just tomorrow to patients basically notifying them of how we're going to be taking care of them through this.

Brian: The interesting thing is, for direct primary care patients, it's going to be terrific in some ways because their doctors were already willing to embrace technology and reach out to them virtually. And a lot of direct primary care physicians don't charge for telemedicine visits. They just include it in their monthly membership. But good luck to you, if you're a patient in an insurance practice and you're trying to see a physician and they aren't having office visits and office visits are the primary way they get paid, it's going to be very difficult, I think for fee for service patients to access care in the near future. And I think that the DPC community is actually going to be a little better suited to handle it because we're used to engaging patients wherever they are, whether that's at their home or on the phone or however we do that, 'cause we're available to them on a retainer basis. We don't have to have them come through the door to keep our revenue model going.

Ron: Let's talk about the advice you would give a patient or a doctor that works in your network to give a patient if they feel sort of symptomatic and then actually symptomatic. They're having the shortness of breath, they're having the sore throat, they're having all the indications of a really severe flu. What are you going to tell that doctor to tell the patients?

Brian: Great question. And in fact I got asked that just today. I was on a network call earlier today with four network doctors and that was the question they put to me. They said, "Literally, we want you to send us a copy of what you're sending out to your patients." And I told them I wasn't making it up myself. I was looking at a lot of resources I got from other physicians in the area. But essentially, I think the strategy we're adopting is we're trying to keep the people that are highest risk away from contact, not only with crowds, but also with medical care. We want to keep those vulnerable populations out of our office. So we're going to be notifying them that, if you're in that risk group, that if you've got a followup appointment, we're going to be moving it three months forward.

Brian: We're just automatically going to take your appointments and shift them three months forward and we'll reevaluate that as time goes by. And for the patients who are younger than that vulnerable population, if they call us and say, "I've got flu like symptoms, but I'm feeling okay, I'm not short of breath." We're probably going to tell them they're better off staying at home and not coming into the office. If they tell us they're short of breath, well then by definition they've got something they have to be evaluated for and given the possible prevalence in the community of COVID-19, we're probably going to direct them to go to a hospital if they're short of breath and have those symptoms because they're going to be somebody that needs to be tested immediately and they may need a respiratory support.

Brian: So most of the patients we're actually going to encourage to come in, at least for the next few weeks, are going to be people who don't have those respiratory symptoms, who aren't sick enough that they need to go to the hospital and who aren't in a vulnerable population. If you're a 40 year old who sprained your ankle, we're probably going to be seeing you in the office. But if you're a 70 year old who needs to come in for a diabetes follow up, we're going to be pushing that down the road. So that's generally the strategy that we're adopting to protect the patients as much as possible and still provide access for those who are lower risk.

Ron: I think you said something important. If you do have this and you have help at home, you're not going to get much better help at a hospital. You might as well just stay at home and not spread. Right? I mean going to a hospital ...

Brian: That's a great point. Even if you have the flu or even if you have COVID-19, coronavirus, if it's not bad enough that you're going to need respiratory support, like from a hospital, you're much better off to stay at home hydrate, make sure your nutrition is good and take care of yourself at home, then get out and possibly

get exposed to something else. I think that's going to be the safest way to handle it.

Ron: Good sound advice, Brian. Thank you. Do you have concern over critical medicines? There's some something like 156 that are already in short supply in America. We're getting them from India and China primarily. And that supply chain is broken. What happens when a renal failure start because we don't have the medications for 600,000 people that are reliant on those medications?

Brian: Ron, I think you're right. I think it's a huge problem. I think that if anything, this is exposing our vulnerability to supply chain, not only for medications but other technologies. And I'm hoping that there's enough stock and there's enough regulatory loosening to speed up the supply chain. That we're not going to have true shortages that are life threatening. But if we got into a situation, for example, where a patient with diabetes couldn't get their insulin, that's what it would be. It would be a life endangering shortage of medication. So, in the same way that we talk about being fossil fuel independent, we need to think about what's more critical to our daily life. And for a lot of people, medication is more critical to their daily life than fossil fuels.

Brian: So, looking at trying as much as we can to become independent in terms of our medication supply is a good idea. I know that a lot of direct primary care physicians actually stock medicines in their offices and dispense from the office. So that they can keep patients from having to go to the pharmacy. I know that we do that. We keep medicines here so, even if we do mail orders, 'cause sometimes mail order's great option. That way you don't have to go to a pharmacy and mail order pharmacies a lot of times have a better chance of having something.

Brian: But you're always worried about that first dose. So if somebody is here in my office today and let's say they need an antibiotic and I order it from a mail order company and it's not going to get there until tomorrow, what I do is I keep those first doses in the office so I can just hand that dose to the patient while they're here, get them started. And that way they're not going to have any kind of delay in getting their medical care, whether it's mail order or whether there is a short supply. If somebody was to come in tomorrow and they needed something and we found out their pharmacy couldn't get it, I would probably just give them whatever I could scrounge up at the office.

Ron: Yeah. In Texas, I'm exaggerating when I say this, but in Texas they'll put you in handcuffs if you try to dispense medications.

Brian: Yeah, it is a problem there. You're right. There are some regulatory issues in some states with dispensing from the office for sure.

Ron: This is just such a fascinating discussion and we didn't really get to touch, but 10% of it, I'd like to do this again sometime soon. We really learn a lot from

people that are the George Washington of a brand new movement. You know what nobody's tracking Brian? Nobody's tracking how much direct contracting is going on in America. So we know Walmart is direct contracting now with centers of excellence, so they're going to surgery centers. They're going directly to imaging to of course, pharmacy. They have access to wholesale rates. But anytime somebody does that, the costs drop. Walmart saved $1 billion on a $4 billion spend. That's a lot of money. That's equivalent of 1500 stores they would have had to open last year with their margins.

Ron: So nobody's tracking how many employees in America, we know half a million or so or maybe to closer to a million are direct primary campus patients and members. We don't have any idea how many are direct contracting through the likes of Walmart. Do we?

Brian: Yeah, I don't know that number. And I think that you have to also add, you mentioned Paladina earlier. There's a lot of onsite clinics, and onsite clinics sort of count in that too, 'cause that's direct contracting. Just onsite. So I don't know what that number is. I know that it's a lot more than people think. Just two weeks ago we brought on an employer with 44,000 people that's going to be spread out across the network. When an employer gives you that many patients, obviously they have a lot of faith in what you can do for the health of their employees and also for the cost. So I think, there's an underestimation right now how much direct contracting is going on.

Ron: Yeah, it's big. It's something that needs to be tracked because it's a big part of our healthcare economy and of they drift away from the insurance companies into the direct model, that story's not being told properly in my opinion. Okay. Well thank you. How do people find you and find the bootcamp if they want to sign up?

Brian: So the easiest place to find us is AccessHealthcareDirect.com. We also have a shorter and easier to remember website. It's actually for one of our apps, but you can also get to us through that. It's AHDRX.com and if people want to send email they can send email to BrianForrestMD@Gmail.com and that's Forrest with two Rs. BrianForrestMD@gmail.com is probably the easiest way to directly get me. I will warn people that there are many days that my, I get 200 unique emails. So sometimes it takes me a little while to get through to them, but I do eventually. So just be patient.

Ron: Where else are you going to be able to get the private email to the George Washington of a movement but this show folks? That's the free bonus you get today. Thank you. Brian. If you could fly a banner over America with one message to Americans, what would that say?

Brian: Wow. That's a tough question. I wish you would have prepared me for that one.

Ron: You can talk your way until you figure it out.

Brian: I think if we all persevere through flexible innovation, we can improve the healthcare of all citizens.

Ron: And there you go. Thank you again, Brian Forrest. We'll look forward to our next show with you and when that study comes out, we hope we are right there in the middle of it. Thank you.

Brian: All right. Thank you Ron.

Ron: Thank you for listening. You want to shake things up, there's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes, or wherever you get your podcasts, and subscribing, and leave us a review. It helps our megaphone more than you know. Until next episode...