Primary Care Cures

Episode #25 - Dr. Paul Thomas

Ron: Most problems in healthcare are fixed already. Primary care has already cured, on the fringes, reversing burnout, physician shortages, bad business models, forced buy outs, 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 us, Ron Barshop, CEO of Beacon Clinics. That's me.

Ron: PCPs have a moral imperative to be happy. We all do. Lives depend on it, including their patients, and their employees, their whole universe, in fact. We can all make the jump that burnout is directly linked to earnings. After all, the worst compensated doctors correlate directly with higher burnout rates, and it's the model's stupid. Residents start exhibiting burnout after day 20 of their residency, and by the end, 75% have experienced it. Practicing docs at any given time, 35 to 75% are feeling burnout. It's the model' stupid. The profession is awesome, and the two fixes to the model will eliminate burnout. Today, we deep dive into one of them. Because comp is 100% determined by a lousy model, and the model is not fixed unless that's fixed, every primary care leader simply has to seriously pursue either ancillary income opportunities or direct primary care, DPC, today's expert. It's the only model work around that is fast, easy, sensible from every angle, whether you're the payer, the patients, or the providers.

Ron: In this case, the payer is the patient for DPC. Today's guest made that call very early in his career, and we're going to both be telling you to stop feeling sorry for yourself, and these are hard words to hear, but there, I said it, because you can take control by helping more patients with incredibly convenient ancillaries or switching even part of your practice to DPC. We're going to explore that. On a personal note, I expect to open a DPC clinic or two in the next year or two. So I'm a fan boy of the model. I'll just say that right now. Our guest is a TED Talk sensation. He promotes DPC, Dr. Paul Thomas, welcome to the show.

Paul: Ron, thanks for having me on. This is great to be here.

Ron: Well, we want to get the platform out there, because it is a solution that not as many should know about that should know about it. So let's talk a little bit about your history, and how you discovered it, got into it, or did you just go straight from medical school into direct primary care?

Paul: Well, when I finished, I heard about the model during my medical school and in my residency. So I did residency after med school for three years in family medicine. And my last year of residency I did a little road trip and visited two really successful direct primary care practices. One in Wichita, Kansas, Atlas MD, and one in the Greater Denver-Boulder, Colorado area. And that's Nextera Healthcare. I really took the best of what they're doing back to the Detroit area. So when I graduated from residency, I pretty much immediately launched my direct primary care practice and started serving my community with affordable and accessible healthcare.

Ron: Do you know any DPC docs that have burnout?

Paul: Well, I mean, I don't know. I guess I don't know them personally well enough to say, "Oh, this person's definitely burnt out," but I can speak from my own personal experience that I definitely had feelings of not wanting to practice medicine in the fee for service system, feeling fatigued every time I went into the office, and not really being focused on caring for my patients because of all the bureaucratic barriers that I had between myself and my patients. And it's a huge relief to be in the direct primary care model. I would say I work even harder in this model, but it's actually compelling work, because every time I work for my patient, it directly impacts their health. And so it helps me stay focused and take care of my patients the way they should be taken care of. I know I didn't directly answer your question, but I think me personally, my kind of symptoms of burnout, as you might say, are way less in this model.

Ron: It's an interesting thing that should be studied. I would bet DPC could attract a lot more doctors if we could show that burnout is negligible.

Paul: I would just say join us at our next conference. The direct primary care docs typically meet up three times a year. There's the AFP Direct Primary Care Summit. There's the Nuts and Bolts Conference put on by Dr. Lee Gross down in Florida in November every year. And it's a conference like no other conference you'll attend, because the doctors are smiling, engaging. We actually know each other reasonably well. We have a great time together, and I think the proof is in the pudding if you come out to one of these conferences and see how we interact with each other.

Ron: Great Resource. We'll put that in the show notes for sure. Okay, I have one jib, one jive against direct primary care and all the rest is good, good, good. So from the patient's perspective, it's unquestionably a better model because you're not shuffled in and out while somebody's on an EMR, because they've got to get paid. They've already been paid. It's prepay. The second issue is from the doctor's perspective. We'll be talking more about this, but clearly the model works because you're not pressed into volume and into fee for service pressures that are created when you're having to deal with the insurance companies. Obviously, there is no

more billing and coding issues or chargebacks, because that just simply doesn't exist in direct primary care.

Ron: But here's my concern. If every doctor went into direct primary care from primary care like you did, we would have essentially a cohort to 500 to a thousand patients versus the 2,500 to 5,000 that typically a primary care practice has as its census, which would mean for public health that would be awful, because there simply wouldn't be enough DPCs to go around. There would simply be a massive shortage of care, which is already starting to show itself and certainly in rural areas. But for sure it's going to show itself, even now in the urban areas where doctors are plentiful, because they're all booked up. I mean, you simply can't see more than you can see. And this is a second question really, is it's an affordability issue. There's 55% of Americans can't put their hands on 1000 bucks, and to ask them to have an insurance copay and deductible plus this, or even if to substitute for this so they just opt out of their plan. A lot of people simply can't afford a hundred, 150 bucks a month.

Paul: Yup. Okay. So here's my answer to those questions. According to the AHRQ, Agency for Healthcare Research and Quality, there are about 240,000 primary care physicians in the United States. That's as of 2010. Then according to the AAMC, the AAMC, they project a shortage of 100,000 doctors by 2030. So we need 100,000 more doctors. Now, there's some other studies that have shown that doctors are spending more than half of their time on nonclinical tasks like the bureaucratic things like checking boxes, sending in prior authorizations. Doctors are spending more time taking care of their EMR than they are taking care of their patient. So I would say we don't have a physician shortage problem. We have a physician efficiency problem, because we really need a 25% increase in physicians according to this data. But really, if you think about it, we just need a 25% increase in our efficiency, and we'd be able to take care of the demands of a growing and aging population.

Paul: So the other part of this is if we demonstrate that primary care is actually a desirable field of medicine, then more and more residents will choose family medicine and general internal medicine and pediatrics over the traditionally more lucrative specialties like, let's say, the road to happiness, radiology, ophthalmology, anesthesiology, and dermatology that are so highly coveted. Those are highly coveted because they come with a high income, they come with steady office hours. And if we can demonstrate that direct primary care physicians can have a really high quality of life, a higher income, and greater satisfaction from taking care of a fewer number of patients, we're going to see more medical students and residents choosing family medicine and that will help allay our physician shortage.

Ron: Thank you very much for that very clear and cogent answer. It's amazing that in my grandfather's generation, 70% of residents chose primary care. In my dad's generation it turned down to 30%, and today at 16%, and my son and daughter-in-

law both graduated from top five medical schools, and in their class of 200 only 2% chose primary care, and many of those might even not even choose it later. In other words, they can get out of the residency and go to fellowship. And I watched the match day numbers when they came in. Match day this year, the top schools were getting close to 8%. So I don't even think it's 16% anymore. You're arguing that income's higher. Let's talk about your income or just the income in general of a DPC. Is there any statistics that we can share with the audience?

Paul: I think the movement's so new at this point that there isn't going to be that great of data about income. One thing I will say is that nothing pays like autonomy. I have the ability to take care of my patients on a time schedule that works for me in a way that works for me. Oftentimes, I'll have a couple half days a week off where I can just spend time with my family and still carry a patient load of, right now I'm around 450 patients, and I can answer texts and emails from home and really work on my schedule for my patients or whenever they need me. And the income is right now by myself, 450 members, I'd be making roughly what I would have made if I were employed and turning out 25 to 30 patients a day. Right now I'm seeing about four to eight patients a day on average. So there's no question I have greater autonomy. I feel way better about the practice of medicine. I feel way better about the quality of care that I'm delivering to my patients, and I'm leaving each day satisfied with the work that I'm doing. If I can make more money in this model by adding more patients, that'd be great. But even if I stopped adding patients as of today, I'd be really happy and satisfied with my choice of pursuing this direct primary care model.

Ron: As will your family, and then probably your employees. Let's talk about that. It seems self-evident that the employees are also going to be happier, more satisfied, unlikely to leave. You're not going to have a turnover, because they're dealing with lower volume, and they're dealing with less stress, and they're coming home not exhausted, unable to feed their kids because they're wiped out.

Paul: Yeah. Right now, I currently operate everything by myself. So I have no staff, no employees. I have a one room office. Sometimes I have PA students, and medical students, and nurse practitioner students rotate through my practice to help me with some note writing, et cetera. But really, I'm doing this on my own. Over the next three months, I'll have a new doctor joining me. She's starting on July 1st, and then at that point I'll probably hire a medical assistant to help with some of the faxes and things like that that we receive. So I can't really speak to how my employees are feeling, because I don't have any yet. But probably in a year we can touch base about that and I can let you know all about it.

Ron: We will be following up for sure. Hey Paul, the unusual thing about your story that you started fresh out of medical school with zero patients. You didn't take over an existing practice.

Paul: Yeah, it started out of a residency. Yep.

Ron: So typically I would imagine a practicing doctor with a cohort is going to take a percentage of those on that can afford to make the payments. Is that unusual that you started fresh green and with no patients?

Paul: Yeah, I'm relatively a rare bird in the movement, so to speak. There aren't too many doctors who've started straight out of residency, but there are a few. Nick Thompson with Antioch and a Luke Van Kirk with Command MD, and then Alison Edwards as well. She's a Kansas City DPC. So there are a handful of us, a few of us, but it is uncommon to start fresh. And then I did my training in Western Wayne County, and I started my practice on the east side of the county in Detroit. So I had zero patients follow me over. Basically what I did to build up my practice was I really leaned heavily on social media, and blogging, and traditional media opportunities that I earned through speaking at like TEDx, or just meeting journalists in the community and talking with them and telling them my story. All of that organically allowed me to grow a practice where two years and four months into it, I'm up at about 450 patients.

Ron: So let's talk about telehealth. How does that play into your model, if at all?

Paul: Well, I leverage texting, emails, phone calls, video chat as much as I can to help my patients with the care that they need when they need it. I don't try to shoehorn everyone into a traditional office visit, and I see people in the office when they need to be seen. So it allows me to take care of my patients in a more efficient way and in a way that's better from the customer experience perspective. If you've been out in the woods and you came into contact with some poison ivy, you now have rash. I can quickly call in some triamcinolone or clobetasol, depending on the severity, and maybe some prednisone, and have you follow up with text messages until you get back into town and then I can have you visit our office. If somebody is up north and they get poison ivy without that component, they'd have to go to an urgent care and spend another $100 and then $50 at the pharmacy or whatever. So I really try to help my patients as much as possible. People text me for a med refill. Hey doc, I'm running low on my Lisinopril. Great. Come in, we'll get your blood pressure. It'll take five minutes, and then you'll walk out with your prescription in hand. That's the kind of convenience that I want to provide for my patients.

Ron: Has anybody studied population health of DPC patients?

Paul: Yeah. That's, again, I think the movement is so new that there's not going to be robust studies. But I would say look for that to come out. I think a Qliance out in Washington state may have published some information, but you'd have to check me on that. Dr. Erika Bliss, Qliance. They may have released some information because they were working with larger health insurers, and taking care of part of their population. So you could look into that. I don't think the data is going to be as robust at this point.

Ron: I don't know if DPC has a website that patients can go to a portal that if I live in Houston I can find my doctor and the list closest to me. I'm assuming that you're all unified and have some sort of a unique portal for direct primary care to find patients?

Paul: Yeah, we're loosely affiliated. I wouldn't say we're all unified. Once you see one DPC practice, you see one DPC practice. They're all unique in how they approach patient care, and how they ... each doctor has their own strengths and weaknesses. You may find someone who's really good with geriatrics or sports medicine or adolescent health. Doctors are also going to charge different prices. The best resource to find out where DPC practices are located geographically is the DPC Frontier Mapper. And so that is, I believe it's Mapper.DPCFrontier.com. That has a updated map of all the direct primary care doctors across the country. Really interesting, when I started my practice in November, 2016, there were probably about 400 practices, and right now there's 1,038 direct primary care practices in 48 states and Washington, D.C. So it's really interesting. Check out the map. It's put together by a DPC doctor, Phil Eskew, who's also a lawyer, very knowledgeable in this space, and he's done everybody this great favor by putting this information out on his web page. It's really awesome to look at.

Ron: I can't imagine why the other two states don't have any.

Paul: It's North Dakota and South Dakota. So you could say the population is pretty low or spread out. So maybe it's coming. Maybe somebody brave will start one up there. If you want to find us, we're Plum Health DPC in Detroit, Michigan, and we're on the map. Pretty exciting.

Ron: Plum Health as in the fruit.

Paul: Yeah, plum and P-L-U-M Health. Plum Health DPC. And that DPC is for direct primary care.

Ron: All right. If I'm a doctor and I'm considering switching over, and we're only talking really to primary care doctors here, what website, what videos, what books should I be reading and learning from?

Paul: Well, I put out a book about this: Direct Primary Care - The Cure For Our Broken Health Care System. It really just walks through the ethos behind direct primary care, why I did it, and how it can be beneficial for you as a patient, as a community, as a physician. So if you want to dip your toe into the pond and kind of take a look at a day in the life of a direct primary care doctor, that's there. I also really love the AFP DPC Summit, as well as the Nuts and Bolts Conference in Orlando, Florida, put on by Dr. Lee Gross. Those are great, because it gives you the most updated information on how to start a direct primary care practice. And I'm working on something to help doctors with this question, because I get more often than one might think. And I do some consulting for doctors starting their

own DPC practices. So I'm trying to take all those consulting sessions and all that knowledge that I've built up over the last three years and put that online for doctors to use and interact with. So that's going to be coming. Startup DPC is in the works.

Ron: So other than my irrelevant question earlier about population volume, are there any downsides in any possible way for DPC from the patient perspective? Well, I guess the insurance companies lose big, but do we really care about them? I don't think so. But is there any losers in the world in DPC if DPC was spread everywhere?

Paul: Well, I would say insurance companies actually win, and if they're really smart, they could even win bigger, because if they identified really successful direct primary care practices like mine, and then discounted their members percentage of my membership fee from their insurance premiums, they would know that they've got an on-call on-demand doctor, and I could prevent X-number of urgent care or emergency department visits per member per month, and it would be really a cost saver for them. So I think eventually you're going to see more and more insurance companies get on the bandwagon.

Ron: Boy, I hope you're right. I can't imagine that happening. That's just, that seems to me impossible that you're asking an insurance company to discount a premium for any reason, good or bad.

Paul: Yeah. Well, one can hope, and I'm an eternal optimist. I think it's, with them, the realm of possible. The other thing that's coming out is one challenge we have right now is vaccines. Vaccines for children are relatively expensive. At this point I send folks to the county or city health department to get their childhood vaccines. And then some adult immunizations are really inexpensive. Like TDAP is $45 in our clinic. If you're traveling abroad a typhoid vaccine might be $80. So vaccines are a bit of a weak point. But I'm excited for the free market to try to fill in that space, create some free market options for docs to get at-cost vaccines for their patients. We can, at this point. But like ordering, usually you have to order 10 at a time. So if you're ordering 10 MMR vaccines, it's going to put you back $700, and then you might get stuck with a few leftover. So that's kind of a weak point.

Paul: But other than that, I think the direct primary care model is very strong and can help folks of all ages and stages and deliver an affordable, accessible healthcare option. And there's just so many people left behind in our traditional system, especially those folks who are making too much money to be enrolled in Medicaid. Like the cutoff for Medicaid is about $16,000 in Michigan. So if you're making $17,000, or even $25,000 or $30,000, you probably disqualify yourself for Medicaid, but then probably can't afford a health insurance premium of $300 or $500 a month. So in terms of serving folks that are underserved, medically underserved, this is a great model as well.

Ron: Do you have a pharmacy in your clinic? Because I heard you say sometimes they'll come in and they'll get their meds right there.

Paul: Oh yeah, absolutely. We have a pretty full medication closet. Let's say I dispense medication out of my office. I wouldn't call it a pharmacy, because I don't have a pharmacy license. I do have a physician's dispensing license, which in the State of Michigan allows me to dispense medications out of my office. So what I do is I buy, let's say you need metoprolol for high blood pressure. That might be $5 or $10 at the pharmacy, but when we buy a bottle of a thousand metoprolol, it costs about 20 bucks. So you're getting that medication for two cents a pill.

Ron: Very nice.

Paul: Or 60 cents a month if you're taking it once a day, $1.20 if you're taking it twice a day. So we can save our patients, we're saving our patients thousands of dollars each month on their medication costs alone.

Ron: Do those numbers follow for Albuterol, and then insulin, and other common drugs?

Paul: Not for albuterol. Albuterol, the cheapest I'm getting is about $40 with a coupon from GoodRX, which I help my patients figure that out and get a less expensive albuterol by getting those coupons. I am able to get free insulin from certain manufacturers. So I go to Nova Nordisk, and I have Tresiba and Novolog, and I have stuff like Victoza, et cetera, to help my folks who are diabetic manage their blood sugar and hemoglobin A1C and keep them in check with those.

Ron: Do you find that because of the time you're able to spend with four to eight patients a day, you're talking more wellness, you're talking more preventative care, you're talking more precise medicine than somebody who has 10 minutes, 15 minutes?

Paul: Yeah, most definitely. When you have an hour for your first patient, the first time you meet a patient you really get to know who they are as a person and figure out are they going to take this medication, or is it going to be too cumbersome, or too expensive, or will they go through with this therapy plan or plan of care? It really helps you to understand who they are, what makes them tick, and how you can meet them where they're at and help them to get them to the next step in terms of their health and wellness journey. Because a lot of times doctors in the fee for service system, they just don't have enough time to really get to the root of the problem, and when they do, it's overly prescriptive where you must take this because you have this, and it doesn't allow for that good back and forth where you actually figure out if the patient's going to take it or going to follow your care plan, because they might've tried in the past, it might not have worked or there might be a cost barrier, or some other barrier either physical, emotional, mental et cetera, that's keeping them from following that plan of care.

Ron: The last numbers I saw showed adherence at 6% of prescriptions being followed. The numbers before that a couple of years ago were 16%. So five out of six, and then maybe even more, patients aren't even taking their meds as they're supposed to. If they're not taking them at all, they're usually, it's a financial issue. They can't afford them and I think you've cracked that nut.

Paul: Yeah. For, let's say, 90% of medications, we've really lowered the cost. There are some, the brand new meds that haven't gone generic, are still going to be expensive, and the albuterol's and the insulins of the world are a little bit more challenging. But we do what we can to help our patients in a meaningful way.

Ron: So you get to fly a plane over the world with a banner on it, or you get to buy a billboard that the whole world is going to see. What is your message to the world?

Paul: Oh man, that's a tough one, man. I don't know. Stop throwing plastic in the ocean. I don't know. That's a big problem. But in regards to the health care in the United States or health care, and for me, I'm really focused on delivering affordable, accessible healthcare in the City of Detroit, and trying to bring care and access to folks who have been traditionally locked out of a system, because the fee for service system disincentivizes primary care. So if I were to send a message to our broader community, let's make our healthcare prices transparent, let's give people options in terms of finding care at the right costs at the right quality to really help people get through their conditions and live their best lives.

Ron: I tell you, I'm super excited about this initiative by POTUS to require transparency of the hospitals and insurance companies disclosing all their backroom deals, because that is just ... sunlight is the best thing for a disease, and this is a disease for sure.

Paul: Yeah, totally. I think people are always shocked when I say that, oh, I'll test your cholesterol today. And they're like, well, how much does that going to cost? And I'll say it's $6, whereas they would be paying $150 through their health insurance. It gets crazy. The cost inflation in the system that really hurts individuals and families and in my city, our country, our states. It's a shame, and I think when all of that is exposed, people are really going to wake up to the fact that there is a better alternative for getting medication and lab work and imaging studies at a reasonable price.

Ron: My God, if I'm in a hospital and I'm only spending 150 bucks for those labs, that's not going to happen, right? They're going to be charging $600, a thousand bucks for the same that would cost you six bucks.

Paul: Oh, but definitely, if you're hospitalized things are much more expensive. But even just going to their affiliated clinics, getting the blood draw, having it sent back to the mothership, you're going to get a big bill for those.

Ron: Yeah. And affiliated clinics is now 55% of all PCPs. They've been forced into selling their businesses, because they just ran into too many obstacles, and DPC apparently wasn't an option for them at the time. So folks, the simplest thing I can advise if you're a primary care is you got to look at ancillaries if you're going to stick with your current model, or you've got to consider either DPC going full on or partially, because you can blend it into your practice. And remember, please don't use plastic anymore, because Dr. Paul Thomas wants clean oceans and so do I. And so do you.

Paul: Yep.

Ron: Well, Paul ...

Paul: Got to save the wildlife here.

Ron: Yeah. Well, we don't want our fish, our salmon on our plate to have plastic in it. So thank you for your time, Paul. We'll check in with you again when DPC is 2,000 and 5,000 and growing, and maybe even the day South Dakota, North Dakota will crack open a bottle of champagne.

Paul: Yeah, it's only a matter of time, because as time goes on, more and more people are waking up to the reality of direct primary care, and the good things that it can bring docs, patients, families, and communities.

Ron: Okay, thank you Paul. We'll check in with you again soon. Thanks for your time.

Paul: All right. Thanks, Ron.

Ron: Thank you for listening. Do 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.