Primary Care Cures

Episode # 17: Ches Williams

Ron: You know, most problems in health care are fixed already. Primary care is already cured on the fringes. Reversing burn out, 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 cost and the deceleration of reimbursements.

Ron: I want you to meet those on this show that are making a difference. With us Ron [Barchampsale 00:00:29] at Beacon Clinics, that's me.

Ron: "It's the economy, stupid" won an election for Bill Clinton with little help from Ross Perot. And if I were campaigning to lead reformation of primary care, and health care by extension, my catch phrase would be "It's the model, stupid".

Ron: This applies so much of what is wrong in health care. I'll give you a few examples. If primary care could have a worse model, I can't imagine it. In another episode, we'll actually score models, so you can see how your business stacks up, with actually a score card.

Ron: You simply couldn't do worse than primary care. It scores literally a one out of twelve. The bricklayers are paid by the brick. The barbers are paid by the haircut. The only path to more pay, lays laying another brick or cutting another head. The independent PCPs in the exact same bind. You can work longer, or you can see them faster. Those are your two options. The average office visit is about seven minutes today, fifteen if they're lucky. Most have cranked up their hours as much as they can tolerate. So that leaves them with a factory medicine: see them faster. Get them in, and get them out. It's a direct path to burnout. It's a sure fire path. And it's a bad model from ten thousand feet if you're just a business guy looking down. And you can't afford a scribe, which is often offered as a solution because at twenty bucks an hour they take up most of your profits.

Ron: So is there a way out?

Ron: In fact, there's two ways out. There's three ways out, in fact. And let me tell you the worst. Sell to the man, for essentially nothing today, but used to be an [inaudible 00:02:11] multiple, and that's gone. But hospital systems can double your take-home the day you start with them. Because they get quadruple billing, for what we're charging the insurance companies. It eliminates business hassles and expense pressures are essentially going away. All the regulatory stuff, billing,

coding, it's gone. They can, because the can charge, as I said, four times for the same things you were doing before. Tests, procedures, exams. But now you work for the man, so there's a whole new set of pressures I don't need to get into because everybody understands those.

Ron: Option two: go the direct primary care route. DCP typically takes on two to five hundred getting started, these patients are typically willing to pay anywhere from fifty to a hundred and fifty a month, so if you just take the middle ground, five hundred bucks a month, that's a pretty good living you can make if you only have one other tech working in the clinic with you, or maybe a manager. But you need bill or coders anymore, and you don't need a big staff. The DCP I interviewed on our last show, literally has no staff and 450 patients. But he only sees five a day. It's an easier gig, it's more free time. It's a throwback to the Marcus [Wellby 00:03:23] days of the sixties and seventies. But DCP is clearly a model that works for a lot of doctors. Make what they deserve without killing themselves and burning out.

Ron: Except, one little problem. Every DCP who had to abandon patients knows this is true, if they took on five hundred, they left two thousand behind. Twisting in the cold, cold, wind.

Ron: My favorite way out works really and virtually in every primary care practice. If it has enough space. It requires no investment, for most options. It requires no training, for most options. And it won't mess with your workflow, for most options. And most importantly, it flips the model from a one to about a six or a seven. So it changes the models significantly, from worst in class to at least the middle of the pack. Because patients happily return they get ancillaries added. They need these tests, they need these treatments. We particularly offer allergy, or guest day offers another set of services. And they are so happy that their PC makes their lives that convenient, because the tests can be done in the place they trust. Their cost is covered, their twenty ancillaries like the allergy, and like the guest we have today, in verticals that we'll explore in future podcasts.

Ron: The twenty ancillaries services reimburse you nicely with your in-network carriers. [inaudible 00:04:49] with cash paid services, so I'm not going to be talking about [Juvaderm 00:04:51] and [latisse 00:04:52] today. That's a whole nother world.

Ron: Today you're going to meet a principal, one of the best, and they check all my boxes for risk assessment, patient outcomes, really focused on doing the right thing, by the doctor by reducing every possible risk they can. Chess Williams is not only a friend, but he's a principal of frontera Strategies, one of the earlier players in the ancillary world. And so therefore, they're in six states now. I can't wait to celebrate, today they make it into a whole lot more.

Ron: So Chess, let me welcome you to the show, I'm glad to have you.

Chess: Well thanks for having me, Ron.

Chess: Glad to be here. I hope I can add some value to the conversation. The start was pretty impressive.

Ron: So Chess, I'm really glad you said that. In my opinion, there are lots of ancillaries firms out there, but most of them are mercenaries. The missionaries in the world are guys like Frontera Strategies, like you and your two partners. Because you guys are focused on patient outcomes. You guys are focused on doing the right thing, from the doctor to a risk profile. And you're only all about quality. You don't cut corners. So, really hard to find models like yours where it's not all about money, money, money, money. Do you agree with that?

Chess: Yeah. Yeah, I would agree with that. I think there are, you know, I jokingly refer to some of the players in the industry, it's kind of this whole health care wack-a-mole situation where there are operators out there that are just looking for ways to game the system, make as much money as they can, once one of them figures it out, then you get this proliferation of moles that pop up all over town. We've got multiple examples that we could probably discuss, if you wanted to. And then, ultimately the payers kind of get wise to it, and start wacking the moles, and they go away.

Chess: I think that our philosophy has been we're not trying to game the system or hit home runs everyday, we're just trying to do good, honest work and hit singles everyday, just do the right thing by doctors and their patients. And in the long run, we think that that's the winning model, and it's allowed us to be in business for, gosh, almost I guess twenty years now.

Ron: You know, I think there's something when I first joined this world that you've been in for twenty years, ten years ago, I noticed that there was a mistrust of business people getting into healthcare. Because they just got to be all about the profits, baby. You know, they're not crass commercial business guys, they're not physicians with outcomes in mind.

Ron: did you face that in the beginning, too?

Chess: Oh, I would think so, yeah. Definitely, was some people, quite frankly, twenty years ago, I think, and we can get into that I'm sure at some point during the show, but there really, at least in the primary care market, there weren't a lot of people bringing in ancillary services into a physician practice. So immediately you were met with some skepticism and concern, and maybe just not understanding exactly why you were even having that conversation with them. And your a business guy, and you're wearing a suit, and immediately the walls go up, but over time, I think, we're all about trying to build trust and do the right, and it's maybe gotten a bit different, but yeah, there's always that trepidation and fear.

Ron: So, we can start a kind of one on one with frontera. Set up the problem frontera is solving, and why you even started this company as a solution.

Chess: Yeah, so really originally being in kind of the technology industry for a long period of time, then transitioning into looking for opportunities in healthcare, I think my partners and I were looking for different opportunities in areas of pain and healthcare, where we thought we could maybe solve some problems, and one of the problems that we identified early on is that primary care has a host of problems, but even back then, it was, salaries are kind of stagnant, if not going down, they're having to see more patients just to keep the lights on. Expenses were going up, and you're having this, you talked about it earlier, just burnout. And it seemed as though primary care, a lot of them were relegated just to seeing just the very, very simple stuff, and everything that was even remotely complex had to be referred out because that's just what they were relegated to doing.

Chess: And so it was very rare that you would find primary care doctors that were doing anything other than just a traditional office visit. Whether it be a well visit, cough, sniffles, flus, anything about that is just, hey, I have to send that out to my buddy because that's above my pay grade, or above my license, so that all goes out.

Chess: And we thought, hey, if there's a way we can empower certain doctors just to be able to pick and choose the right things that they could do and bring them back in their office, we thought there was a real opportunity to do that. And so, with some research, we found what we thought to start the business, was an appropriate test for primary care that we began offering, we can get into that, too, whenever you'd like.

Ron: Well, you and I both know the story of a gentleman in the middle of nowhere, Texas, who started a family practice with a couple of thousand square feet. And when I met him, he was at twelve thousand, maybe fourteen thousand square feet, of which, the vast majority were ancillaries. His net take-home on a good year was two million, but he didn't have to work that hard, so sometimes he scaled it back, and dialed it back to a million four, a million two, and he showed me his tax returns. This is his take-home I'm talking about, not his gross. How did he do it? His primary care practice was secondary to his ancillaries.

Ron: And what he viewed ancillaries as, was not only the main business, but a giant convenience factor, so that they wouldn't have to go to a specialist to get that work up. So virtually and work up you and I can think of, maybe outside of some rare things like podiatry or psychiatry, those work ups can be done mostly in primary care. And you're firm decided to take a few of those on. So I want to hear, what are the verticals that you've taken away from the, so the specialists don't like you?

Chess: Well, it's interesting you say that, because that was, I'll tell you, one of the first, I guess the most common objection we had. Not only from primary care doctors

kind of being afraid, if you will, to do these tests in their office, and I'll talk about them specifically here in a moment, but the specialist's saying, hey, you're taking my referral base away. So when we first started, we really tried to identify, what are things being sent out of a primary care office? And naturally, cardiovascular disease has got to be top of the list so, inevitably we found that anybody comes to their doctor with even vague chest pain or family history, smoking history, maybe they're sedentary, or obese, they would automatically be sent out.

Chess: So we did some research, and found what we thought would be a perfect way to kind of solve that issue, and really help the primary care doctor be a better gate keeper. So we began using technology that was, at the time, widely found in large hospital systems like Mayo, for example, or research facilities. And the tests that we began offering into a primary care office, was a cardio pulmonary exercise test, and it was really the only test that could combine assessments of a patient's heart, their lungs, and their fitness level, and give the primary care doctor enough information to decide, do they really even need to be referred out? Or are they just de conditioned? Do they have a heart issue that warrants further evaluation? Or is it a little problem?

Chess: And by using this technology and this test, along with one of our qualified clinical exercise physiologists that we would send into the primary care doctor's office to conduct the test, it was just very, very successful; it gave them all this wonderful relevant information that they could then kind of take control back over that patient, or really figure out who should I be sending out of my office in the first place? And who can I continue managing here? And that's kind of how we got our start.

Ron: You know, the Gallup poll for the last twenty years I've been following, rates the most trusted professions in America, and usually, it used to be the po-po and the firemen, firemen are still up there, but the po-po have fallen way down for no good reason, but the number one and number two were nurses and doctors. It sounds a little crass to say this, but the trust factor is such a big part of a patient's experience, they don't necessarily want to go to an allergist, in our case, they don't know, or in your case go to a pulmonologist or cardiologist they don't know. They don't know the staff, they don't want to do a whole new file and fill out all that paperwork all over again. And they know and trust, they know the team. They know how the game is played.

Ron: So, you bypass that by saying, you don't need to go do that anymore. So, you didn't upset the specialists, is what you're saying?

Chess: Yeah, I mean, I think once the specialists really understood what we’re doing, for the subset of patients that we're dealing with, I call them kind of the worried well folks, they're not patients that have known disease, or are already under the care of a specialist, they're kind of the middle-aged people that may have a couple of mild symptoms, or risk factors, that's who we're really catering to, and our

research indicated that most of the time, when a primary care would send that patient out to a specialist, oftentimes they would ultimately find their way back to the primary care, anyway.

Chess: So why go through all the hassle of sending that patient out, oftentimes the patient wouldn't even come back. So if they're referred out to a specialist, for example for a cardiac work up, they may end up staying with the specialist, and never making their way back. You think about, would a barber refer you out to another barber for an advanced haircut? No, you'd want to keep them in your own practice, as much as possible, it didn't make a lot of sense. When you don't have to send them out, don't send them out. If we can empower you to do more and do just an amazing comprehensive work up in your practice, and give you the data you need to make the right decision, then man, it's a homerun for the doctor.

Ron: So when I think of your firm, I think of nerve tests, I think of cardio and pulmonary tests. You do a lot more than that, though, don't you?

Chess: Yes, so we're really focused on three modalities.

Chess: One, we mentioned is a really comprehensive cardio pulmonary exercise test. We use this metabolic cart. We put it in a specialized van, we wheel it into a doctor's office, it fits in a normal exam room, and we bring in an exercise bike with that. And really, if you think about a traditional stress test, this is a stress test on steroids. We're basically measuring the oxygen that the patient is consuming, not only at rest, but during exercise and post exercise.

Chess: We're basically taking all the elements of a cardiac stress test, adding some pulmonary and physiological measurements to it, and it makes it a far more accurate test. Certainly more specific, which means if a patient comes, if we get a normal result from that, we can say with a super high degree of certainty that the patient is completely fine, and they definitely don't need to be referred out.

Chess: It's also more sensitive. So, it's more sensitive than your tradition treadmill test, meaning if we pick up something that looks to be abnormal, then we have a higher degree of confidence that that is the case. So we run those types of tests. No longer do you have to, if you need the routine stress test, I went through this whole process not that long ago, where my internal medicine doctor said, hey, you're about to hit a big milestone age, you need to go get a stress test. I kind of secret shopped a specialist, and had they been using something like us, they wouldn't have had to do that. If that makes sense.

Chess: And then, from that point on, we were looking at other things that doctors send out. Sonography is something sent out quite often. Echocardiograms, for example. Just look at imaging of the heart, your carotid artery for heart attack and stroke prevention. Really, all kind of different body parts that we can scan, we do that

with a separate team of qualified technicians, and then we also do nerve conduction and EMG testing.

Chess: So really, three modalities. Exercise testing, sonography, and nerve conduction. But we can bring in on a fractional basis, really to any doctor's office.

Ron: So I'm hearing internal medicine, I'm also hearing family practice. What other physicians do yo all find in your sweet spot?

Chess: I would say a lot of primary care and internal medicine, they're sending out tons of these tests every single day. So we really work well with them. There are some other specialists that we work with, such as endocrinologists, that have large populations of diabetic patients that certainly can benefit from these things.

Chess: We even do a lot of pre-operative clearance for doctors. We can even do them for the surgeons directly, or oftentimes the surgeons will send them back to the primary care doc and we can do a really comprehensive work up on the patient that's going to make sure, with a very high degree of certainty, that that patient is healthy enough to undergo a surgical procedure and have a great outcome.

Ron: So I want to ask a policy kind of macro question, then get back to the specifics of your model. Chess, the statement I'm about to make, true or false: if more PCPs had more ancillaries in the office, we would not have as much corporate medicine enforced buyouts. Would you agree that's true or false?

Chess: I would say that, absolutely. That would be the case.

Ron: So this monologue I gave, or rant, whatever you want to call it, before the show, was really about ancillaries and DCP are the solutions to corporate medicine, and corporate forced buyouts. People having to sell, because they're just fed up. And you and I both know dozens of doctors that are fed up. You can call them burned out, too. But if-

Chess: You say that, when you talk about burnout, that implies speed. I think the stat you cited earlier was the typical office visit was seven minutes. You really can't do a good assessment on a patient in seven minutes. Having ancillary services available helps that physician really just slow down. And take more time with their patient, and do a more comprehensive of really understanding what's going on with that patient, and not just try to see them, and get through, and see the next forty patients for the day. Which is kind of what they have to do just to keep the lights on.

Chess: So when you have all these different services available, you can really slow down and be a better doctor; practice at the top of your license.

Ron: Love that. Great, well put.

Ron: So Chess, back to your model again, I know bring you guys in, do I need to set aside a discreet room for you, exclusively? Do you need it on Thursday, every other week? What is my space requirements, because that seems to be my number one hitch in my get along, is most of my doctors, one, we can't find the exam room for me.

Chess: So it really, yeah, that's something that's tough to overcome if the doctor, if every single room is being used, every hour of the day, it makes it difficult to bring in somebody like you, or me, for that matter.

Chess: We kind of come and go, depending on the need of the practice. So, if you feel you would only have a couple patients here and there, you call us and we'll find a time to come in when you have a room open, we'll do our testing set up for that amount of time, we'll do out stuff, and then we'll leave.

Chess: We have other doctors that say, hey we have an extra room, we'd like you here more often, we'd like for you to at least maybe have exclusive use of a space, we can certainly do that, and be there five days a week, if needed. We'll right size it, just depending on on what the needs of the customer are.

Ron: You know, the odd thing about your model that's different from mine is, you're relying on the doctor to schedule a full day for you. So you're going to invest time and energy and equipment not used elsewhere to just dedicated office for x hours, maybe the whole day. But the doctor now has to line up the patients to fill your day, and patients are notorious for not showing up. How do you get around that problem?

Chess: You know, that's a great view, and I think it was you, as a matter of fact, that had described my model, and other people who kind of employ my model, is the show up and hope strategy, which is a tough thing to do, so what we really tried to do is understand what kind of patients the physician thinks would be appropriate for this type of testing, and then we can use different types of technology to identify all those people that are coming in on a given day, or even just some forecasting in the the future to determine who are appropriate candidates? And we'll try to line up as many of those people that match up to an evidence-based guideline that suggests it's appropriate to have a stress test, for example, or an echocardiogram, or what have you.

Chess: And really just try to match up to ensure that we're completely utilized when we're there. It's good for us, it's good for the patient, and it's good for the provider.

Ron: All right, you may not be able to answer this question, but is there an income range the docs can expect if they do your minimum offering versus your maximum offering? Is there some kind of a two thousand [crosstalk 00:22:43], or is it higher?

Chess: That's a great question. It really kind of depends on the model that we employ there. They're typically compensated as a function of the amount of time that we're there, because we do require supervision of our team while we're there. It can range from hundreds of dollars a month, to several thousand dollars a month, just depending on how busy we are, and what kind of work that they're offering us.

Ron: Okay. [crosstalk 00:23:09]

Chess: It's kind of vague, it's just, yeah, and I'll tell you, a lot of doctors, I mean, they just love being able to do this type of stuff in their office. I think any type of revenue that they earn because they do have to perform duties associated with having this test in the office, all though it's nothing complicated, but all the tangential benefits are huge. Whether it's what we do, what you do, what other ancillary service providers do, I think it's just all those benefits are extraordinary to a practice if they really start employing these different services in their office.

Chess: Whether it's using an outside person like us, or even doing it on their own.

Ron: So how would health care change if frontera was in every office it should be in?

Chess: You know, I think that's a great question. You would see a couple things.

Chess: From a patient perspective, you would see really good convenience and satisfaction, so you're not being bounced around all over town. You can go kind of a one stop shop. And I think that's huge; you don't end up at a really expensive place, having tests that are unnecessary. You go to your primary care doctors, which is where you should be, and you work with them to ensure that you're getting the right kind of testing, and I think that would be a huge benefit.

Chess: From the primary care doctor's perspective, I think that they're going to see happier patients. They're going to see compliance go up because they know whether or not patients are following through with their orders. And ultimately, you should see a significant savings in just the system because we're not having patients that are leaking out to all these very expensive places for different things, when they could have had it done where they need to have it done, at that primary care doctor's office. So I think you would just see a large amount of savings in the industry.

Ron: What is your, and your two partners, biggest challenge you have right now?

Chess: Generally speaking? Or just the business?

Ron: Well, besides your two partners being your challenge, what other challenges do the three of you all face? Someday you could be in fifty states, what's preventing you from growing?

Chess: Well, as you very well know, the consolidation in the markets it's difficult to contend with. We've had situations where we worked with some doctors for a period of time, and then for one reason or the other they make wave the white flag and then join a system and become that employed doc, and start working for the man. And that's a difficult thing to deal with. There's a lot of pressures going on, you know a lot of pressure to really just create consolidation. So the independent guys, it's getting tougher and tougher to remain independent, and that's really one of our missions in life is to help them remain independent, so that's tough. I think payers can sometimes be a challenge, in terms of creating hurdles to have necessary testing, just creating an environment where you have to have everything pre authorized, no matter what. Even if the doctor says hey, there's a legitimate reason to have the test done, they create a lot of hurdles.

Chess: And really, declining reimbursements, it's very challenging. Reimbursements don't tend to go up, even though premiums go up double digit, increases pretty much every year, reimbursements seem to go down. I've never understood that math. Maybe you can explain it to me, but

Ron: No, it's simple math, you've got basically two percent of the cost of health care overall, the three trillion dollars spent, two percent is primary care payouts. And by taking two, let's call it, let's be generous and call it five percent by including nurses and PAs and everybody else. If you take five percent and you cut them five percent every year, the fractions, I can't even do, is it .0125 percent? It's not even measurable.

Ron: So the savings that it's creating for the health care system, if you will, are negligible. Whereas that's not the case with hospitals. They can just kind of charge whatever they want for many of these procedures, and get away with it.

Ron: That's a whole other topic, and I want to talk to you about policy in another visit, in another time, because you and I have a lot to talk about. But let's talk about what people should be reading, listening to this podcast if they want to know more about either adding ancillaries, or a new model for primary care, what books do you like that you think would be a good read? I haven't found any out there.

Chess: You haven't found any? The things that I do to kind of keep up with what's going on in the industry, I look at the, I think it's the Weekly Jist, from [Chast Roads 00:28:00], I think her name is Lisa [Blemowicks 00:28:04], I believe, MD. It's a weekly newsletter that I find quite fascinating, that you can sign up for. I think it's called the Daily Jist, actually, it's really good. And then Rock Health Weekly's another one that I sign up for. If you're wanting to know what is going on, really just in healthcare in general, I mean I follow people on Twitter, Day Chase is a good one. I listen to your stuff, I look at your Linkd-In postings a lot, I think you've got great information. I learn more from that than I do a lot of things.

Chess: Those are a couple of my go to things, I guess, Ron.

Ron: Well Chess, let me say not only are you very handsome, you're also very smart.

Chess: Well, no, that's a stretch.

Ron: The smart or the handsome?

Chess: I don't know, both.

Ron: All right, in a sentence, you get to fly a banner over America; what is your message to all the PCPs listening in today?

Chess: That's a great question. Let's see, I would say, if we could even help one physician improve their ability to care for their patients and increase the likelihood that they can keep their practice afloat by partnering with us, we consider that a small victory.

Ron: Okay, well if I'm a doctor and I want to reach out to you because I've heard how handsome and smart you are, what's the best way to reach you, Chess?

Chess: Pull up our website, its www.teamfrontera.com and you can drop me a line there.

Ron: Great, okay. I'll look forward to our next visit. There's a lot more to talk about with you. Thanks again, Chess.

Chess: Thank you.

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 up 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.