Primary Care Cures

Episode #19: Nora Belcher

Ron Barshop: 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 cost 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 Barshop: You know, big healthcare in some ways reminds me of the finest steamboat ever built. It was amazing, I'm sure, in its time, and the kids today don't want to ride a steamboat; they want to ride a yacht that has jet skis and water slides. They want a cigar boat with 3100 horsepower engine.

Ron Barshop: The bigs are powerful. They're richer than Midas. They have more power in Washington than any other organization ever has in history. They're comfortable. They rule the game. They have the dice loaded in their favor, and they like the steamboat, because she's tooting along and they're having a grand old time and a nice ride. Yet we all know the steamboat days are over. Their days are past.

Ron Barshop: A healthcare executive told me the other night, we were throwing axes, and he said, "You know, I think the bigs are walking dead. I think they're done." As we started talking about it, whether we're talking about big hospitals or the big middles, which are the PBMs and the brokers, or the big insurers, they're all trapped in a gilded cage of their own making, whether it's a pricing dilemma they have, a big capital expense structure, an operating expense structure, or whether it's a model that's fading and they don't even see it in front of their eyes that there's newer upstarts coming to replace them.

Ron Barshop: In the end, the superman that's going to rescue big healthcare is not going to come from Washington D.C. or from Austin, Texas, or any other capital because those folks are already owned by those that can afford them, and that's not us. The transparency initiatives, the impatience of millennials, a woke media and a democratic media that's now... the blogosphere is enormously powerful... technology threats, and frankly, telehealth, which

we're going to talk about today, are all threats to the bigs. They're trying to dovetail them in to make their model better, but these are really enormous threats in the nicest sort of way.

Ron Barshop: Today, I'm super excited to introduce you to Nora Belcher. Nora is the executive director of the telemedicine association which is known as the Texas e-Health Alliance. The biggest telehealth companies are in Texas. Teladoc is by far the largest. Texas is sort of a center of gravity for this space.

Ron Barshop: She was also the deputy director under Governor Perry for the budget policy and planning, which sounds innocuous, but that means that all of the HHS money, which is $40 billion, was her biennial spend. Medicare and Medicaid as it got spent in Texas, particularly Medicaid, was under her watch. She's also working on a project called the PULSE project, which I can't wait to hear more about.

Ron Barshop: Nora, welcome to the show.

Nora Belcher: Thank you so much for having me. It's a joy to be doing this instead of being at the capitol. This is a nice break for me, and I'm excited to have the conversation with you today.

Ron Barshop: Well, I was so glad when I met you before, and you're such a great advocate for telehealth and what's going on. I was shocked after we met to discover that the adoption rate among the insured patients is less than 1% today. What in the heck is going on?

Nora Belcher: You know, Ron, I think it's one of those things where we're going to wake up one morning and that's going to have changed. I think there's a number of reasons why the adoption rate is low. I think providers have been slow to adopt it. I think, 10 years ago, if the providers had been all over this, there would be no room in the market for a Teladoc or an MDLIVE because people could just get telehealth from their own doctors.

Nora Belcher: But because their own doctor didn't step up and provide telehealth, patients have made it pretty clear that they want options. They want options in the evening. They want options on the weekend. They don't want to go to the emergency room. The adoption curve, I think, has been hindered a little bit by the medical profession not quite understanding the unmet need for these technologies out in the marketplace. I saw a statistic today that we might be at 15% provider adoption, and that's still pretty low. But I think we'll get there.

Nora Belcher: There was a day, if you'll remember, when America Online sent everybody that CD-ROM in the mail. Remember that?

Ron Barshop: Yes.

Nora Belcher: Your grandmother thought it was a coaster and she just put her iced tea on it, and she never even put it in her computer. Then we woke up one day and everyone was online. I think we're going to come to a tipping point with telehealth where it's going to become just another way that we do healthcare.

Nora Belcher: What we're living through right now is that transitional period where it's frustrating because you can see the promise, you can see the value, and the system is so large and so clunky. As you said in your introduction, the incentives to change for the bigs aren't necessarily there, but it definitely is taking I think a lot longer than a lot of advocates would've expected or liked.

Ron Barshop: I'm a personal user. My employees are personal users of telehealth. I'll talk about that in a minute. First, our mutual friend Kirby Kaden told me that the unnecessary office visits, particularly in primary care, are somewhere around 70%. Is that right?

Nora Belcher: You know, I've heard numbers along those lines. I think one of the phenomenons where telemedicine can be enormously useful is patients want reassurance. They might not even necessarily need a diagnosis or a prescription, but they want someone with the expertise that a physician brings to the table to tell them that they're okay or to say, "Yes, that's the flu. Sleep for three days. You'll feel better."

Nora Belcher: I think there are a lot of things that people seek medical care for that don't necessarily require you having to miss half a day from your job in order to be seen. If we can provide that reassurance through telemedicine and telehealth at the workplace or through an employer... It delights me to hear that you're a user, I've been a user myself, and that you offer it for your employees. The more of that we can do, there are upsides both for the individual person and then for their productivity as an employee.

Ron Barshop: My typical employee is an Hispanic female single mother with kids at home. They have the same darn stink eye, pink eye. They got the same old ear infection day after day. They know exactly what it is. They don't need a doctor to make them wait half a day to have a seven-minute visit to prescribe something.

Ron Barshop: Now my employees miss less work because they're calling it in. They know that it's pink eye. They know it's an ear infection. It's not rocket science. That has been great for my absenteeism and my presenteeism. When you're worried about your kid and you know you've got to leave at 2:00, and you're now worried about your job because you're out of time

off and your kid is pretty sick, they're not there mentally for me. But they're there now that they have this option that they can just literally make a phone call.

Nora Belcher: That's absolutely correct. I'll take it a step farther. There are some things on the market like the Bluetooth otoscope that actually allows remote viewing of the inside of a child's ear from your house through your cell phone to your doctor.

Nora Belcher: When I look at how much women are spending on baby strollers at their baby showers, I think a Bluetooth otoscope ought to be given to every new mom maybe by her health plan when the baby is born because we all know babies only have ear infections at 8:00 on Saturday night when your car is in the shop. It's like a secret that's passed from baby to baby, "This is when we do this," right?

Nora Belcher: That mom doesn't have a lot of options, especially if she doesn't have transportation. Maybe it's a 911 call. Maybe it's the emergency room. We ought to be living in a world where she has the tools between her cell phone, maybe an otoscope if she needs it, to reach a physician, and then in my dream world, the drone delivers the antibiotics to her house. Now, this is Texas, so we have to be careful about drones not getting shot out of the sky. That worries me a little bit that we might not be the drone-friendliest state quite yet.

Nora Belcher: But this is the last industry, and you and I have talked about this, where we make the patient go to the healthcare instead of the healthcare going to the patient. The beauty of telemedicine is that it turns that paradigm upside down, offers that reassurance so they can be focused on work, they've got a tool they can use, and they're not at the mercy of the doctor's office is running three hours behind and they're sitting in the waiting room, frankly, exposed to other sick people while they're sitting there, which is something I think we don't point out enough.

Ron Barshop: Yeah, you can get sicker at the doctor's office than you can get at your home every day.

Ron Barshop: Let's talk a minute about macro problems that telehealth solves. It seems to me that if we have less office visits needed, then we have less doctor shortages coming at us in the next 5 to 10 years. The numbers they're talking about grow with every projection. It was 108, then it went to 112, today it's 120 in the next six years, because of the silver tsunami that's going to be needing care, and the retiring silver tsunami of about a third of our doctors are over 56 years old.

Ron Barshop: As doctors age out, there's not nearly enough young, green doctors to replace them, and the Medicare, Medicaid enrollees are adding 10,000 a day. We have an enormous tidal wave of baby boomers that are going to need care that aren't going to have doctors. If telehealth is not just adopted by the younger but by all folks, that's less office visits, right? So the shortage doesn't bench us.

Nora Belcher: I agree with you. I think part of the hesitancy to embrace this practice modality by physicians has been some concern that if those easy primary care cases go to telemedicine, then that's revenue out of my pocket. On an individual practice level, I can see where an individual physician, especially if they're not interested in providing telemedicine to their patients, might have that concern.

Nora Belcher: But what they're losing sight of is the phenomenon that you just described, which is we're about to have a massive primary care shortage. Medical students going into residency are not selecting primary care. We know we have a wave of retirements coming on top of the baby boomers aging into higher utilization years. With all due respect to the millennials, who are I think going to be super disruptive, I'm betting that the baby boomers are going to take a good hard look at this physician shortage and declare it to be unacceptable and demand solutions that work for them, and the solution that will work for them will be telemedicine and telehealth.

Nora Belcher: The other thing about it is we spend an enormous amount of money, taxpayer money, to educate a physician, right? Medical school, residency, maybe student loans. That's a huge investment. To get a return on that investment, we need those folks to be practicing at the top of their license. If telemedicine and telehealth can pick up these basic things, the pink eye, the ringworm, the ear infection, the flu... People should not necessarily have to go to the doctor when they have the flu. When they do, they just touch everything and they spread it.

Nora Belcher: There's another way to look at this, which is you could be using telemedicine, you could use telehealth, you can get them assessed, you can get them treated if they need it, you can even send them... There are plenty of telemedicine models that incorporate labs. I think one of the critiques I hear sometimes is "Oh, you just don't want anybody to ever go to a lab again." No, no, labs are really important, but you don't have to have a lab for every visit. You send somebody to a lab when that's important. You can completely integrate that into a telemedicine model and make it more efficient for the patient.

Ron Barshop: Well, you've brought up so many subjects, there's no way we're going to get this done in one interview, but we'll do our best. Let's talk for a second

about wearable sensors. You mentioned that. Wearable sensors are going to be invaluable.

Ron Barshop: In Sweden right now, they're chipping everybody's thumb. There's chips that go into glucose monitoring and can tell real time what's going on with your glucose without having to have a blood stick. We now have a shirt that measures EKG and reports into the physician as needed. We have rings and watches for blood pressure monitoring, and dozens of other applications that are on the boards that are coming at us.

Ron Barshop: The wearables that we hear so much about are here. They're now. This is not the ring tied to your Apple phone. We're talking about medical wearables that give your doctor real-time information. That is going to also be helped by telehealth. They seem to almost be partners as they march forward, aren't they?

Nora Belcher: Absolutely. I think there has been enormous success in using devices, Bluetooth devices, wearable devices, with patients, not just high-level athletes that might be running a marathon. They have a role every day in helping people manage their healthcare.

Nora Belcher: I think one of the most exciting policy developments in this space is that Medicare just added a home care-based remote patient monitoring benefit. You know this, Ron; it is really hard to add a benefit to Medicare. It's so big. It's so complex. You have to prove that it works. You have to prove that it saves money. Using technology to monitor basic things like blood pressure, like weight, like blood glucose, sharing that information back with your physician and then using telemedicine and telehealth to intervene and talk to the patient rather than making them have to come to the physician wraps a whole package of services around someone who has a health issue and supports them every day as opposed to just every six months when they go into the doctor.

Nora Belcher: Yes, those are natural partners, and I am super excited, not just to see the Medicare changes, but we're also extending remote patient monitoring through the Texas legislature for Medicaid this session. I think we are about to really be in the era of these devices becoming mature and robust and becoming something that gets prescribed at a doctor's visit that helps a patient feel more empowered about their health.

Ron Barshop: Nora, I'm fairly certain I'm accurate in what I'm about to say, but I believe there's three new CPT codes that have just got approved, maybe four, that are tied to telehealth and wearables that weren't in existence literally two or three months ago. Things are going in the right direction. There's a long way to go.

Ron Barshop: Let's talk for a second about the... We know what a food desert is, but not many people know what a medical or healthcare desert is. There's over 20 counties in Texas which have zero doctors, zero, and then there's several dozen more that are underdoctored pretty dramatically that are mostly rural. Texas is no different than any other state in the Union; we're just bigger, so we have more counties that are deserts. What does telehealth do when we are looking at rural care and health deserts?

Nora Belcher: I think there are two things that telemedicine and telehealth can do for counties that have those sorts of shortages. The statistic that always stands out to me is that we have 254 counties, and 196 of them are rural. It can really help with primary care because it is difficult to attract a primary care provider, and frankly, you don't always have the volume in a county like that to support a full-time primary care physician.

Nora Belcher: Using telemedicine and telehealth to provide primary care, and then backing that up with specialty care for the patients is also really important, because it doesn't help if you live in Big Spring and you find out you have a condition and the only physician that treats that condition is in Houston. For a lot of patients, they're not just in a medical desert. They may have employment or transportation issues that keep them from getting to this specialty care that would be right down the street in a big city. I think that piece of it is important.

Ron Barshop: Okay. I don't often say these two words in the same sentence, but the VA has done something very exciting. I would say VA is a real good model to show you what the federal government can do if they wanted to run healthcare. It's not a very exciting or appetizing prospect. If you're a veteran, you know what you're dealing with.

Ron Barshop: The VA state licensure just came down crashing all over all 50 states, so any doctor that's in the VA now has rights, privileges in every other one of the other 49 states. That could be a model for telehealth licensure for doctors, right? Because why should a doctor be restricted to the state he has to test in only when he is doing telehealth?

Nora Belcher: Absolutely. I think a lot of folks are going to watch the VA move to see how that works for patients. I will tell you that historically the resistance to a national level of licensure has been the ability of the patient to file a complaint against the doctor if they don't live in their own state.

Nora Belcher: Again, that's a very... I have to fill out a form. I have to go to an office. There isn't any reason why there couldn't be virtual medical boards in each state where patients could file complaints against physicians. That's always been the objection, and it seems to me like there's a very easy low-hanging fruit technology solution to that problem. Using the same

technology that we use for telemedicine to open up licensure across state lines. There's got to be a better way than the way we do it now.

Ron Barshop: Yeah. There's many states that have reciprocal privileges, but you still at some point may have to sit down and take a test that is ridiculous, and you've got to study up for it. What tends to happen is the younger doctors get licensed in all the states they could ever imagine they want to live in when they're young, and then it just gets so much harder when you're older. Huge, huge barrier.

Nora Belcher: That's a huge barrier, and I'll take it a step further. I have been told it can cost up to $100,000 to get licensed in every state. By the time you fill out the forms, pay the dollars, take the test, get the documents, it can be cost prohibitive. If you were a specialist that wanted to have a multi-state telemedicine practice, it might cost you $100,000 to legally be able to practice in all 50 states. That's a lot of money, even in healthcare land.

Ron Barshop: Nora, what excited you about going from a $25 billion spend to $40 billion spend a year to going into telehealth? That seems like quite a sideways move for you. Why is this exciting for you to be working in this space?

Nora Belcher: I'll be really honest with you. It's because telemedicine and telehealth actually has the potential to touch every single aspect of that 25 to 40 billion dollars. We're just coming at it sideways. We need to be doing it in nursing homes. We need to be doing it in assisted living. We need to do more of it in hospitals.

Nora Belcher: I'm working on a project right now to do it in rural hospitals to support trauma care. We can literally do telemedicine to support patients from prenatal care to delivery through school-based clinics to work site wellness to palliative care and hospice. There is not a single aspect of the healthcare system that I can't touch. While I might not have the checkbook anymore, I feel like I'm still playing in that whole space because this is an area that is so ripe for innovation and so desperately in need of disruption that it's going to be another 10 to 15 years before I'm done pointing out, "Oh, here's a problem, and we've got solutions, and hi, you're going to have to change."

Nora Belcher: The world is changing and the world is innovating, and the winners and losers are going to be the ones that figure out patients need to be back at the heart of the conversation. When you pair those two things together, it's a really powerful cause. It's one that's worth fighting for.

Ron Barshop: You know, there's an exciting thing that just happened in allergy. I'm just going to mention this for a minute. We were literally penalized if we tried

to call the patient to talk about compliance and coming in and get your shots because these are your own medications made just for you, and come on in, there's been a lot of money spent; let's get you taken care of here. We got penalized. We would actually get docked. Now the telemedicine laws allow us to make that call and have the doctor call them and encourage them to come back and be compliant.

Ron Barshop: The medical compliance rate for people taking their pills when they're supposed to, as they're supposed to, is... The numbers I've seen for the two best studies seem to be somewhere between 6% and 16% are taking their medications as prescribed. That means that a lot of them can't afford it, and that also means that a lot of them don't understand it and a lot of them are confused by it. They're just not doing the job. To have a doctor reinforcing the importance of those scripts only can be done through telehealth, right?

Nora Belcher: Absolutely. I completely agree with that. I think medication compliance and adherence is a huge issue that we don't talk about enough, the number of prescriptions that are written that patients, for whatever reason, don't take. Cost and affordability is maybe a separate issue from today's podcast, but I also known that patients just get confused. "Tell me again what this pill does." "Where's that piece of paper?" "Where's the explanation?" "I was already stressed because I had just gotten this diagnosis, and now I'm expected to remember all this information dump that just happened to me."

Nora Belcher: Frankly, I think they're also a little... Sometimes patients are embarrassed to have to go back and say, "Hey, what exactly again? When am I supposed to take this, and am I taking it with food? What am I supposed to do?" Having a way to have a telehealth consultation with a physician or, frankly, with a pharmacist can walk the patient back through it without having to make an appointment. We ought to make it easy for people to take care of themselves, and we don't do that. These tools are really a way that we can get there.

Ron Barshop: Something nobody talks about much, Nora, that is another opportunity for telehealth is something in the order of 70% of folks that are referred to a specialist never make it to that specialist for a hundred different reasons. Again, a gentle call from the doctor that says, "I haven't heard that you've made it to the podiatrist that we sent you to. What's going on there?" That's not a telehealth call; it's a gentle prodding by someone they trust enormously more than...

Ron Barshop: In every Gallup poll, and just about anybody, PCPs are right up there with firemen, nurses, and then politicians and used car salesmen are at the very, very bottom of that list. But if your PCP were to call you and say, "Hey,

yeah, I see here that you didn't make it over to the oncologist. It's time to make that visit," that is another way that telehealth is... It's not thought of as a telehealth visit, but it's certainly an important phone call.

Nora Belcher: Well, and I think the other piece of that, Ron, is there's been this enormous resistance to the digitization of all of our healthcare data, and frankly, with some good reasons. Some of the way that electronic medical records was rolled out maybe wasn't... Well, let's just put it this way. They didn't ask me. I might've done it different.

Nora Belcher: But they did it. They pulled the trigger. They tried to get everybody to get an EHR, make the data digital. The other piece of that is making sure that the pharmacy just gets the data back to the physician, "Hey, this prescription never got picked up."

Nora Belcher: We sometimes think about that data being fragmented as a good thing because it protects the patient's privacy, but we really need to be looking at the patient as a whole person, their visits, their prescriptions, all of those things. Because that PCP is trusted, we should all be doing things that support that PCP so they can check in with the patient and say, "Hey, the pharmacy let me know you never pick up your blood pressure medicine. What's going on with that?" and start to have a conversation that moves the needle away from noncompliance and towards the patient getting to a healthier place.

Ron Barshop: Anything that gets the doctor and patient relationship tighter is going to be a naturally good outcome for health. All the middles, whether they're brokers or hospitals or urgent care or PBMs, all of these folks that are in the middle really just sort of get in the way of that relationship. Telehealth really is a way to reestablish that relationship and strengthen it.

Nora Belcher: It's ironic, I think. I have people frequently say to me, "You're just trying to replace doctors with technology," and my response is always, "The best world is going to combine high tech with high touch from an actual physician." No one is trying to get rid of physicians, but as you pointed out, we don't have enough of them, and particularly not in primary care. You need to be automating the things that you can so that that precious face time, whether it's virtual or in person, is laser focused on that patient and their needs, so that they feel heard, they feel comforted, they feel reassured, and they're more likely to be compliant.

Ron Barshop: Who is threatened by telehealth? It seems like it's a nonstop avalanche, that it's going to be happening whether folks want it or not. Who seems to be... Who's not advocating on your behalf?

Nora Belcher: You know, I think the physician groups for a long time were resistant. I've talked over the course of this conversation about some of their resistance. I think that that is starting to turn as they're starting to see that there is opportunity.

Nora Belcher: I also think I would like to see employers elevate this past just an HR issue. Sometimes I see that, "Oh, yeah, we have a telehealth benefit," and I say, "Oh, that's great. What's your utilization rate?" "I don't know. It's 1%."

Nora Belcher: Well, those employers ought to be in the headspace that you're in, which is thinking of this as a presenteeism tool, as an employee health tool, really as an employee benefit and embracing it more. But I think with the employers it's just a matter of we've had this wave of change over the last 10 years with healthcare, and a lot of them are just worn out with the constant rate of change.

Nora Belcher: The physicians have come a long way. They've got some space to go. I'd like to see the employers move along, I think, a little better.

Nora Belcher: Then, finally, the area that's really ripe for a revolution is long-term care. We don't talk about it. There's significant need for disruption and change that telemedicine and telehealth can support for the long-term care system.

Ron Barshop: Absolutely. The way to get in touch with you at the Texas e-Health Alliance is how, Nora?

Nora Belcher: Folks can email me, very easy email address, nora, N-O-R-A, @txeha.org. There's a form on my website, txeha.org. On the contact page, they can fill out, send me a note. I'm happy to visit, happy to answer questions, have conversations, connect people to resources.

Ron Barshop: Okay, so what are your biggest challenges? Then I have one more follow-up question before we wrap this up for you.

Nora Belcher: What are my biggest challenges? I think the biggest challenge is that right now, ironically, even though you and I have been talking about the barriers, I think there's a lot of pressure on people to do telemedicine, to do telehealth, and I worry that people are going to buy equipment or buy services and really not have a business plan for using it. Sometimes when that happens, then we look less appealing as an industry, because, oh, yeah, well, our hospital, we did that two years ago and nobody used it, so we're not going to do that anymore.

Nora Belcher: I really am trying to encourage people to have a business problem that they're using telemedicine to solve. If you approach it that way, I think you're likely to be more successful.

Nora Belcher: We also have some work to do particularly with the ERISA plans. The federally regulated plans are not required to cover telemedicine and telehealth, and that's unfortunate because they make up such a large percentage of our commercial market.

Ron Barshop: It's almost as simple in my case. Our telehealth numbers shot up dramatically when I gave them a sticker with a phone number to put on their laptop.

Nora Belcher: Love it. Yeah, that's great.

Ron Barshop: Super simple.

Ron Barshop: Tell me about the PULSE project. Then I have one stumper question for you to finalize this with.

Nora Belcher: The PULSE project is a national public-private partnership. PULSE stands for Patient Unified Lookup System for Emergencies. This is a health information exchange that allows shelter workers during a natural disaster to access a person's prescriptions and medical history with, of course, the consent of the patient.

Nora Belcher: This came out of some work that we did after Hurricane Katrina where we realized the evacuees had no idea what prescriptions they took, and we had no way to get that information. In some cases, time can be everything in terms of getting somebody their medication if they've been disrupted and displaced by a disaster. There is a large group of us partnering nationally, particularly a lot in the Gulf Coast states, to be ready for hurricane season so that we can prepare our emergency shelter workers to help people with their prescription drugs is the most important thing, but also like a dialysis plan that a patient might not bring with them when they get evacuated and their doctor's office is underwater. Lots of good work to be done with technology and disaster response.

Ron Barshop: That's funny you say that. When Katrina came, my physician friends called me from around the country and said, "What can we do?" I said, "Empty your pharma closet and send me your insulin and send me your hypertension drugs. Send me everything, all the most common drugs. I know it's probably illegal what I'm asking you to do, but just send them to this church at this address. They are dispensing drugs in areas that are so hard hit that they're like islands of Venice. You can't get to them through

the city of Houston. Maybe there's some way we can get them to these churches," and it worked. It actually worked just great.

Ron Barshop: Let's talk about, if you had an airplane, the world's largest airplane with the world's largest banner that had a message for Americans, what would that message say?

Nora Belcher: Stop what you're doing and read a book by someone you disagree with.

Ron Barshop: Okay. Do you have any favorite books that you disagree with that you'd recommend to us?

Nora Belcher: Not off the top of my head, or maybe a news source. Maybe I'd say a news source. Every day, I read a variety of news sources from the far left to the far right, credible news sources, not propaganda. There's a difference.

Nora Belcher: I think we are in a place where we're isolating ourselves from the rational voices on the other side, and I think that's unfortunate because no side is absolutely right or absolutely wrong. We've got to come out of these bunkers, and I think part of the way we do that is by educating ourselves on what the good people on the other team think. And those people do exist, no matter what team you sit on, and we don't go seek that information out. We sort of let ourselves be spoon-fed by our own tribe.

Ron Barshop: I have this theory every four years Thanksgiving gets really complicated, and then it eases up again.

Nora Belcher: Well, I don't think we've ever seen a political cycle... I've been in politics a really long time. We've really never seen anything quite like this, but that doesn't mean that everything that your political opposites think is wrong and incorrect. If we stay in that place, I don't see things getting better. For policymakers, then it becomes all about politics and not about policy, and good policy ideas like telemedicine, we get lost in the noise.

Ron Barshop: Okay, I'm going to break my rule and just ask you one question since you brought this up. There's a proposal made by the president to basically stop funding these 60,000-a-year salaries for the residents. If you multiply that across 35,000 residents, it's not a lot of money, but it's significant in that they're billed out at 2.4 million each inside a hospital. Once a resident's salary is paid for by the feds and there's zero cost to the hospital, they're billing that doctor out at a couple of million dollars for PCPs. That's the typical markup if you look at the numbers.

Ron Barshop: I don't have any problem, and I don't think it's a political issue that we're overspending for some things that we just sort of have been asleep at the wheel at. I think Democrats, Republicans, and Independents could all

agree we don't really need to be spending money on everything. We can let some of the big boys take care of their own small problems.

Nora Belcher: You know, the Institute of Medicine study that showed that about a third of the system is waste, fraud, and abuse of some kind or another. We keep piling money onto inefficient things.

Nora Belcher: Yeah, I think I agree with you. I think we need to be a little more thoughtful as taxpayers about what our taxes pay for, and this is where both sides I think have some valid arguments about the way we spend our money. It's just so difficult to break those spending patterns because when you do that, someone loses, and that someone gets mad and they get a lobbyist and they go to the newspaper and they cause a big stink. Yeah, I mean, as a taxpayer, should I be paying... some of my money go to $60,000 that then gets billed out at 2.4 to a publicly traded company? I think a lot of people would wrinkle their noses at that.

Ron Barshop: How about to a nonprofit that pays no city, federal, or state tax? How about that? That's another consideration.

Nora Belcher: Yes. Don't get me started on actual tax reform versus fake tax reform. A lot of the heart of our problem with the healthcare system has to do with the inequities of the tax code.

Ron Barshop: We are going to talk about that next visit, but we're out of time this visit, Nora. I promised you the time you gave me, and I really appreciate it and will look forward to our next time we get to catch up.

Ron Barshop: 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. 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.