Primary Care Cures

Episode #27 – Dr. Josh Umbehr

Ron Barshop: Most problems in healthcare are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced to biops, factory medicine, high deductible insurance that squeezes the docs and it's 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 Barshop: I met the other day with a terrific PCP group who asked me when I'm leaving the fee for service model and diving into value based care. And I answered very carefully and very respectfully this because I don't really see a real future in fee for service as we know it. I think it's going to be replaced for sure because of the incentives in the wrong place. The value based care, while it's a wonderful concept, I told them it keeps heads out of beds, but it has a hat trick to do it and the hat trick is treat the 15% to 20% chronics that are actively sick, that are not well and hope zero healthy patients come in. That's really the ideal model for value based. And really pay attention because these severe cases really want the help and need to help, which is a patient you want to have they in desperate need and they're compliant.

Ron Barshop: That drives the savings largely in my humble opinion, but here's the rub because 94% of Americans are not adherent to their medications. On the most recent study I saw, I've seen studies lows 86% as well as 50% but 94% was the latest people that are not taking their meds right. 50% are not going to the specialist after being referred. 12% of people smoke and there's been billions spent on a campaign to keep people from smoking, but vaping as quickly reversing all the gains we got from these campaigns. So most patients will not tango with their doc because they just don't care. I estimate two thirds to three fourths and don't care. They want care when they want it. They don't want weight loss clinics they don't want smoke cessation programs. They want diets that work and none of them work except maybe January 1st to 15th that's it.

Ron Barshop: You can gamify patient engagement to try to reverse these trends and you can even try fear. But they just don't complex stuff when they're very sick. So the savings and value based care I'm betting are largely with these severe and chronic cases of hypertension and asmatics and diabetics, et cetera. VBC is important for overall health care savings vary because a third of our spend of this $4 trillion healthcare economy is in the third of those folks that are super chronically sick. But macro population health stats, I don't think VBC is going to move the dial. There is no incentive to treat the non-chronics. They're not going to come to the clinics that's good for the doc. If I'm wrong, tell me why. So you want better care and lower costs. I think there's two options, and this is my humble opinion, but I think number one, you have to break up the PCP consolidators. And since that will never happen, here's what will.

Ron Barshop: Teach PCPs, how to make a great living with direct primary care and ancillary services if you're going fee for service. There are PCPs in both of those areas in celery and direct primary care who make more money than plastic surgeons and who have a better life. And that's the model that works. The traditional model does not work. I've seen tax returns, so I know this to be true. Today we're going to meet not only a thought leader, but really an innovator in direct primary care. So this is a baby movement. It's only 1100 physician practices across America right now. They're in not even all 50 states. Dr. Josh Umbehr is the founder of Atlas MD and he lives in Dorothy and Toto country, Wichita, Kansas.

Dr. Josh U.: Yes sir.

Ron Barshop: Yeah. And you were raised in Alma and married your high school sweetheart, is that right?

Dr. Josh U.: That's correct.

Ron Barshop: All right, so does she wear a blue gingham dress and carry a little basket with a dog in it?

Dr. Josh U.: Not lately.

Ron Barshop: Okay. Well, Atlas MD is so impressive when you get to know them down deep because they're really an ideal medical practice in my opinion, because they've been able to shrug off the burdens and restrictions and the government and insurance regulation and can focus solely on the patients and they have published their prices for pretty much every procedure you can imagine a PC has. And am I right about that?

Dr. Josh U.: We try to do as much as we can. Absolutely. It's always a question like you alluded to of how much value can you provide to the customer in this case, the patients?

Ron Barshop: All right, well I want to get into your model a little bit here, but let's talk about, I want to get your opinion on a few issues there, pressing. How does value, I'm sorry, I'm not talking about value based care, I'm talking about direct primary care affect physician shortage as if more residents were exposed to direct primary care like Atlas? What do you think would happen with primary care shortages?

Dr. Josh U.: Well, I think there's two great ways to answer that. I mean, history for us has shown that when the patients or when the residents are seeing a better lifestyle, they gravitate towards this. There are some preliminary and resolving fears about where would this movement be. But we started this 10 years ago when no one knew what this was and it's only growing faster and faster. So yes adopting a new model comes with some residents' concerns about lifestyle and income and little bit of risk. But really when they start to compare it to the current model, the breakdown falls apart. 70% chance of burnout in the current model, declining revenue, inclining stress. So each year that comparison has gotten more of a win for direct care. But what we are also seeing is physician are not just retiring and quitting the industry all together, they are pivoting towards the direct care model because it's really everything they wanted. It's providing great care with lots of time to their patients at a lower cost that saves a patient's money while still being sustainable or better for the physician.

Ron Barshop: Yeah. Let's talk about the better for the physician part because I'm going to ask you a very course question. When I went to Israel I got asked a million times, the many times I go over. "How much money you make in America?" And I tell them, "How much sex do you have in Israel?" And they go "What, that's so personal." I go, "well, is your question and that's not a polite question.' But I'm going to ask you an impolite question. What are DPC's ranges making percentage wise? Are they making 20%, 30%, 40% more than a typical PCP or are they right on average? Do you have any sense of that?

Dr. Josh U.: I think it really depends on the area, not to oversell it in the sense that we've got family physicians across the country who are doing variations on inpatient, outpatient, OB procedure heavy scopes, 40 patients a day or 60 patients a day. And depending on the system they're in obviously heavily affect with the average income looks. But I know what a lot of residents are being offered locally coming out in these big hospital owned systems and it's 130,000, 140,000 base plus some benefits. And plus the idea that if they hit production, they can get more. But that's the trick is they'll never hit production. The hospital systems locally at least have

central scheduling and make sure that the simple stuff gets farmed out to the store clinics and not to the docs who might get a $40,000 bonus.

Dr. Josh U.: So that average can vary. But if they're coming out at 130, 140, we're offering our docs a salary of 200,000 a year for seeing six patients a day. And I think the money's not as high as it could be. You'd relative to, like you said if you're working the insurance system and seeing 40 people a day, you can make more. But we're balancing income and lifestyle. But we also have physicians who say, "Look, I'm happy seeing seven or eight or nine or 10. So I'll take a slightly higher patient panel and make 250, 000 or 300,000 a year on this model." So there's a range and it's good to better.

Ron Barshop: One of the amazing things about your careers that you went straight into DPC as a lifelong goal, in other words, you did not do a stint anywhere. You went straight to your own practice and started a model that really was not even in place. Is that right?

Dr. Josh U.: Correct. We'd been dreaming about this for 10 years basically from a new grad until we launched two months after we graduated from residency.

Ron Barshop: That's a very impressive, I want to get into that a little bit, but let's talk about these other issues. So doc shortages, I think you're telling me more will choose primary care if they can make something equivalent to what a specialist makes with a lot less stress and a lot less work. That's what you're saying, I think.

Dr. Josh U.: I think everybody goes into medicine with the grand ambition of being very patient focused, but it's a lot of work and it's a lot of stress. And at some point you balance that. What would I love the most verse what gives me the best lifestyle, revenue, longevity.

Dr. Josh U.: It's fun to be family medicine, but if you had to be a popper to do it or have the highest burnout rate, high divorce rate, et cetera, that's not good. So we can show them in a weird way, you can have the best of all options here. And that often sounds too good to be true. But especially with med students as they're making these pivotal decisions, they follow passion. And if they go and see primary care and see no passion from the doctors and nothing but stress and burnout, they're not going to be incentivized regardless of what the money is. So we have to show them that the lifestyle's better, the patient care's exciting. There's a lot of variety and choice and professional autonomy and less stress from government and insurance, et cetera. So once they see that they, I think will gravitate to primary care.

Ron Barshop: Are there any residency programs in Wichita that allow the residents to spend a day or two with you so you can show them how the practice works?

Dr. Josh U.: Yeah. We have a med school in town and two different residencies, so we'll have internal medicine, pediatrics, family medicine residents come through just from local. But then we're fortunate to have students and residents from across the country. So I'd say most months out of the year, at least six months out of the year, we have somebody shadowing us where they're a few days or a couple of weeks.

Ron Barshop: Very encouraging. That can move the dial for sure. Let's talk about burnout. I'm sad to hear there's no studies that have been done on direct primary care burnout because I guess you all just assume that it doesn't exist, but I would love to see a comparison of your world of 1100 practices against just the norm out there and show what amazing difference it would be. Are there any studies you're aware of?

Dr. Josh U.: No studies yet. But I think a lot of evidence to show an improvement because all the burnt-out doctors that started their own direct care practices and can point to the fact that this changed life. That it was leave medicine entirely or go direct care. You go to the conferences and they're the happiest conferences in medicine because the doctors are doing what they want to do. They're learning from each other on how to do it better because ultimately it means they're helping their patients.

Dr. Josh U.: I think if you look at the studies to show what are the root causes of burnout, it's everything that we don't do. Is high patient volume. It's high stress, it's high insurance bureaucracy. It's prior authorizations for lisinoprils that costs 60 cents a month. It's just ridiculousness of over designed system and doctors. They went to med school to take care of patients, not paperwork. Direct care lets them get back to that.

Ron Barshop: How much time doc, do you spend on your EHR versus the numbers we're hearing obviously in the larger world, there's two hours, for every hour in front of a face-time with a patient. What is your paperwork with your own? I think you have your own custom design EHR you created at Atlas.

Dr. Josh U.: We did, we created our own system because there was nothing that did what we needed it to do in a new model. But because we're not charting for insurance, we can chart what matters. Charting for insurance now has become a game in a billing process. Not to say that all of these things can't be important, but we won't pay you if you didn't do enough review of systems. Yeah, but I wanted to chart by exception. Well you can, but we won't pay you for that and now we won't pay you if you didn't review smoking history and family history, but if it was strep throat or I was

really busy with all the other things I did or if I don't document, I didn't do it. So now we've created charting as billing know ways and things that are getting automated.

Dr. Josh U.: Like you had an orthopedic visit for a 16 year old male that was documented to be eumenorrheic which I guess technically is correct. But it might just be overly zealous EMR clicking to get paid for what you did. I conducted in a strep throat note in 30 seconds. I can say what is really important. I can do a mental health visit that maybe took an hour and summarized it down into just what I need or a very long note. But it's up to me. I'm already paid for the work I've done. Now I'm documenting for this as a reference point. And I think it gets us back to what clinically matters. So yeah. I wouldn't say I spend 30 minutes a day charting, but I only see six or seven people a day in the office. And then when we're helping patients by telemedicine, all the calls, texts, emails, go right into their chart. So the conversation I'm having with the patient is the documentation, which I think is fantastic.

Ron Barshop: Lovely. Well, I'm going to throw you, you've never heard these before, I'm sure, but these are the concerns that people have with DPC. And I'll start with my own personal concern because you have such a small cohort, I mean, you may have 10,000 patients for all I know at outlets, but if you have six a day I guess you're treating people that want to get treated there. So they're self-referring and you're not seeing those that just don't need to be seen. But how in the world is six patients a day going to take care of 330 million Americans if it became universal?

Dr. Josh U.: Well, actually I think that's a great question and some fun math. So I'll ask you because it's more fun that way. What is the average number of patients per primary care physician?

Ron Barshop: 25, call it 20, 25 a day.

Dr. Josh U.: A patient panel size total?

Ron Barshop: Oh, they'll have 2,500 to 5,000 per doc.

Dr. Josh U.: Okay. And how many primary care physicians, mid-levels, et cetera, are there?

Ron Barshop: Well, you call 400,000 when you throw in the mid-levels. So little over 400,000 times 2,500 takes you out to 100 million people, if my math is right.

Dr. Josh U.: No, it's a little bit close to a billion.

Ron Barshop: Oh a billion.

Dr. Josh U.: Yeah. We don't have a billion people. So the stats I usually use are 2000 patients per doctor and about 500,000 docs who could be doing primary care between family medicine, [inaudible 00:16:10], women's health, mid-levels. Just simple math. And you're probably right. It's probably somewhere between 400 and 500 and somewhere between 2,000, and 3,000 or 4,000 patients. Point is we're not seeing that, right? We don't have a million people. What we do have is, again, just for simplicity of math, 500,000 primary care physicians and providers time 600 patients each is 300 million Americans. So I actually think we have the right number of doctors.

Dr. Josh U.: Like to be contrarian obviously that's our whole model and everyone talks about the physician shortage, but then I mentioned those stats. The American Academy of Family Physicians did a study and they have the most conservative numbers that says only 22% of a doctor's day is wasted doing non-clinical paperwork. Other studies have it as high as 75% when you include EMR time and whatnot. But if you took 22% of the day and applied it across the primary care workforce, this study showed that's the equivalent of 165,000 full time equivalent physicians added back in. But we don't have a numbers issue. We have an efficiency issue. We have doctors spending all their day clicking boxes on EMRs for payment for something that clinically didn't take them very long. And we're kind of throwing the baby out with the bath water there when you have insurance paying for a medicine, pick Zofran, that could be $200 at the pharmacy that we get 30 pills wholesale for a $1.53. But the doctor is so busy that they don't think about dispensing it in their office.

Dr. Josh U.: They send it off to the pharmacy, the pharmacy gets to uphill, insurance goes up. So insurance requires more paperwork to try to sense down on these problems and then, or it gets denied or the patient asks for a different medicine and now we're chewing our cud because in between charting for the rest of the patients, we have to try to rework the things that we did earlier in the day. The reality is when a patient can call, text, email their doctor a picture of their rash, when they can email their physician at 2:00 AM when they're thinking about their depression and not have to wait to an office visit, that's only seven minutes long. I think we get a richer, more involved, more productive care. And I think there's enough patients and there's enough physicians. We just have to be smarter about what we're doing.

Ron Barshop: I think the Texas telehealth association numbers that say something like 70% of all physician visits are completely unnecessary if you use telehealth, to your point.

Dr. Josh U.: Yeah, to some degree. I mean, I can see both sides of that because I think telemedicine implies to some degree that there's already a great relationship with the doctor and that if the picture of the mole looks suspicious and they have somewhere to go, or they'll talk to you about their anxiety because they've met you a couple of times and have some trust and rapport with you. But yeah it's amazing how much of what we do is payment model driven EKGs for example. Why do we build people for those? The hard cost is 36 cents. The coffee in my waiting room is 60 cents a cup.

Dr. Josh U.: Some of these things that we do are ridiculous. I've done several procedures, a hemorrhoidectomy twice this week and for free because I don't have a $2 in supplies and these are people who are paying on a consistent basis and that's the power of a membership model. It's why Blockbuster is bankrupt in non-existent and Netflix is thriving. It evens out the bumps between providers and patients so that we can just provide the care that they need when they need it, without having to upcharge everything.

Ron Barshop: I like that. If you were to double your cohort, if you had... I don't know how many patients you have, but if you doubled it, would you be seeing 12 a day or would you still, would you start refusing patients or how does that work in your world?

Dr. Josh U.: I think it's very much patient driven, business model driven. Yes, it would be nice to double the patient panel and double the revenue, but if you double the work and you're not efficient and patients can't get in same day, they can't get their phone calls, text messages, emails answered in a responsive way, then they're going to go vote with their feet and their dollars and they're going to go to someone else who is available to them.

Dr. Josh U.: So I think 1200 is probably far too much, but I think there's wiggle room. I think geriatrician might have 400 but at $100 a month make more than I make at my 600 patients because we're from $10 to $100 a month. But a pediatrician might have 1000, at a different price point and it's kind of like running a restaurant. If you have a restaurant that seats 60, but you have a kitchen that feeds 30 you've built it wrong, and you're going to have upset customers. So here we're trying to balance out what is the expectation from our clients and our patients and their need with a sustainable business model.

Ron Barshop: So you have four white coats between your two locations in Wichita. And I'm going to assume that four white coats each have roughly as many patients as you have. So do you all have roughly 1600 to 2000 in your panel?

Dr. Josh U.: We have five physicians each with a little over 600. So we're closer to 3,300. I have one partner who is able to take more patients and so he makes more revenue.

Ron Barshop: Well, okay. So I'm not going to go back to your math because it was interesting and quite complicated for a radio show. But in the end if you take 3,300 patients and divide that into 100,000 of the 500,000 number you gave us, that doesn't cover America. Now we're covering half of America.

Dr. Josh U.: No, 600 patients each time is 500,000 would be 300 million.

Ron Barshop: Okay. So we're close. I got it.

Dr. Josh U.: We're very close. Give or take. And could the physician see 700 or 800? Yeah. And that means slightly shorter times, but again, depends on the day. But I think you also have patients that want the Kia and the Mercedes and everything in between. And-

Ron Barshop: What is the overwhelming prejudice that's keeping the other 499,000 away from this model? I don't get it.

Dr. Josh U.: Well, we get that question a lot. Like if this is so great, why don't I see it everywhere? And I think in context, you realize that when we started in 2010 there only were five clinics doing this model across the country. And now we have over probably 1200 clinics doing this for 1200 docs. And it took Starbucks 17 years to get 17 stores and we've gone from more or less zero to 1000 plus in nine and half years. It's really amazing growth and I think always going to be craving up.

Dr. Josh U.: Pandora's box has been opened. Once patients know that they can get medicines for a penny, a pill, unlimited visits, no copays, free telemedicine, 24/7 access to physician that they have a relationship with. That's all great. But for the last six, seven years, we've been pushing into the insurance side, showing small businesses and their insurance companies how to work with this model to decrease insurance premiums by 30% to 60%.

Ron Barshop: And I'm trying to imagine if this works in pediatrics, well, like a pure PD practice or a pure internal medicine or a pure ob-gyn, is this going to work well in all the PCP verticals?

Dr. Josh U.: It's slightly different tweaks on the business model, but we have pediatricians doing this. We have endocrinologist doing this. We have a pediatric endocrinologist doing this. Dr. Robert Ferry in Texas. So it's really, we have neurology, psychology, anything that's on a chronic care

spectrum. This is perfect for. Women's health, post-menopause health and then anything that's more on the acute care, its more fee for service. And then you have room for things in the middle.

Dr. Josh U.: So radiology and pathology are dear God, I hope, always fee for service. I hope you're not so sick as to need a membership pathologist, but a dermatology mostly fee for service with probably 10%, 20% option for a chronic care membership. Something like cardiology [crosstalk 00:25:23].

Ron Barshop: I thought the precise opposite. I thought you don't want chronics in your population. You want just to healthy, but you're telling me it doesn't really matter to you. You prefer people that are managing their chronic conditions.

Dr. Josh U.: I mean, I think on some level you say, "Boy, it'd be nice to have 600 patients who never need me." But then when you're in that model and that's how you feed your family, you start to realize how weak that connection is to them. If they're healthy, like, hey, if I don't run, then why do I go to the gym? And if I don't need your services, yeah, I might pay for it for a while, but it's not a value add. So once I need that money more than something else I'm gone.

Dr. Josh U.: Chronic care patients, ideally our best patients, I mean we want to keep them healthy and showed them how to decrease their issues. But if you've got migraines and my Imitrex is $3 a month, generic wholesale and it's $200 cash price at the pharmacy, then you're thrilled. I'm providing you a value every month. Netflix in theory would make more money if people signed up and never watched because they don't sell any ads. So if you don't watch, you don't use any bandwidth, you save them money. But they want people watching. They want an attraction that keep brings you back.

Ron Barshop: So you blew mind twice or three times in this conversation. Well, the first thing you said was that $10 a month you can make a profit. That blows me away. The second thing you said was that geriatrics will sign up for a monthly fee when they have Medicare. I don't get that.

Dr. Josh U.: Well, I don't think most people are real happy with Medicare. It's good at what it pays for and not great at what it doesn't. Docs aren't thrilled with Medicare. Maybe they pay well or consistently when they want to, but at the same time, MACRA and MIPS in all the hoop jumping is only getting worse. And you couldn't have a private practice built entirely on Medicare because it wouldn't be profitable. And those patients are realizing that, they realize they don't have choice because not all doctors are taking Medicare or taking new Medicare. And there's for example a medicine that a lot of Medicare patients need that's $66 cash price at the pharmacy that we get wholesale for 13 cents. So I'll argue that the $100 a month

Medicare patient is cheaper than the $10 a month child because I can save the Medicare patient in excess of their membership.

Ron Barshop: Interesting. No, I'm going to dig into your site a little bit and tell you that it's a 10 out of 10. I've never seen a site so clear. I wish your pricing sheet was more easy to find. I had to really do a little bit harder than I needed to probably for that. But let me just read from your website, what is just at no cost and it's going to blow everybody away that's listening. Free EKG Free Holter monitor, which is a heart test. Is that a hard test of some kind?

Dr. Josh U.: Yep. You wear it for 24 hours to monitor your heart.

Ron Barshop: DEXA scan is just a bone density scan, right? Free bone density, free body fat analysis, free spirometry, which we use in allergy for asthma regulation or measurement, breathing treatments, cryotherapy. I can't believe that's in there. Lesion removal, laceration repair. And there's a bunch more on your list of free services you offer. How do you make money giving this away?

Dr. Josh U.: That's the really kind of interesting part. So I'll back up and tell two of my favorite little business stories and that I think help identify why this works out, but why it doesn't make sense to people in the beginning. Well, the first one is Christopher Columbus's egg, whether or not it's true, it's a good tale. He discovers the world's around and they kind of already knew it, but he comes back and all the king's horses and all the king's men say, "You're not that smart. Anybody could have done it." So he offers them an egg and ask them to make it stand on it. All the king's horses and all the king's men swear it can't be done. He takes the egg crunches the bottom, egg stands up. And what seem impossible to the masses now is so benignly simple, you could teach anyone. We put a pin in that and then talked about Napoleon's aluminum and aluminum was so rare and so difficult to get out of box site that when Napoleon wanted to impress dignitaries, the generals ate off silver, he ate off gold and they ate off aluminum.

Dr. Josh U.: Now fast forward to a technological innovation and electrolysis makes aluminum so easy to get out of box. We'd literally throw it away and back then that would've been insane. So we take these two things and say, there's no way that you can make healthcare cheaper and faster and easier with less insurance. And then you show them and suddenly they are like, "Oh, you mean I can buy the Imitrex that's $200 at the pharmacy for $3 to $5 depending on the dose? You didn't have to Redo anything. It's been there the whole time. I just didn't know where to log in. Yep. And then you say, well, but surely you need, you can't make the rest of healthcare cheaper. And we insert the new innovation of a business model of platform for direct care that says, yeah, if you can get people to pay you a small amount monthly, you can give them a value in excess of that several times.

Dr. Josh U.: And we can do a CBC for a $1.50, a thyroid test for a $1.69, an A1C for $2.25. And I can get you 1000 metformin pills for $11.45. And we were talking on the Facebook forums for Direct Care Docs today about a doc doing a prior off because the patient was going to be charged several $100 for 30 days of metformin generic.

Ron Barshop: It's just amazing. This is not a Pharma made in Vietnam and sweat factories, this is the real deal you're talking about.

Dr. Josh U.: True. This is the real deal. This is where the pharmacists get their medicines, that's the funny thing. It's always been this way. We didn't invent anything in that regard. Cash prices, client bill prices have always been an option for the labs. Now if you go through insurance, triple surprise on everything because more paperwork, more headache, more hassle. You've talked to Peter Thiel, the co-founder of PayPal or Peter Diamonds, he's author of several great books, but Abundance and say, if you look our exponential organizations and other, if you look at all this innovation that's happening what we'd call unicorns or Silicon Valley type stuff, it's always a simplification of a previous business model. We're going to make getting hotels faster, easier and cheaper. We're going to make getting taxis faster, easier, cheaper. Movies, food, Amazon, whatever it was.

Dr. Josh U.: It never got more complex and more expensive for the customer. But that's the direction we've gone in healthcare. So if you apply those same business principles that make a better product for the customer to health care, it's kind of amazing. It took us this long, nobody's been happy, doctors, patients, employers or insurance companies. But we've rejected this idea of business innovation at the bedside because it's unprofessional, unbecoming of a caring clinician to be business focused. And that led to what I'd say great harm to our patients, the violation [inaudible 00:33:02].

Ron Barshop: You must read with amusement these Pharma pricing alarms that are coming up everywhere. When you read them, you just go what guys? It's just, give me a call. Come on. So let's talk about the three most common drugs. Well, what does the patient pay for albuterol with Atlas versus retail?

Dr. Josh U.: Albuterol is one that we don't have the huge discount on, the vials would be about $2, $2.50 for 30 vials and inhaler would be about a $20 for 60 puffs, $34 for 200 puffs. And then on GoodRx you can see it anywhere from 25 to 54 for 60 puff inhaler anywhere from 40 to 80 for a 200 puff inhaler.

Ron Barshop: That's pretty significant to me. Now what about, pick your favorite hypertension drug?

Dr. Josh U.: Hydrochlorothiazide, the price will fluctuate, but at its best price, we've got 1000 pills for $5.

Ron Barshop: My God, and then what about insulin?

Dr. Josh U.: Can't get insulin cheaper because there's not a generic. But what I like to think was Lilly who back in March decreased their costs of Humalog by 50%. And I'd like to think in small part maybe very small part to this growing movement of direct care and price transparency is when patients have high deductibles, they're very price conscious and when they have a service like direct care where the doctor has both the time and the ability and the knowhow to look for the best prices, then they do and they saved them a bucket. And maybe not in insulin for type ones, but then for type twos it's a little bit more flexible or just get them off of it and spend an hour a week with the patient until they need lessons. And patients are demanding that same kind of price transparency that they can get from us from the other key segments in the healthcare ecosystem.

Ron Barshop: There's so much to talk about. And we don't have a lot more time, but your brother is a consultant for any practice that wants to convert over and he's on your staff. Am I right?

Dr. Josh U.: Yep. Kirk.

Ron Barshop: And I think Kirk is a whole nother interview. I'd love to hear what he does from the very top to the very bottom when he's consulting with a traditional doctor about converting over to your new religion that you are touting. Because I'm really just totally amazed that this is not out there at 5 or 10, 20,000 scale after 10 years. It just seems so logic, so simple.

Dr. Josh U.: I think that's it. I joke that for as much as the Canadians take a national pride in their healthcare system works and all. We sort of have an odd national pride in complaining about the system, but not expecting it to be fixed. I mean, we've heard every politician from both sides of the aisle suggest something. And it's always, I mean, some variation on more insurance, more government, more headache but this is finally an elegant solution to the problem. So Kirk will do all the consulting free to any doctor no matter if they use our software or not. We're passionate about watching this movement grow in the right way, rising tide raises all ships. So soup to nuts walk docs from nothing to in a launch clinic because if we don't, the results are much worse.

Dr. Josh U.: It's patients who are getting poor care because we've burnt out doctors who work too many hours are too sleepy, have no empathy, that are depressed and anxious themselves. I mean, we lose a physician at day to suicide, that's how bad it is out there. So we kind of feel like that's our way

of giving back to the industry as well to not hoard this solution, but we'd get it out there so we can move as fast as we can. But you think-

Ron Barshop: If you take our physicians suicide rate against the veterans, we're actually higher in all of medicine than we are in veterans. So veterans, 40 a day, suicides physicians, one and a half a day. There's no comparison of the rate because of the small number of physicians.

Dr. Josh U.: Which is absolutely insane. But we've yet to have a suicide in direct care. And I don't know if we have the statistical power there yet, but go from zero to 1000 plus doctors in one to nine years. I think we'll start to show that this is a way where physicians can have some work life balance while providing enough care to all the patients without any preexisting conditions. You're flat pricing, unlimited visits, no copays, free procedures, wholesale meds and labs. We've done breast cancer, chemotherapy for $6 a month. I mean breast cancer will always be scary, but it's a lot less scary when it's $6 a month for your medicine.

Dr. Josh U.: And then if you're saving 50 to 60% on your health insurance, I mean, people are paying more on health insurance than they are in their mortgage right now. And that [inaudible 00:38:08] families, so even the healthy are suffering, let alone the sick because they're missing out on life opportunities that they would have if this insurance wasn't such an albatross around their necks.

Ron Barshop: So I have to ask this final question because I have a lot more questions. I think we need to do another talk sometime soon. But if I have a catastrophic event, so that's one in 10,000, one in a million, it's a low odds deal, but it is everybody's worst fear. The cancer, the car accident, the stroke, how does that get handled if I'm strictly DPC? Don't I need a catastrophic layer on top of that?

Dr. Josh U.: I think we get the impression that we are anti-insurance or antigovernment when in reality we're pro efficiency and I think this hits very near and dear to us. My daughter was born unexpectedly with down syndrome when we were in med school three weeks in the ICU and that was only $160,000 back then. I hate to see what that would be now. But thankfully we had insurance because the school makes us and it covered it. And we appreciate that those things happen. But we also appreciate that they are relatively rare and made rarer in the catastrophic financial sense, if you can decrease the cost of healthcare by 80 plus percent, we can get an MRI for $300, not 3000. And if you can decrease what you're spending on health insurance by again, 5 to $800 a month, then you could be healthier.

Dr. Josh U.: It's less stressed at work, less financial stress. You can join the gym, you have more time, you have all these opportunities. But now you can treat

your high cholesterol for a penny a day, $3.65 cents a year and your blood pressure and your other things. You have unlimited access to text your doctor, means you don't have delays when you have depression because you have such great access. And that could be available to just about anybody. I think people underestimate our goal there to make health insurance available to the masses, but we just want it done in an affordable, effective way. Take Medicaid for example. I think direct primary care is a must for any sustainable state Medicaid system. When you think that Kansas at one point was spending $400 a month for generic Keppra for seizures, that I can buy at wholesale for $12. So, pardon my French, but why the hell does CVS get a $388 check every month when the at-risk individual is only given $12 in value? I can maybe not double the budget for Kansas and Medicaid, but I can double the purchasing power and that's just as good, there-

Ron Barshop: You're flattening out the PBMs, you're flattening out the brokers, you're flattening out the insurance companies, you're a gigantic threat. You're FedEx and Southwest Airlines and Netflix all rolled into one. The status quo must not like you very much.

Dr. Josh U.: The only ox we gore really is retail pharmacy. I'll happily throw them under the bus and often try to flip them on social media to get them to pay attention to me. And they very wisely choose not to because they would make us a martyr. We can offer a level price transparency that even the government can't. President Trump has tried numerous things lately to encourage or force price transparency and met with great resistance because it would have to pass legal mustard or legislative session, et cetera. But the free part of the free market is what makes it so powerful is I can get these meds at these prices now and it's sustainable and profitable way for the wholesalers. And they can't stop that. So we don't need a law against PBMs when we intuitively don't want a PBM because you can't make it any cheaper.

Dr. Josh U.: That's the reason these unicorn companies are doing so well is they find value and if that means carving it off another business, they will. Costco, that's the same idea. How big of a store can we build and mark everything up only 14% so that you see value in your membership? Why it took so long to apply it to medicine is kind of beyond me. But this means the insurance companies have told us their profit margins are four times higher working with direct care because we're out competing CVS and Walgreens and Caremark and no one else has been. So if we can do that, when they can't, then they can lower their premiums and have so that they can gain more market share. This is why I don't blame insurance companies, I blame doctors, it's our fault for not innovating in ways that directly help our patients. But now that we know, we can reverse that.

Ron Barshop: How do we number one find Dr. Josh? And then how do we find Kirk?

Dr. Josh U.: Kirk is a probably best reached at his email. Kirk K-I-R-K@atlas.md. And then my email, D-R-J-O-S-H@atlas.md or Twitter or Facebook. We help any doctor free of charge. We have all kinds of materials online. Whenever this hits a low national attention, we get a ton of contacts from patients and we can send them to a map atlas.md/M-A-P map so that they can look for doctors in their area. And it was only a few years ago where we'd open one or two clinics a month. We opened 22 clinics in May, 13 in June and 15 in July. So this really is a grassroots movement that is picking up momentum.

Ron Barshop: Very exciting. Okay. You get to fly a banner over America with a simple message. What is your message to Americans?

Dr. Josh U.: That the free market works here. Direct primary care is a viable and a sustainable option and they can embrace that, that they have a solution that means more care, more often for less money with great insurance at half the price. And if it sounds too good to be true we understand, but that if they embrace this, they can take it to their doctors. The doctors benefit a lot from seeing the positive demand from patients. They just need the extra push. So I really do think that the future is bright. The future is here. It's just not evenly distributed. But the more that patients hear about this, the faster it grows, the sooner everyone will be in a better place.

Ron Barshop: Well, I can't tell you how refreshing this interview is compared to the usual complain and explain solution we hear so much on main platforms. This is really quite a breath of fresh air and thank you for your time and we'll do this again very soon.

Dr. Josh U.: Looking forward to it.

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. 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.