Primary Care Cures

Episode # 28 - Dr. Clint Flanagan

Ron Barshop: You know, most problems in healthcare are fixed already. Primary care has already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and 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.

Well, 2019 marks two giant pivot points landmarks this year that are in healthcare. Number one, department of HHS, Health and Human Services spends more officially this year than the rest of our federal budget combined. So 86% of HHS budget is entitlements, which would be Medicare, Medicaid, and then you've heard of NIH, National Institute of Health and Center for Disease Control, CDC. They're all in there too, but 86% belongs to healthcare expenses. Now the silver tsunami we've heard about so much has adding 10,000 Medicare enrollees everyday for the next eight years, so another 30 million are jumping into Medicare and we're all living longer, so these two facts alone only grow the HHS budget. It will not shrink, it will only grow.

And if you throw in Social Security and interest payments, HHS and those two, are just shy of 75% of our total federal budget. So add Defense in there and that's 86.7%. So the way to visualize this is imagine the cabinet table, the President's at one end at the driver's seat if you will, and half the other table is Health and Human Services and the Treasury, which writes those interest check payments is on about a fourth sitting with Social Security Administration, which is not on the cabinet, separate agency.

And then Defense would take a little slice of the table and then the rest of the whole other side of the table is shared by, only 13% of that table is shared by all of the other cabinet positions combined. So that's Commerce, Education, Energy, Homeland Security, Housing, Urban Development, Interior Labor, State, Transportation, Treasury. You get the idea. So the whole cabinet is not even spending a fraction of what federal health entitlements are.

So interest can only grow. We're at an all time 10 year low. Historical low for interest, so that's going to take up a bigger portion of the table of Treasury. And of course Social Security is growing, so the rest of the table is getting squeezed. Second thing that's happened that's a landmark is over half of all workers cannot access their policy this year due to the illiquidity of high deductibles. So the average deductible is 1350 and well over half Americans can't access $1,000 in their bank account or any liquidity whatsoever.

So half of Americans are also, according to the Wall Street Journal yesterday, priced out of home ownership due to healthcare costs. Two thirds of all personal bankruptcies are medical bill related and one third of all GoFundMe accounts are medical bill accounts. So the takeaway is healthcare bigs have completely overplayed their hand on the game board that they've set up and owned and it's been rigged by them with Congress helping. The costs of care threaten all of these agencies, all of these services that derive our deficits spending like no other single category. "Healthcare has stolen the American dream," says Dave Chase on a TED Talk, if you want to hear something fantastic, 14 minutes. "It's the tapeworm of our economy," says Warren Buffet. "Healthcare," Bill Gates says, "Has stolen our school budgets." So as it stands, it's added so much misery that the voter patients are now actually seriously considering Medicare for all as a very serious debate this cycle, and it's a no kidding joke.

So healthcare today really threatens our way of life more than any other single factor, more than climate, more than extremists, more than China, Russia, irreligious, [inaudible 00:00:04:07], privacy of the Kardashians, you name it. We know from history where this is headed and at what point do the bigs collectively ease off to preserve the host, they're feeding off of, we the tax payers, we the patients, we the employees. Well today we have your answer. If you're a patient, if you're a doc or especially if you're an employer, these folks are specialists in for you guys. You can tune out if you're not an employer, an employee or a doctor, but I think that's pretty much everybody listening to me.

Meet Dr Clint Flanagan, he's the CEO and founder and pioneer of Nextera Health. And when I say pioneer, there are maybe on one hand that many DPCs in America in 2009 when he started his idea. He's a pioneer and he has a vision, and let me tell you what his vision is, that's a unique twist for direct primary care. He has got the state of Colorado very well covered, Iowa, Nebraska, they're covered for employers. So the problem with the DPC if you're an employer, is they may have one location in your metro. Houston has, for example, 15 different DPCs. They're spread out everywhere and they're not a united front, so you can't engage with them. If you, you're a school district for example, and you want to use DPC to

reduce your costs and get wholesale drugs. You can't cut a deal with 15 different industry, but you can with Clint Flanagan in Colorado, in Nebraska.

So Clint was named a top 20 Who's Who in Direct Primary Care in the US. He's been invited to the White House to discuss the future of healthcare. He's a founding member and a co-director of Direct Primary Care Coalition in DC and he's lobbied for state laws that are relevant to their industry. Welcome to this show.

Clint Flanagan: Well thank you so much for that introduction. I really appreciate the opportunity. And you know this all began seeing so many barriers for patients getting access to their primary care physician and having worked in the existing system for a number of years, it became pretty crystal clear to us that we needed to do something different. And truthfully at the time, we didn't even know what Direct Primary Care was. We just started calling it Monthly Membership Healthcare, and that's how it started. Then, I've found a few across the country that were doing something very similar to what we were doing, and that is charging a monthly fee, kind of like a gym membership for access to your primary care doctor, and that fee would cover all your medical visits that you would have with him or her.

So whether you were seen once a week, or whether you had a phone call, or whether you were seeing three or four times, that one monthly membership fee would cover those visits. So we had some similarities to these others in the country that were running Direct Primary Care practices. So we said, "Hey, we're going to join forces," and that's where it all kind of begin and we're having a lot of fun.

Ron Barshop: So Clint, why do you think there's only still 1200 out of half a million PCPs that are in the movement? I don't understand why it's going so slow. It must seem like it's ballooned dramatically from five or six or seven to 1,200 in 10 years, but still that's, 1200 is just a dot on the map. What's going on?

Clint Flanagan: Yeah, I agree that, you'd say, "My gosh, there were 130,000 family medicine physicians in the country. Why are there only maybe close to a couple of thousand primary care physicians doing direct primary care?" And I would just kind of say, a few things. One, years and years ago, we were in the proof of concept phase, right? So we think of us like a startup and the beauty of that was failure, right? So that was the motivator. But I always like to say the bar was set so low with the existing model of care that we have in this country when it came to primary care and fee for service and insurance, that it didn't take a lot for us to step over that bar. So we start moving along, and kept moving and kept moving.

Then we got support the American Academy of family physicians. So that was really helpful, right? Because they represent over 130,000 family medicine physicians across the country. So as this support grew, then you had a number of docs saying, "Oh my gosh, I own my own fee-for-service insurance practice, maybe I should start doing a little bit of direct primary care." So you have that group of physicians, and we call those docs hybrid docs. They're doing fee-for-service insurance and direct primary care. Then you had some of those fee-for-service docs, they're like, "You know what, I've been doing this for 15 or 20 years. I'm surviving but I'm not thriving and I see these barriers. I'm going to close my fee-for-service practice and open up a direct primary care only practice." So you have that kind of a group of physicians and then there's a whole another group of docs that are employed.

And part of what frustrated me 10 years ago, is I saw more and more of my colleagues that had owned their own private practice, that were closing their practice and, or selling their practice to large systems. And, I think one of the best things in America is small business and when it comes to healthcare, I think some of the best healthcare that you can get is from that physician that owns his own practice, so private primary care. So that was super frustrating to me.

So you fast forward here to 2019, and a lot of primary care physicians are employed by big systems, right? And it's a little bit challenging for them perhaps to step away. So what we're providing in direct primary care is a lane for that, a, very experienced doctor to step away from an employed position in a large system.

B, that primary care doctor that owns his own practice that is, let's say maybe struggling a bit in that fee-for-service insurance world, to start a a different lane of revenue to his practice that's way more reliable than the typical insurance fee-for-service insurance lane.

And or c, I think one of the funnest things is you see medical students and residents coming out of residency, like Dr. Paul Thomas, and starting their own direct primary care.

So you know, it just takes time for these things to happen, and people look at us, "My Gosh, you guys have 60 locations and you're taking care of thousands and thousands of people and that's awesome." That didn't happen overnight. It takes time like any business, but fortunately now, there are playbooks for people to look at that make it easier for them as you're moving forward. When cell phones came out, was everybody using one day one? No, but you look at it now, everybody's using a cell phone for all kinds of things.

So, I think it's like anything. You've got to move beyond your startup. You've got to move beyond the proof of concept phase. You get into the lane where you're doing really well and others see that. And when it comes to our lane at Nextera Healthcare, we deal with a lot of employers and there are a lot of moving parts there, as you engage with an employer and or a benefits advisor or broker, a lot of moving pieces and parts. And some people in this kind of dysfunctional healthcare ecosystem, they want to keep things the same. So there are forces, and we just like to be transparent and say, "We're going to charge your monthly membership fee and we're going to take really good care of you. You don't need insurance for that. You need insurance for cancer and heart attack just like you need automobile insurance for your car when it gets totaled, but you don't really use your automobile insurance to put gas in your car or do prevention and maintenance on your car."

It's a bit of a paradigm shift and we've got to get people thinking a little differently. And that is that you don't need an insurance card to get primary care in this country. Primary care is low cost, getting a hip replacement, it's a high dollar thing, so that's a little different ball game. So I look at it understanding that when we started there was just a few across the country and now you have DPC in nearly every state, and you can really see us, probably out in the last probably 12 to 18 months, it's on a trajectory that's pretty impressive, and hopefully here pretty soon we'll hit a tipping point.

Ron Barshop: So let's talk about the offer. I think you addressed it a little bit. If I'm an employer and I come to you and I say, "I want a cheaper way and a smarter way to spend my 15,000 that I'm averaging for my premium. How would you design your practice, they can catastrophic pieces of it that you just mentioned, the heart and the cancer and the car accident, the specialists that I need to go see for some rare situations, but still you need to have a referral. How would you design that plan or do you let the benefits brokers design that and just you're piece of the puzzle?"

Clint Flanagan: Yeah, great question. So I by no means am a benefits advisor or a producer or a broker, but I've, trial by fire learned over the years that there are a lot of opportunities for employers when it comes to designing their benefit plan. And the way that we look at it is, if you as an employer are happy with the amount of money that you're spending for your healthcare premiums and you're happy with your care, then we move on. Nextera doesn't have much of a conversation with you.

What we found over the years is hardly any employer and or employee is happy with the care and spend. So you mentioned earlier in the call, you know, the amount of money that we're spending in America, 3.7 trillion or whatever set to be eventually five to six trillion. For that amount of money

we should be getting top shelf care, right? But we're not getting that at the primary care level. you have benefits advisors and brokers selling PPO plans that for a family of four are 25 to $26,000 a year in premiums. And yet that family is getting an overworked primary care physician that works for a large system that maybe has five minutes with them on their checkup. So they're not even getting top shelf primary care.

So we look at every employer, whether it's an employer of 10 or employer of 10,000 saying, "What are you currently utilizing? What kind of plan do you have for your employee? Are you happy with your benefits advisor?" And we actually look at that as a team approach because a lot of these benefits advisors are innovative and they know way more than we do. So we very much like to approach that from a team perspective and saying, "What can we do to best meet the needs of the employer in the most affordable way?" And obviously where we have expertise is that direct primary care way. We really believe that every employer in America should be offering direct primary care to their employees.

Some of the employers we work with don't offer any health benefit. They're a company of electricians that have maybe 10 electricians and they offer zero health benefit, but they're able to take that money and give their technician a bit more salary or hourly, and when we come onto the ranch, we're $99 a month. So we let that employer know, "Hey listen, you can pay that directly, 100% of it or you the owner can pay 50% of that and take the other half of that out of the employee's paycheck and we'll invoice you once a month." So sometimes that's the type of conversation we're having with small employers, much much different than larger employers.

As we move down that pathway, some of these employers are fully insured, some are level funded, some are self funded. So there's definitely some differences, and we, over time, it wasn't our initial goal to become experts in that area by any means, but we started to find out, my gosh, a lot of these employers are paying a lot of money for things that could be got at a more much more affordable price, number one. But number two actually better care, so we're pretty hell-bent on that better care front.

Ron Barshop: Well, it seems to me if I'm spending 15 on an employee, my employee spending 5,000, which is the national average, there's room in there for the brokers commissions to design these creative plans around direct primary care. In other words, the fee will come out of the dollar saved. You're not having to come up with in other words, to commission to engage these creative brokers to come up with these alternative plans that are self-funded, if you will.

Clint Flanagan: Correct, and brokers are realizing that, and often times they have been and even up until this day, they paid a per member per month or per employee

per month, and sometimes those fees, I've seen them range anywhere from $20 up to $50 per employee per month. When you look at that monthly premium, direct primary care fee is typically less than 10% of that monthly premium.

So let's say the premiums is a thousand dollars a month for the health insurance plan with Blue Cross, United, Anthem, Cigna, direct primary care, our prices on average are around $70 per employee per month or per member per month. At Nextera, we charge 99 for the first employee, I'm sorry for the employee, 79 for the spouse or partner in $49 for kids. So when you look at actually what you're spending for direct primary care, it is a fraction of your overall premium, but the important piece that a lot of people don't realize is that, that spend can affect all the downstream spend.

So that's what we've been able to show employers is that when you give your employee and their family access to high quality primary care, that where there's no copay, there's no bill, employees start to come in more. They get a relationship with their primary care doctor, which is one of the most important things, and that doctor can take care of up to 90% of what patients need. And in this case, it's $1,200 or less per year, if you look $99 times 12, it's 1200 bucks. Shoreham had an article here in 2019 that showed that employers are paying up to $15,000 a year per employee. So as we have these artful conversations with benefits advisors and employers, we're very transparent about our fees, we're very transparent about what we do. And those savvy brokers are starting to say, "Hey listen, rather than being paid a per member per month from United or Blue Cross, I'm going to be paid as a healthcare strategist. Pay me a lump sum essentially, and you the employer pay me that.".

A lot of these benefits advisors, while they work for benefits firms, technically it's United, Anthem, Aetna and Cigna that are paying them, right? So we just think there should be transparency there. We think that employers, when they're writing checks, they should know where their money's going, what it's going to get them. And we're so focused on that with, we at open enrollment meetings, we actually bring our physicians to the open enrollment meetings and say, "Hey, listen, here, employees are the physicians that are within your catchment area." And we found over time that, for years and years and years, physicians have never gone to benefit meetings. So imagine that as an American or an employer owner, you're paying for something and you have no clue what you're getting. That's just not the American way.

So we really see a lot of change happening. And to your point earlier, this is why it's been a bit of a slower process than one would might expect because there are a lot of moving pieces, and one of those pieces is so many of the larger employer groups are fronted by benefits firms. And, I

think it's important to have transparency, pull that Wizard of Oz screen down on how those brokers and advisors are being paid.

Ron Barshop: I'm going to assume that most of your employer customers are going to be smaller businesses and that some of them have multiple locations and that's why you've got Colorado and two other States covered with these 60 locations and you're growing. I really like your model and that you're taking care of ... You're really designed for employers with a universal offering, unlike the Houston example I gave.

So what data are employers requiring when they have multiple locations to make sure they're on top of all this? What new reporting do you have that you didn't before you became an employer's DPC model?

Clint Flanagan: Yeah, there are a number of different answers to that question, so I'll try to keep it simple. So there are fully insured plans, and in fully insured plans even employers don't get that much data. Then there are level funded plans and self-funded plans and in those plans there is more data that flows. And what we like to look at, I'll give you an example of a couple of employers that we take care of. They're self-funded, they have a TPA, and then that TPA and, or the benefits advisor, they have some analytical capabilities. We also have analytical capabilities when it comes to looking at every single claim that that employee has. And I like, being from Nebraska, I like to call it, we have what's called the Nextera ranch.

We like to keep almost all of the medical encounters on our ranch. But a lot of times employees may go off our ranch and when they go off our ranch, let's say for hip surgery or carpal tunnel surgery or a hospital stay, that's a claim that claim moves through the TPA, hits the plan, and oftentimes as an employer, employer is actually paying that claim. They're playing, let's say, the United Healthcare rate with the local hospital system.

So we think it's really, really important to understand every touch that the employee has in the system, it can be a little challenging trying to get those touches, but we're able to do that and I think it's even a better step to compare the total spend per employee per year in the Nextera bucket with the other buckets of healthcare that the employer offers.

So I'll give you a direct example. We have a school district that we take care of. They have Nextera attached to a PPO plan and then they have a PPO plan that doesn't offer Nextera. We like to compare those two buckets. And when we did that for 2018, we saved this school district about 29.4% on total spin compared to the other PPO bucket that didn't have Nextera.

Ron Barshop: So you're making the case that as you call it, top shelf primary care where they have the time. So let's give an example. Your average day looks like what? I spoke to Scott, six to eight is a busy day, when I spoke with Josh, six to eight is a busy day. What is your busy day look like?

Clint Flanagan: Yeah. So if we go back two years ago, our busy day was seeing 30 to 35 patients a day. That was a classic fee-for-service system where you're seeing probably a minimum of 25 to 35 patients per day. Every patient's a transaction, you don't have enough time with your patients. You're moving from patient to patient and you're doing so because that's the chassis, that's that fee-for-service insurance chassis that primary care sits on. And I'm telling you, there's hardly a doc in America that in his medical school or her medical school essay said, "I want to see 35 patients a day in billing code and be a data entry specialist for a third of my day." Right? That's not where we signed up for, but that's what we have.

If you transition, I'm sorry, if you contrast that with Nextera Healthcare, our docs maybe see 10 to 15 patients a day. That depends on which doctor you see in our community of Nextera physicians, because some of our next physicians own their own DPC practice and they're part of our Nextera community, and part of what we can do for them is send employees and members their way. They may see maybe five to 10 patients a day. Some of our busier docs that maybe have a bucket of Nextera patients, but still a bucket of fee-for-service patients, they may see 12 maybe to 15 patients a day.

Understand though that those visits don't always have to be face to face. Some of those visits are on the phone. So those virtual visits are included in that total amount. Virtual visits and fee-for-service insurance hardly ever happen, right? Insurance companies typically require that we bring the patient in, in order to bill. So if you're doing virtual care as a primary care doc on a fee-for-service chassis, you're not able to generate revenue and your practice fails.

And so, in the direct primary care chassis, whether you see a patient face to face or you handle their concerns over the phone, we just wanna make sure we're doing good medicine and doing it in a convenient way. So, direct answer to your question, direct primary care doctors see less patients than fee-for-service docs and have more time, half hour, an hour to spend with patients versus five or 10 minutes. We like to laugh that, in a fee-for-service world you spend more time in the lobby than you do with your doctor, versus in the direct primary care world, that's exact opposite.

Ron Barshop: So if I'm a PCP listening in, and I do have a lot of those kinds of listeners, there is a couple of questions I have. Number one, okay, so I'm saying six to eight to 10 a day, plus I'm texting maybe on the weekends and the

evenings, but what happens to my 2,500 patients? How many will sign up? And the numbers I've heard is 10 to 20%, maybe 250 to 500 patients will sign up for this 99 or $100 a month service model. Is that about right?

Clint Flanagan: You know, I don't know that there's been any direct study on that, but as I've pulled my colleagues over the years, let's say, most family medicine docs have maybe about 2000 to maybe tops 3000 patients on average. I know there are some that have 5,300, okay? But on average they have about 2000 if they'd been in practice, let's say 10 years. You send out letters to all those patients say, "Hey listen, I'm going to convert my practice over in six months," and I would say just to be conservative, that maybe 10% come along. So out of the 2000 you have 200 that come along. So that's a little more aggressive way of transitioning.

Others will say, "Hey, I want to open up a DPC business, maybe a separate tax ID number within my existing fee-for-service practice, and I'm going to start to advertise to the 20 to 40% of patients that walk through my door that have high deductible health plans." That's what we did back 10 years ago, because a lot of our patients were like, "Hey, I can see you once a year for a checkup, but when I've come in for my high blood pressure follow up or my cholesterol follow up, I'm out of pocket that 150, $200 for the visit until I meet my five or thousand, or $10,000 deductible.

So that's a bit ... Many, many years ago, a light bulb went on for us and we're like, "We need to not be beholden to Blue Cross. United, Anthem, Aetna, Cigna on the primary care side. We're going to go directly to our patients and say, we're going to charge a monthly fee a and we'd really like to take care of you and you can use that insurance with that high deductible plan in case you get cancer."

Ron Barshop: Okay, so Clint, I'm on the math here. I'm looking at what you just said. I'm taking 200 patients times the hundred dollars a month, that's 240 grand a year, I've still got rent to pay. I'm going to need some staff, I can't go completely staff-less, I have no biller-coders anymore, but I may need some front desk and some exam room cleanup. so a couple of MAs. So 240,000 I just took a big pay cut, but of course I'm also going to be marketing, which I've never had to do before as a physician to my neighborhood, to my radius. So maybe a four mile radius, I have to start doing social media. I have no skillset for that.

So I think a lot of the leap into the DPC world is looking at these numbers and saying, "Well, you know, it's just not enough for me to make what I was making before. I'm gonna probably get need to get another loan to finance my practice to rose and can support maybe 500 or 600 patients. So

I can see where there's a little fear factor with this low number of a 200 maybe converting.

Clint Flanagan: Completely agree, and you know what, not every family medicine doc wants to be an entrepreneur, so many of them are completely fine with being employed. And I think that statement needs to be understood across the family family practice landscape in this country is that many don't want to do what you just said. They don't want to get an Instagram and a Twitter account and post to Facebook and all that jazz. So that's why, fortunately there are direct primary care companies out there that employ physicians. My company's one of those. I hired four providers, physicians last fall and I pay them a annual salary that is very competitive to the large systems here in Colorado. Again, they're working maybe 35 to 40 hours a week, four days a week, salaried, and then as their membership grows, there is some kind of bonus or further compensation on top of that. And they're seeing maybe 10 to 15 patients a day, not 25 to 35 patients per day.

So, there are other options for primary care physicians in this country versus you must open your own practice and it'll always be that way. There always be employed physicians and there will be those that want to own their own practice. So at Nextera, we offer lanes for all of those. If you want to be employed, we're happy to hire you, number one. Number two, if you want to open up your own DPC practice, but you're struggling getting members, connect with us and will help drive membership your way. And, or number three, if you're a fee-for-service practice and you're like, "I don't want to close my doors and my fee-for-service world, I've been open for 20 years, but I would like to step in the direct primary care arena," connect with Nextera Healthcare and we can show you how to do that. We have a playbook on that, we've been doing for years and we have expertise that allows us to do those kinds of things.

Ron Barshop: Okay, let me just get a one word answer from you on these laws. Which laws go away if I'm not accepting fee-for-service? Stark law, does that go away?

Clint Flanagan: I don't know that that goes away and I will, disclaimer, I have very smart attorneys that help us.

Ron Barshop: Okay. Anti-Kickback, I'm fairly certain goes away because you're not taking federal.

Clint Flanagan: We're paid by employers and paid by our patients.

Ron Barshop: So now Anti-Kickback HIPAA is going to still be required?

Clint Flanagan: You know, that's a good question. We've kind of debated back and forth about that, especially if you don't have contracts with CMS or Medicare. We fortunately have a healthcare attorney that's a HIPAA guru. So I defer all those questions to her. But you know, I see where you're getting at in the in the short is you'll have less things regulating you.

Ron Barshop: Yes. Well so again, the real interesting thing that I noticed when I looked at your locations, you seem to be on the fringes of major metros. You like small towns, don't you?

Clint Flanagan: I'm from a small town in Nebraska. We started, in our early days here at Nextera, one of our clinics was in rural Colorado, and DPC can be done about anywhere. You just got to find the right lanes to do it. And early in the call, you mentioned our locations and I just want to be clear, we have about 30 locations here in Colorado and then we're in seven other States, and those States are Michigan, Maryland, Virginia, Washington, DC Area, Florida, Iowa, and Nebraska.

Ron Barshop: Congratulations on your success. I think you're showing the folks how to do this right, because again, the big employer dissatisfactions, they can't seem to get geographical coverage for their employees and you are solving that problem in spades.

Clint Flanagan: Yeah. You know, it's over time ... I'll give you an example. We have a trucking company we take care of or moreso the truck drivers, are within an hour of our clinic. But one thing that we've designed is rather than spend $99 a month for the truck driver that lives, let's say, an hour from our office or two hours from our office, we lower that rate to 59 and offer virtual primary care. And so we do that with the understanding that those truck drivers need care, but they live, let's say, in a small town where there is no primary care. And HR and CFO and CEO want to offer primary care services to this truck driver, so what we've designed over time is we've designed a system that allows us to provide primary care and in that case it's virtual, most of the time. Some times they'll come in face to face, but it's a virtual care solution where they can be on the road and connecting with their doctor.

Ron Barshop: That's very nice, and they're probably bored out of their mind on that highway. So let's talk a little bit about, if I'm a physician and I want to think about converting and I'm not in one of your States, what resource would you send my way to learn more about this?

Clint Flanagan: Yeah, so fortunately there's a lot of information now. A great place is DPCfrontier.com. So Dr Phil Eskew has put together an excellent website that has a mapper on there showing DPC docs around the country, that's

pretty up to date. He's got all kinds of nonacademic and academic articles on DPC. Excellent, excellent place, number one.

Number two, if you Google Hint Summit videos, a company out of San Francisco, Hint has archived videos from conferences that they've held as well as I think even other conferences. And there's just a treasure trove of information for at least three years, on physicians speaking about their direct primary care experiences. So that's a second place for information.

The third place is Docs 4 Patient Care Foundation. So Dr. Lee Gross has a foundation and they have a Nuts and Bolts Conference every year down in Orlando, that is awesome. I spoke at it last year and and I believe they archive those videos as well.

So those are some places online. The American Academy of Family Physicians has a DPC resources online as well. So those are some good places to learn about DPC. On our website, our website's Nexterahealthcare.com and again, it's the next era because we weren't happy with the first era. N-E-X-T-E-R-A healthcare.com. We've got a fair amount of information as well. And then there are typically at least three or four summits and conferences across the country, and the one that I mentioned is the Hint summit, that's usually about every April or May. Number two is the DPC Summit put on by the American Academy of Family Physicians. And then number three is the Docs 4 Patient Care, Nuts and Bolts Conference down in Orlando, typically every November.

Ron Barshop: All right. So Clint, I have a couple of final questions. How do people find you if they want to go to work for you in those five or six states that you're located in?

Clint Flanagan: Couple of ways. So number one, our website is Nexterahealthcare.com and then on that website you can click through careers and send information our way there, number one. Number two, you can call our main number is (303) 501-2600. So those are two pretty good ways to get ahold of us.

Ron Barshop: And my final stumper question is, if you could fly a banner over the country with a simple message for Americans to read, what would that say?

Clint Flanagan: Yeah, that's a no brainer, DPC for everyone.

Ron Barshop: I agree. I really cannot find in my mind anybody that wouldn't be a good fit for. If you're an employer, if you're an employee, if you're a doctor, physician, primary care, even a specialist or starting to join the DPC movement I'm seeing. So it's very exciting times for you guys.

Congratulations on all your success and we'll look forward to having you again sometime soon.

Clint Flanagan: Thank you. I really appreciate the opportunity, and thanks again for everything that you're doing to put the message out.

Ron Barshop: You Bet.

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