Primary Care Cures

Episode 39: Dr. Paul Thomas of Plum Health DPC Part 2

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 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.

Wiki defines a pure monopoly as a single seller with no competitors. Pure monopolies are pretty rare. Monopoly power, however, is the extent to which a firm can influence and even set the market price or influence the quantity supplied to the market. In 2000 update to the competition studies by the AMA, [inaudible 00:01:01] insurance carriers undermines the physician practices and can harm patient care. So, concentrated market squeeze doctors, prices only rise. The study examines market share concentration data for 50 states and DC, 380 metropolitan statistical areas. And researchers found that most commercial health insurance markets are highly concentrated in this right for the exercise of this monopoly power.

Hospital Metros aren't much different. In fact, they're more monopolistic. They're completely concentrated in this same SMSA. 93% says a 2017 study, and there's dozens of areas of medical devices that are maybe concentrated to two or three players. Hospital beds and fusions come to mind. Two big ones.

Dental suppliers, there's only three or four big ones. And even in PBMs, there's only three big 800 pound gorillas today. So, these are the largest revenue wise of all the bigs or the PBMs. Pretty good indicator. So this is what happens to monopolies. One day, they aren't anymore. History is replete with fallen angels. The DOW looks radically different every 20 or 30 years and the bigs get broken up. So how do you opt out of this specially designed medical game of monopoly, but this monopoly game board is tilted and it's not in your favor as a patient and employer or as a doctor. The dice are loaded, they're rigged. The rules are not in your favor either. You get 200 pass and go, but the other guys get 800 pass and go, sometimes 2,000, and the bank is not in your favor.

The rent is double or triple yours on the same orange or purple street and they're not paying any taxes, personal property taxes, income taxes, and you're paying all that. They're not paying state and local taxes, county taxes, inventory taxes. You're paying all that. They pay none of that yet. Yet, they enjoy every government service you do. In fact, one tax you pay is to the community just as a county hospital tax to the other player. Think about that for a little bit. They throw galas with those dollars to raise even more dollars if they're a nonprofit. And over 70% of the 50 top hospitals are nonprofits and they are the best party in town every year.

They have the most respected community board members and they're impeccably professional and deeply respected CEOs at the local chamber of commerce. The go to jail rules that exist for you don't exist for the other players. They can self refer in bonus, but you can't. You have to hand back all that monopoly money if you do the slightest clerical error. So, here's a novel idea, opt out of the monopoly game. You don't have to play. Today, you're going to meet round two with Dr. Paul Thomas of Plum Health. He's a Ted Talk sensation from the PCP world. And Paul road tripped during his residency his way to pit stops like Atlas MD, NextEra Healthcare, and he met with Dr. Josh [inaudible 00:03:55], a pioneer in direct primary care. Paul, welcome back to the show.

Dr. Paul Thomas: Ron, thanks so much for having me on and I really think you hit the nail on the head there in terms of the monopoly that the healthcare ecosystem has right now, where it's hard to be independent and you're seeing a lot of doctors driven out of independent practice and into these larger and larger and more and more consolidated hospital systems.

Ron Barshop: Not only is it not fair, but there is an option. You took the high road and decided you weren't going to play monopoly. You did something that I would consider an outlier. I don't know how many residents go straight into direct primary care, but you chose not to even do a stint and fee for service. You just ran straight into direct primary care. Tell us a little bit about that choice and how you learned from the best before you launched your own practice near Detroit.

Dr. Paul Thomas: Yeah. Well, in my last year of medical school, I actually heard Josh [inaudible 00:04:50] on a podcast and I kind of filed that idea in the back of my brain because I thought I was going to be a professor at a teaching hospital and seeing patients and working with the residents and students, but the deeper and deeper I got into my residency, the less and less time I had with my patients. And I found myself really unsatisfied in the level of care I was able to deliver to my patients simply because I didn't have enough time.

And then I got to see Clint Flanagan, Dr. Clint Flanagan of NextEra in Michigan. He was speaking in a conference in Michigan. And so, I talked to both of these physicians and I asked if I could visit their practices. And so in my last year of residency, I wrote a curriculum, a direct primary care curriculum, and I drove out to these two practices and I took the best of their ideas and I brought it back to my hometown in Detroit. And that's where I started Plum Health. And that's three years later from that moment, I'm full with 500 patients and I've brought on a second doctor to help me meet the additional demand.

Ron Barshop: It's so funny to hear somebody say full with 500 when the typical fee for service is got a panel of 2,500, 2,000.

Dr. Paul Thomas: Oh, yeah.

Ron Barshop: 500 and you're full though.

Dr. Paul Thomas: Exactly.

Ron Barshop: Tell us about your day. What does a day look like for Paul Thomas?

Dr. Paul Thomas: Well, typically most busy on Mondays and Fridays and I'll typically see about five to eight patients each day. Typically, one hour for new patients and 30 minutes for followups. I'll do a lot of texting and phone calls with my patients. I typically field about 20 to 30 text messages each day and just answering some simple questions or coordinating appointments or texting my patients and asking them, "Hey, I saw you on Wednesday with a runny nose and cough. How are you feeling today now that it's four or five days later?" So, that's a workflow that I have and I'm typically in my office 9:00 AM to 5:00 PM.

Ron Barshop: I'm really sorry that you have to sweat those eight person days. That's a really tough schedule. But of course you're texting and you're not sitting around playing Candy Crush. You're busy, but you're also not crushing a 25 panel day. You're just eight panels. Eight persons, that's not exhaustion.

Dr. Paul Thomas: Right. The other part of it is like on a weekly basis, I'm working on blog posts. I write a blog post and shoot a short YouTube video and post that onto my blog. And then on a weekly basis, I reach out to a small business in my community and ask them, "Would you like to enroll your people into our membership model?" And so, there's different hats that I wear. I'm of course always checking like the finances of the business and making sure that our profit and loss statement is lining up each month. So, there's other things beyond patient care and I just fit those between my patient visits so that my business remains healthy as well.

Ron Barshop: So, let me just suggest to you my observations of the difference between the two mentors you had. I believe Josh, his model, he has two different practices at different parts of Wichita. He's got a couple of doctors at each. They're pretty much full, but they're still taking patients that are seeing 500 to 600 each. And their model is really more kind of riding the momentum of being an early pioneer. So, they have some employers and some social media like you do. I would say you're more purely social media and I would say NextEra is more purely employer. There's no such thing as purely, but you know what I mean. I think they're more focused on getting the employers locked up and you're more focused on more of maybe more of a balanced practice. Am I hitting that right?

Dr. Paul Thomas: Yeah, I think it's important to develop relationships with small businesses because I really believe that if you're a small business and you're not offering some sort of health care benefit, you would be doing your employees a great service by offering something like this, even if you can't afford health insurance. This is something where offering like direct primary care can help employees maintain a good level of health and have something where they can actually access a physician and have guidance through their illnesses and injuries. And then, I'm also really focusing on social media and reaching the general public. That's where 90% of my members are coming from. So yeah, I try to strike a balance of landing some larger groups, some larger customers, and also maintaining an outreach to individuals.

Ron Barshop: The good folks at [inaudible 00:09:29] office told me that if you go too big and you land too big of a client, if they disappear from the market, you've got an interesting problem all of a sudden.

Dr. Paul Thomas: Right, right. Yeah. I mostly am focusing on those employer groups that are fewer than 50 full time equivalent because those are the folks that aren't mandated to provide health insurance for their employees and they often end up in this messy middle where they're not doing anything because they don't know what's out there.

Ron Barshop: How much time do you spend with the brokerage community in your town so that they are presenting you as an option? Because it seems to me that the employers can opt out of monopoly too. They're playing a game where over half their employees... Well, 70% of the employers are making less than $15 an hour. Over half their employees have deductibles. They simply can't afford to even opt into because of their liquidity. And so, they're sitting on a policy that really gives them no sense of taking care of their family and they're afraid to use it. And the copays are just and the deductibles are just simply out of reach. So the brokers, there was a tipping point this year. Over half of the employees now have hit that unusable policy. They basically got called shareholder insurance. It's not

employer insurance or employee insurance anymore. So, how much of this is educating brokers in your community?

Dr. Paul Thomas: I think that's one of my weak points. In full disclosure, I really don't have any relationships with brokers in my community because I haven't been able to find someone who understands what I'm talking about. Or if they do, they want to have some massive cut on my business. So I'm not really down with that. And I've been successful in growing my practice without brokers so far. If I find one that works well for me and aligns with my mission, vision, and values, I'd be happy to work with them. But at this point, I'm not really seeking any out.

Ron Barshop: I understand. It just amazes me that employers have not discovered the power of DPC, that they could maybe add a small catastrophic policy on top of what they have and they could use a local DPC. Now I think one of the reasons DPC has been stymied is because you don't have a geographic footprint in Detroit for example. You're not aligned with the others that are in your business. And so, you can't go to one employer and say, "Here's our universal plan."

Dr. Paul Thomas: Right. Yeah, that is one barrier, is developing quote unquote a network of direct primary care doctors in a region, and then taking that network and then offering it to larger scale employers, maybe somebody with 200 or 500 employees and offering this as a viable option with geographical coverage. Now, I think some doctors are scared of that because they don't want to be a part of the network. They have nightmares of HMOs and problems there. And so they are just happy to be independent. So, how do you convince a lot of doctors to band together is a unique challenge.

Ron Barshop: The very reason they went independent is to be independent.

Dr. Paul Thomas: Right, exactly.

Ron Barshop: Let's talk about if I'm a physician, I don't have to live in Detroit to get help from Paul Thomas. You, sir, have figured this thing out. You're a Ted Talk sensation. You've got a model how you did that. That's not something you just wake up one morning and do. You've become a social media maven to some degree to fill your panel up. You're hiring a second doctor, which is pretty cool. You've done all this with no employees. This is all you, isn't it?

Dr. Paul Thomas: It is, yeah. Yeah. It's been a lot of work but really enjoyable. And additionally I'd add to that list, I've been able to speak at some of the national direct primary care conferences, the AFP conference, the summit. I've spoken to the last two and then the Nuts and Bolts Conference in

November in Florida with Dr. Lee Gross. I got invited to speak last year and share my experience and how I did all of this.

Ron Barshop: You know why you did? Because you don't say the word you know and like about every third word like my other friends your age do.

Dr. Paul Thomas: I try to avoid those.

Ron Barshop: It's amazingly sickening. Okay, so let's go to the first step. I'm interested as a physician, I've got a nice family practice, 1,500 2,500 in my panel. I'm sick of the monopoly game. What's my first step with you to get started? What do we do?

Dr. Paul Thomas: Well, I actually get this question so much that I decided to put all of my knowledge into a website that I recently created and it's in a soft launch right now. It's called startupdpc.com and it's just startupdpc.com. And folks can go through and read how to, how to start a direct primary care practice. There's a long form blog post that I put there where you can read through, okay, do I have the right mentality to start this? Am I willing to give up the paycheck? Do how to come up with a great name for my practice? How to develop a website? How to build out social media channels? And that kind of gives you a broad overview of if this is something that you want to tackle on your own or with a partner or with some help. And then, I take it one step further and I take a really deep dive into individual topics. And I put together some courses that people can take to really cement their knowledge and become proficient in the skills that you need to become a great direct primary care physician with a thriving successful practice.

Ron Barshop: It's just so much about professional courtesy, isn't it? I mean, just got to be nice to people, don't you?

Dr. Paul Thomas: Yeah, that's a big part of it. A lot of people in medicine have no business experience. And one of the things I often tell people is business is relationships. So as a primary care doctor, we are the most friendly, outgoing doctors that there are. And so how do you cultivate good relationships with people in your community, with small business owners, to create a practice that works for you and works well for your patients?

Ron Barshop: Okay. So, step one is you're going to help me make sure I've got the right mentality. We're going to work on a name together. What happens next with you?

Dr. Paul Thomas: Well, I do a lot of consulting with people around making sure that their website is designed to convert people from thinking about direct primary care to being a paying member of your practice. And I call that the direct

primary care sales funnel because you need to take people off of the channels where they hang out like Facebook or Instagram or YouTube or Amazon and bring them back to their website so they can purchase a membership in your practice. And a lot of doctors don't know, one, what that concept is. And if they do, two, they don't know how to execute on that. So, I really coach physicians on how to bring people from a Google search, back to their website through tools like search engine optimization, right?

And these are foreign concepts to doctors. If you're hearing search engine optimization for the first time and you're a physician, that's really why I put together these courses online because it is foreign. It's not something you learn in medical school. It's definitely not something you learn in residency, but it is an essential tool that you need to use to build your direct primary care practice.

Ron Barshop: It's funny, the reason I'm even here today as the top divorce attorney in Houston was I was having lunch with a guy and he has a reptilian face. He looks exactly like James Carville. He's got a very narrow... He's got a forked tongue. I think he has scales and not human skin, but the guy is brilliant at SEOs, search engine optimization. And I said, what did you do to become number one in a city like Houston that has a bajillion guys that have been working with the moms and the moms and the moms for generations? How did you break through that and become number one? And he said it's all about content. He had hired the top attorney out of UT, University of Texas, to do nothing but write content for a year. If it has to do with toenail fungus and divorce, she wrote about it. So, she tied everything she could into a year's worth of effort of divorce. And it just popped up to number one in Google. And I think with your videos that you're doing and with your content that you're providing, maybe that's why Plum Health... And what a cute name.

Dr. Paul Thomas: Oh, thank you man.

Ron Barshop: Cute as a plum, right? It's just-

Dr. Paul Thomas: Yeah, plum awesome.

Ron Barshop: It's plum awesome. You can't miss that word. It's going to stick in your brain, but that is I think maybe that's one of your secrets too, is that you are memorable and that your content is probably very, very solid.

Dr. Paul Thomas: Yeah. So riffing off what you just said, content is king, as we say in the digital marketing world. And so, if you're able to consistently create high quality content that's engaging, that brings your audience in, they'll be wanting to come back to your blog or your YouTube channel over and

over again and it helps your message resonate with people and it increases your search engine optimization. And that's really the goal. So, that's the bread and butter of this course that I'm producing right now called search engine optimization for direct primary care doctors.

And it really walks you from A to Z how to create the content, put it onto your blog and get people back to your website. So, that's a crucial skill that I want every doctor to learn how to do. Because I really believe in primary care doctors. I really believe in family medicine, in lowering the healthcare costs in America. And if I can make it easier for doctors to convert to this practice, that's what I will do. And this course, this website is one way to help doctors help themselves and better serve their communities.

Ron Barshop: And I'm assuming there's a fee to get into the material.

Dr. Paul Thomas: Well, I have a bunch of free content on my blog, so if you... I've had people just ask me questions and I've written blog posts and I've shot YouTube videos to answer those questions. And there's a lot of great content there. We call it like freemium content, but if you want to get into the premium stuff, you can take one of our courses for $99. And that's the cost of one patient, one or two patients per month. But this is a onetime fee. So if I can help you attract two patients to your practice, which I guarantee I'll be able to do, this course pays for itself.

Ron Barshop: Sure. Well, it's a very generous spirit. I think Kirk [inaudible 00:20:26], Josh's brother does some of that also for free and consults with people. He told me he had consulted with 600 different DPCs that are in practice today.

Dr. Paul Thomas: Yeah. Sounds about right. From the time I started, I've probably worked with hundreds as well. Jus either answering a quick email, taking a phone call, answering a question through a YouTube channel, and I know I've had thousands of people reading my blog posts just from looking at the backside of my blog at the metrics.

And some of my most popular blogs on my Plum health site, which is really geared towards customers in Detroit, are my blog posts about starting a direct primary care practice and how I did it. I know those are physicians reading those, so I was like I really should create a separate website and put all of that material onto the startupdpc.com website and draw people to that website so I can really focus on that demographic.

Ron Barshop: I'm not trying to end this interview earlier, but while you're talking about I want you to mention how they find your blog and your web posts, how would they find that if they're listening right now?

Dr. Paul Thomas: Yeah. If you want to head over to startupdpc.com or you can go to the blog there at startupdpc.com/blog and you can read through the content. And if it resonates with you and you want to take the next step, you can take one of our courses. And I hope you really enjoy the content. I hope it's valuable for you and I hope it helps you serve your patients and your community in a better way.

Ron Barshop: What are the most common fears that physicians have to make the leap?

Dr. Paul Thomas: Oh man, there are a lot of them, but I think the most common is leaving that guaranteed paycheck and starting from scratch and knowing the numbers and knowing the budget and all of that. That's a huge fear. And then the second fear is, well, how am I going to get patients to join my practice or come over, follow me from my fee for service to my direct primary care practice? So those are the two biggest ones. And I really drill down, especially on getting patients, that's my forte. That's my bread and butter. So I really focus on how you can get patients to convert and become members of your practice.

Ron Barshop: Is it a pretty good rule of thumb that, Paul, about 10 to 20% of your cohort is going to become patients of DPC?

Dr. Paul Thomas: It's reasonable. And it depends on the income levels. It depends on a lot of different factors. The proximity to your office, the level of service that you provide to people, whether people like you. One good rule of thumb is if your patients are saying I don't know what I would do without you or you're the best doctor I've ever had. Or if you are a resident, remember your last year of residency when you went into private practice or left your residency? Did your patient say, "Man, I can't believe you're leaving. It feels like time has flown by. I'm really going to miss you."

If people are saying those things to you and you're going to start a direct primary care practice, I don't think you're going to have any problem filling up and getting full. If not, you got to cultivate those soft skills of delivering a wow experience to somebody to communicate more clearly your treatment plans and help people along. So, there are a lot of factors that go into this and that's one of the things I want to help doctors cultivate. How to deliver a wow experience for their patients.

Ron Barshop: I'm going to make a guess, Paul, that your residency did not prepare you to deliver a wow experience in a hospital.

Dr. Paul Thomas: No, they did not. No, they did not. That is not a part of the ACGM curriculum or the residency curriculum.

Ron Barshop: So, this is something either you developed on your own or you just realized common sensically you cannot take much of what you learned other than the practicum into your clinic. You've got to rethink how you present yourself and what you're all about, don't you?

Dr. Paul Thomas: Oh, definitely. And you have to figure out what the market needs and what people in your community need. There's an exercise you can do called like creating a customer avatar. What's your ideal customer look like? And if you can't define that, you're going to have a hard time finding customers because a lot of docs go into this and say, "Direct primary care, that should be great for everyone." And yes it's possible, but how do you target your perfect client? How do you attract the perfect person in your practice? So, these are things that I've learned through taking courses, through reading business books, through attending the summit, attending different conferences, having private conversations with other direct primary care doctors.

And I really just want to distill all of that knowledge into a really digestible format for direct primary care doctors. And I don't think there's a perfect resource out there. So, I'm trying to develop that perfect resource for DPC docs.

Ron Barshop: So, what other resources can people go to to learn more about DPC, whether it's a conference or a book they can read? I know you've written a book, haven't you?

Dr. Paul Thomas: Yeah, I wrote a book for the general public just on what direct primary care is, like what's the ethos of this movement? And that's up on Amazon. It's called Direct Primary Care: The Cure For Our Broken Healthcare System.

Obviously, I'm not biased at all and I think the best way to learn is to develop a mentor, find a direct primary care doctor who's done this well, reach out to them. You can also attend one of the conferences. We just wrapped up the DPC summit at the end of June in Chicago. And then in November, there's going to be the DPC Nuts and Bolts put on by Dr. Lee Gross. And really, check out our blog at startupdpc.com. I'm going to be putting a lot of fresh content there that you can really dive into and immerse yourself in.

Ron Barshop: So Paul, I am a DPC customer, a patient. I walk into my doctor's office, I don't show a card of any kind. There's no copay, there's no deductible. I get same day service if I want it. I walk out without having to show a credit card or debit card. I get as much time with the doctor as I want. I feel like I'm treated specially, like I have as much time as I need. I'm opting out of the monopoly game too. In terms of being a customer of a

traditional insurance company, where none of that happens. My labs are at wholesale costs, my drugs are at wholesale costs, and the same for all my employees. And if they make under $15 an hour, there are assistance programs that my DPC finds basically the drugs for free. So, you also have I think a specialty component like Atlas has, where you pass them through to a wholesale specialist, if you will. Does that make sense? If I need to get referred, how does that work?

Dr. Paul Thomas: Yeah. I actually use Rubicon, which is an eConsult platform and I'm able to take their concern, write it up into a concise consult that I forward to a specialist, like a rheumatologist or dermatologist or a cardiologist, and I get a response typically within 24 hours and help my patient to the next step in their health journey. And that's at no cost to my patients.

Ron Barshop: So, you're giving a care plan or working out a care plan for that patient.

Dr. Paul Thomas: Exactly.

Ron Barshop: And then what about for pharma? What kind of pricing are they seeing with the pharma that you're prescribing?

Dr. Paul Thomas: Oh, I wholesale the medications and I sell them to my patients at cost. So, I get them from a distributor in Florida and I give them to my patients at cost. And we typically save 80% to 90% on the typical prescription prices in the marketplace.

Ron Barshop: Yeah, I just was blown away as they were walking me through the different prices of insulin and albuterol and hypertension drugs. It's just pretty amazing what they actually cost versus what we're charged. So, the bottom line is, since we spoke in our first interview, I had the strangest experience that I've never been in an ER before. I had my 60th birthday in an ER and that's a lot of years to go that walking into one of those. But here was my experience, and it was a man that I love but I don't like very much. So I'm telling you with a little dispassionate story. But I walked into an ER, he had been wheeled in brain dead because he had been without oxygen too long. And so as a brain dead patient, they kept him on life support for four days.

They ran two different MRIs. They ran an x-ray and a CAT scan to just be sure that it was a massive heart attack that killed him. There were four attendings, there was a cardiologist, there was an ER nurse. I mean, this was an $85,000 visit for someone who's brain dead. And I don't know what the next three days cost, but cardiac visits, it's not uncommon around $60,000 to a $100,000. So, his final four days basically as a brain dead patient in a very fine hospital with a bunch of very fine doctors was going to cost Medicare several hundred thousand minus whatever they're going

to negotiate it down to. So what happens in your case when you have a patient that's in their final gasps of life, what is your consult look like with the hospital?

Dr. Paul Thomas: Oh man, I hope to get to people before that happens and I hope to talk to them about their DNR, DNI for end of life care planning with their families. So if I have somebody who's 50 or 60 or 70 or 80 or 90, I'm hoping that they come in now to talk about what's their care plan for their final days. Do they want to be on a ventilator? If their heart stops, do they want CPR? If they can no longer breathe, would they like to be intubated? Those are the conversations that people should be having before that moment. And as a primary care physician, that's part of my job is to speak with folks before it gets to that point so that we can potentially prevent any undue pain or suffering at the end of life.

Ron Barshop: So here's the thing, the children, one of them was a family physician in an urgent care facility and the other one sold for LabCorps. They knew, but again, nothing was done. It just blew me away, the whole experience. I was watching this like shaking my head. This happens every day in America. Well, on less of a downer note, let's talk about the final messaging we want to tell people about Paul Thomas to consultant. What's a a banner we can fly overhead to tell them how to find you or what DPC can do for their practice.

Dr. Paul Thomas: Yeah. If you're really interested in the direct primary care movement or the direct primary care model, I do consulting with folks and I'm putting all that consulting knowledge onto my website to make it really easy for folks to transition from either residency directly to direct primary care or from an employed or fee for service or you own your own fee for service practice to direct primary care. And so, I really want to give you the resources at a reasonable price point and sometimes for free through our blog to help you start your own direct primary care practice. Because I believe in this model, it's worked really well for me, and I've been able to have this successful, sustainable practice. And I want to share that success with you and allow you to practice as a doctor you are meant to be without the restrictions of time constraints or prior authorizations and deliver the best care possible to your patients. If you want that sort of service, it's available now at startupdpc.com.

Ron Barshop: I like how you saved that pre-auth gig for the very end. That'll raise a blood vein or two in somebody's forehead.

Dr. Paul Thomas: Yeah. Sorry if I raise your blood pressure there a few ticks.

Ron Barshop: Yeah, so folks, again, the monopoly game is not a universal game you have to play. There are options. If you want to sound as relaxed and at

ease as Paul, and on a busy day see eight patients, at least check this out. It's worth it. I cannot find any downside as an employer. I cannot find any downside as a user. And if I were a doctor or if I had a son that was a primary care physician, I'd strongly recommend he take a very hard look at visiting with Paul, visiting with Atlas, visiting with NextEra, and figuring this out. So Paul, thank you again. I always enjoy our visits and I always learn something that blows my mind and you did it today. So thanks again.

Dr. Paul Thomas: Thank you, Ron. It's a pleasure to be on and thanks for chatting about this important issue.

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 podcast, and subscribing and leave us a review. It helps our megaphone more than you know. Until next episode.