Primary Care Cures

Episode 40: Dr. Alex Lickerman of ImagineMD

Ron Barstop: 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.

Ron Barstop: Every once in a while you get an inflection point in a different space. In direct primary care, that inflection point was when Alex Lickerman switched from traditional care and medicine and teaching to direct primary care and he's now considered a thought leader in the direct primary care movement by most. Alex Lickerman is the founder and CEO of Imagine MD, a direct primary care practice, and he spent his first 20 years of his career as a leader at one of the top academic medical schools, which is known as the Pritzker School in Chicago, where he ran the primary care for seven years and he taught generations of today's leaders in medicine, and he enjoyed a reputation as a doctor's doctor. So if you've seen Dr. House, this is the guy right here without all the weird predilections.

Ron Barstop: He cares for many physicians, but he also helps them solve their most complicated cases. He's a nationally recognized speaker on the topic of resilience and his book, The Undefeated Mind: On the Science of Constructing an Indestructible Self, can be found where most books are found and it gives you basic steps to increase resilience and it has formed the basis of the landmark Resilience Project, which you can Google and learn a lot more about. And we'll talk a little bit more about today. So Dr. Lickerman, welcome to the show.

Alex Lickerman: Thanks for having me.

Ron Barstop: Yes, I have to get to my first question, which has been burning, which is why switch to direct primary care with this wonderful traditional model where you get to beg for your insurance reimbursements. What's going on there?

Alex Lickerman: Yeah. You wonder why don't I stick in that field, and it'd be a glutton for punishment. You know, what happened to me was I had been at the University of Chicago for 20 years and in the last 10 years of my time there had done a lot of administrative work. And while I enjoyed some of it, the truth was most of us in medicine at University of Chicago who did administrative work, we're doing it because clinical work had become so overwhelming. And at the end of 20 years, I finally just decided I wanted to be a clinician. I just wanted to see patients. But the notion of doing that full-time in the U of C system where I'm given 20 minutes per patient, 10 of which are used up by a nurse checking vitals with patients who really are sort of the sickest of the sick, because they were at a tertiary care center, like the University of Chicago, it just didn't seem to me to be tenable.

Alex Lickerman: I really was already struggling with balance in my life and more importantly, trying to deliver really excellent care to my patients. And with the time allotted, it just seemed to me I need to do something dramatic. And so I did something I never thought I would do, which was leave the University of Chicago because I really loved the place. But in order for me to become a full-time clinician and practice medicine the way I thought it should be practiced and could be practiced, I needed a new model.

Ron Barstop: When you switched to direct primary care, was there even a second place? In other words, was there even another option other than going into your own practice, getting rid of the 16 middlemen that are feeding off the system? Was there even a backup to this?

Alex Lickerman: No, no, actually there was no other idea that I had. And you know, the truth is I thought about this 10 years earlier, probably around 2005 or so, but at that time I really didn't think the world was quite ready for it because there was still certainly at that time, this notion that direct primary care, which outgrew, came out of the concierge medicine movement was really just for rich people. And there was an elitism that surrounded it, I thought, and I didn't want to just be a doctor to rich people. And yet in the intervening 10 years, fee-for-service medicine had become so bad that I think people were much more open to this. And so I was all in from the beginning. I thought this model makes a lot of sense. It's going to enabled me to practice medicine the way I want to. And I also liked the idea of being my own boss for once. And so I really didn't have a plan B. This was it.

Ron Barstop: You know Josh and Bear and Clint Flanagan disavowed me of the same prejudices that I had, which was that VIP is just cut in line and pay a little extra and it's for the top 10%, but the reality is direct primary care in Kansas where he's practicing in Topeka, it's a $50 proposition and maybe

less, maybe 10 or $25 for the children. There's some DPCs that will charge $50 for as many children as you have. And if you're some families, that's quite a bargain. But what I understand about direct primary care now is so different because clearly, if you have a cohort of six or 800 you could take care of America with a number of PCPs that are suffering right now.

Alex Lickerman: You know, I haven't done that math. I don't know if that's true. I think even if it's not true, my answer to people who criticize the movement by saying you're cutting out so many patients out of each doctor's panel, we're going to exacerbate the shortage in primary care. My answer to that is look at how many medical students and residents are going into primary care now, it's 2% of all graduates. And it's because they look at what primary care is like in the fee-for-service world, and they say, "Why would I ever want to do that?"

Alex Lickerman: And so if we don't do something to make primary care an attractive specialty again, to reestablish it as the backbone of our healthcare system, we're going to have a shortage no matter what. So I really think that that's where the solution begins, not just what's been done, which is pile more and more patients into the panels of primary care doctors until they're literally breaking and 50% of them want to quit as one study in JAMA in 2013 found. We're going to have a mess on our hands no matter what we do.

Ron Barstop: You know. So right now roughly a third of all the PCPs are over 56 years old. That doesn't bode well when you have 10,000 Medicare enrollees enrolling every day for the next eight years. That's not a very good supply and demand curve for PCPs. But the math is very simple. If you take 500,000 PCPs and you multiply that times 600 patients, you've basically got America covered. And so that's a very short version of a long story. But here's the thing that really just amazes me is that you have, in my grandfather's generation, about 70% choosing primary care because there weren't as many specialists. In my father's generation, it was roughly 30%, is the best numbers I can find, were choosing primary care. So the numbers were still sustainable to replace those retiring.

Ron Barstop: And then about four or five years ago, the most recent study I found showed about 15%, but when you really dig down into it, it's more like 6% so your number 2% really sounds more realistic because my son and my daughter-in-law graduated from top five schools and no more than 2% were selecting primary care out of these fine schools. And I can't imagine that it's any higher than that at the other schools. So it's just a burnout machine. Do you think that a solution might be to have the residents be forced into some type of a rotation into a DPC clinic or a successful primary care clinic that has lots of ancillaries and good take home revenue for the doc?

Alex Lickerman: You know, that's an interesting idea. I hadn't thought about that. I will tell you that there's a lot of conferences that are now being put on about direct primary care that physicians who've been out in the community for years are attending. And recently I've been aware that residents are beginning to attend those as well and become interested in it. I don't know if attending a DPC clinic would necessarily be the answer. It would certainly give these residents a taste of what primary care could be like, so maybe that's a really clever idea. But keep in mind, you know what DPC is, it's not a new type of primary care. It's a new type of payment for primary care and it enables primary care doctors do what they actually are trained to do rather than sort of have narrowed their scope down to be almost nothing of what they're capable of doing.

Alex Lickerman: So I think what's happening is that as the word is getting out and direct primary care is becoming more well known that residents and even medical students are seeking out what it's like on their own without much prompting, but it's an intriguing idea. I don't know that there's enough direct primary care offices yet that could handle the influx of people who might be interested in it.

Ron Barstop: Well we have roughly 1,200 practices and then people like Clint Flanagan are expanding like crazy. He just signed the state of Colorado and he's got various school districts throughout Colorado. So he has what he calls The Ranch, which has 60 different locations. And so he's able to appeal with sort of a plain vanilla offering to corporations and public entities that Mom-and-Pops in Chicago may not be able to because you have 12 or 15 or 20 different offerings. But he's really got a very clever strategy and I'm a pretty excited about what he's doing to expand it rapidly. And then the word I get from [inaudible 00:09:09] there is that they've got something like 105 practices in some form of, or some stage of taking a DPC on just out of just pure frustration. So tell me what you've seen. I mean you have been on the front lines. What does a burned out doctor tend to do in terms of medical errors and in terms of just taking good notes, paying attention to their family at night when they're really charting. What's going on in that person's life?

Alex Lickerman: It's a mess. I mean what burnout is probably going to turn out to be, is just another version of depression. And so the first thing you see, what I began to observe in many of my colleagues at the University of Chicago is this flattening out of personality, this sort of emotional disengagement from patients. They care to a certain extent, but beyond that, their caring and their efforts just stop. And it's sort of like, imagine literally being on an assembly line that is moving past you faster than you can assemble the widgets you are tasked with assembling. You actually develop, when you realize there's nothing you can do to complete your job and do a job well, you sort of develop what's called learned helplessness, which is sort of the

key or the cornerstone of depression where you kind of stop trying and then you struggle to keep up, work comes home with you, you do this ridiculous amount of charting now in the electronic medical record, which is this double-edged sword and you stop keeping up professionally and then you become depressed clinically, and socially you become isolated.

Alex Lickerman: I think there's clear reason why a study I just saw about physicians have among the highest rates of suicide of any profession now and it's because they're just unable to do their jobs well.

Ron Barstop: Statistically they're just a hair above American veterans. So just if you look at the data, it's just incredibly scary. I remember when I was a kid, dentists were the ones that were severely depressed-

Alex Lickerman: Yes.

Ron Barstop: And they had to look in mouths all the time and they were committing suicide. And boy, they've gotten off the hook now when primary care's put up in the firing line. So here's my question. I don't understand resilience as a solution because I know that's something that's mainstream thinking, and it's also part of your thinking, and I really deeply respect the way you've approached it, but my feeling about resilience is that you've really, you can go into a resilient training, resilient therapy, whatever morning rituals you have, at the end of the day, you still have this nightmare of a meat grinder that you have to step into at 8:00 AM. So tell me more about resilience and why that may be a solution.

Alex Lickerman: Well, I think you're exactly right and I do not think resilience training and mental health support is the answer for what's going on with primary care physicians right now. The answer is the system is untenable. And so when all these physicians, when 50% of physicians or more actually want to quit, you can't say the problem is with the physicians. That's too many of them. The problems with the system they're embedded in. So I want to be very clear. I do not believe the solution is these doctors just need to get tougher. That's not the answer. However, my interest in resilience really predates my interest in direct primary care and it's more about when I was at the University of Chicago.

Alex Lickerman: The last thing I did there was run the student health program. And even back then, this is in 2010, we were getting feedback from, the university that was, was getting feedback from potential employers of our students saying, "Boy, they're just a fragility that we have not been seeing in the past that we are seeing now where these students just really kind of fall apart much too easily, very easily and their expectations aren't unrealistic about what working in the real world is like."

Alex Lickerman: And they're sort of saying to us, "What's going on?" And I had become interested even before I had entered the role as director of student health there in this notion of can resilience be learned? And this I was drawing from the philosophy of Buddhism that over centuries and even millennia, Buddhist philosophers had really been arguing that to be happy, really first and foremost requires strength, inner strength. And they had many prescriptions for this and I became interested to know had modern day science investigated a lot of these 1,500 year old or 2,500 year old Buddhist ideas and given them scientific validity. And it turns out that they really had, and so I wrote a book about that, as you mentioned, called The Undefeated Mind, that really I wanted to be as science-based as possible but also provide practical ways individual people facing the challenges of their daily lives could maximize their inner resources and their strength.

Alex Lickerman: And it turns out there are some very specific, very interesting and very effective ways to do that, that are in some cases counterintuitive. In some cases, once you hear about them, they make total sense, but you wouldn't necessarily think about them on your own until they're pointed out to you. And so my work in resilience really is more my interest in sort of on an individual level, working with people who struggle with depression, anxiety and stress to help them cope with it better. And I'll just add one more thing. It wasn't until I began practicing in a direct primary care setting and I suddenly had all this extra time to spend with patients that gave me the ability to ask them, "Hey, are you anxious? Are you depressed? What are your stress levels like?" And I began to uncover what I kind of consider to be an epidemic of unaddressed and unrecognized or under-recognized stress and anxiety and depression in the working population.

Alex Lickerman: And it just, I think people experience those problems at a level that really often interfere with their ability to function, interfere with the quality of their lives and create a significant amount of pain for them but not so much pain that they necessarily are willing to take what they considered to be the dramatic step of going to see a therapist. But now they have a primary care doctor in me who actually can ask them about those questions and all this stuff comes spilling out. So in fact a lot of what I do with my patients in my practice on an individual basis is give them a resilience training, counseling and sort of how to manage the daily stresses of life that we all face.

Ron Barstop: Well, gosh, I have to ask, is there an app for that? Is there something, is there some shortcut that you've created that allows people to quickly get it or is it going to require a read or listen to the book?

Alex Lickerman: I wrote the book with the intention that people could finish it and come away with it with very practical techniques. They can apply in their own lives. But as you also mentioned in the introduction at the University of Chicago, one of the things I did before I left was actually create a curriculum based on the book and based on the ideas I generated from the research that I did for the book that we studied actually. And what we discovered was the undergraduates and graduates who went through the course that we created actually reduced their levels, or sorry, I should say, increased their levels of resilience by 10%, which on the surface may seem like a little bit, but in terms of a change in resilience, that's a huge change because what that translated into was a reduction in levels of depression by about 45% and reduction of levels of anxiety by about 52%, which turned out to be almost identical to levels of reduction you see in those two things when you treat them with medication.

Ron Barstop: My goodness. Well that's fantastic news. You know, you've proven a point that I have always believed since I've learned about DPC, is that you can bring Eastern medicine into direct primary care either directly by having an Eastern medicine physician on a subscription basis. You can also probably bring Ayurvedic, which is also a cash business today into a direct primary care. I can really see this movement taking on a lot of the best practices from the East and Near East into America because we have such large populations here that would be amenable to that. What do you think about that?

Alex Lickerman: Yeah, so I actually have some complex thoughts about this. So one thing that I've noticed is in recent years there's been a dramatic rise in the number of pseudo-scientific claims that are out in society that people in very large populations are buying into. And my theory about this is that in traditional medicine we have so little time to spend with patients that there's been a shattering of the trust that used to exist between doctor and patient and traditional medical systems. And so patients have gone where they can actually get more time and attention, which is in alternative therapies. Now my problem with alternative therapies is not that they're alternative, it's that often there's not enough evidence to support, one, their safety and two, their effectiveness. So I am a very intrigued with and interested in Eastern approaches to medical problems and to psychological problems.

Alex Lickerman: But for me, especially having been raised, so to speak, in the tradition of the University of Chicago, I'm really a medical scientist. I will be open to any wacky thing as long as there's some evidence to support that it's real and that it works. And it turns out there is, as I said, that was the process of my first book, which is that there's some real science backing these very ancient ideas. And I think that we should pay attention to those ideas and study them and apply them. But as always, we must first do no harm. And

then secondly, have some idea, some evidence somewhere that what we're recommending really does have proof of efficacy.

Ron Barstop: Well there's the wellness movement, which maybe instead of allopathic, we could call it homeopathic medicine, is really blossomed because I believe it has to do with affordability, that something like 56 to 58% of the people cannot get into $1,000 deductible, much less a $4,000 deductible. So they're taking yoga classes and they're taking organic foods and they're trying basically anything under the sun that's listed in the alternative pages, the rags that are in the Whole Foods and they're dying to get healthy maybe in a more holistic way. But my theory is that without a blood test, you don't have a primary care visit, you simply got to have some kind of allopathic start to begin down that path. Do you have any thoughts on that?

Alex Lickerman: I do. I mean, I think the message is right, that there's been an explosion in the last 20, 25 years of knowledge in the medical literature about what we need to do to promote health and prevent disease. And people are getting the message and they're going to these things in droves of course, because people figure out a way to market to them. And the idea of doing something now to stay healthy has become popular. And I think that's wonderful and great. The challenges, there's a lot of misinformation and a lot of unsupported practices going on and so it's very hard, I think, in our society right now to know who to trust, what authority we should listen to and when we're willing to spend the time and energy taking on these behaviors to keep ourselves healthier, are we taking on the right ones?

Alex Lickerman: I mean look at all the controversy now in just what is a healthy diet, we still don't have a great answer. So I think we're simultaneously faced with an explosion of actual knowledge about what does constitute healthy behavior and confusion about which vendor is going to actually help us to follow the steps that will provide it to us.

Ron Barstop: You know, there's always the diet of the year, there's always, I think Keto is super popular right now and intermittent fasting. And you know, circadian medicine looks like it's coming on strong, which is telling you when to eat during the day and when to space it out and when to take your flu shots. There seems to be a lot of different interesting and precision medicine now is being applied, not just oncology, but really to any kind of genomics testing before even a PCP visit. Do you have any feelings or theories that have some comers in primary care that look like they're promising?

Alex Lickerman: Yeah, I do. And let me just say first, there's the reason these things are becoming popular is because there's some real evidence around a lot of this, but the differences and what's happening is that science advances

very slowly and it has often missteps and it goes down blind alleys and it has to back up. And it just, and in our society now, because we're all so incredibly connected through social media and technology, we're impatient and we will read and be drawn to reading things that promise us the answers today. And so a lot of this stuff, the marketing dramatically over-hypes the science and people are leaping in towards doing things before the science has really validated it. And it's not that it's not necessarily going to, we just don't know yet.

Alex Lickerman: So for example, you brought up pharmacogenomics, this notion of precision medicine where you would test your DNA and figure out what medications you're likely to respond to, which ones are more likely to give you side effects, things like that. You know, it's very real and it's very evidence-based, but practically, in most cases it's not that useful yet. There are circumstances.

Ron Barstop: Do you think it's too early for some of these? Just pharmacogenomics right now is well-recognized in oncology. It's well recognizing in a couple of the spaces, but not necessarily in genomics or the general pharmacy panel.

Alex Lickerman: In primary care, yeah. So there are a couple of instances in which I would like to have that, but they actually just haven't worked out the genes in the drug studies yet. So, for example, with blood pressure medications, I have many, many choices about what medicines to use when someone has high blood pressure. I don't have a lot of pharmacogenomic data yet to help me with that. Or another example, people have migraines and they're having them frequently enough, we have to give them the pill to take every day to prevent them. There's so many choices there. I would love to be able to do it other than the way I do it now, which is trial and error to find the right medication that they both can tolerate and that works for them. So I think that's going to be useful in very specific circumstances. But I don't know that everyone who comes in to see a primary care doctor needs to have pharmacogenomic testing just yet.

Ron Barstop: Okay. We're not there yet, because those guests that I've had on the talk about it say that there's basically a fast and middle and a slow lane for your metabolism. Many of the drugs that are given to peak folks are basically in the wrong lane. They're not the fast metabolizing drugs. And so they're basically going into the toilet as useless pharma.

Alex Lickerman: And that's sometimes true. And yet with a lot of medicines in my experience, it doesn't take that much longer to get to the right medicines without that information. And so I think that there's great promise there and eventually yes, we might be able to get to the right answer, the right medication choice more quickly. But in many instances ... So for example,

like with choices for antibiotics, you have an infection, pharmacogenomic data is not yet that useful because it's more about what the bugs are susceptible to. For other things, yeah, it could be very helpful, I see it coming. But from a pragmatic perspective right now, I think that's something that's being a little bit over-hyped.

Ron Barstop: So Alex, now that you're in direct primary care, do you have more time for your hypertensives and your pre-diabetics to talk about weight management and proper exercise and hydration and all the important things you just never had a chance to get to before?

Alex Lickerman: Absolutely. I have more time to talk with patients about everything. And so what this has enabled me to do is bring back into the discussion things that I have always wanted it to be there, but that haven't been able to be there. So yes, certainly for my obese patients, they all get a discussion about how to lose weight and not just a discussion because it's clearly not enough just to educate people about how they should behave. You actually have to help them behave that way. You have to help them leverage psychological principles so that they can actually figure out how to actually change behavior longterm in a way that is not difficult, right?

Alex Lickerman: We all think, for example, the way to lose weight is to exert your willpower enough and that actually turns out not to be the right answer. Willpower ends up being a very weak mental force that in the long run really will not sustain any change in behavior that's meaningful. You have to do other things and so you need people who understand those principles and have the time to coach you through that in the long-term so that your behavior ultimately matches up with what you've been educated to do. But clearly education alone is not enough to get people to change their behavior.

Ron Barstop: So I have lots of theories. I want to try a couple on you because I really respect the way that you approach medicine from a scientific perspective. I think direct primary care has not taken off because number one, there's probably not enough rotations going to direct primary care or the residents would clearly see the benefit and the peace of mind that you have and relaxed day that you have. I call it a relaxed day, I don't know, but I'm assuming seeing six to eight to 10 patients a day is a little bit more relaxed than 25. And more so I think that there's no evidence right now and it would be a very easy study to do that talks about burnout, in direct primary care. I'm going to assume that it's almost zero. I'm going to assume that the suicide rate is almost zero over the last 10 years, and I'm going to assume that that stands up pretty well against the larger norm out there.

Alex Lickerman: You mean in direct primary care? You're saying?

Ron Barstop: I think in direct primary care, if somebody were to do a study that looked at burnout and direct primary care, they would find non-existent.

Alex Lickerman: Certainly anecdotally, when you go to these conferences and talk to doctors who have made the transition, they've been reborn in their practice and it's a totally different experience and certainly that's my own experience. Everyone I've talked to has said, yeah, they've rediscovered their love of medicine again. It varies obviously depending on exactly how they structured their practice, but that would be an easy study to do and I would not be surprised if the findings turned out to be exactly as you predicted.

Ron Barstop: Are you a little jealous of these young docs that come straight out of the residency or straight out of medical school and go right into DPC and don't mess around with the hospitalist movement and screwing around with working in a large group?

Alex Lickerman: No, I'm not jealous of those guys. I'm glad to be in this stage of my career I'm in and actually able to apply my experience in a setting ... Let me put it to you this way. I feel not only am I far more balanced, happy, and less stressed than I have ever been, but most importantly, I feel that I'm practicing the best medicine in my career because I have the time to do it. It's that stupid, it's that simple. Just having the time to think, to ask the right questions, to do a full exam, to read in the medical literature has made such a difference in my practice. And that's what DPC is given me back, time.

Ron Barstop: I wish we could broadcast that over the radio waves every day of the year. So tell me, what is the hold up for direct primary care to take off? I mean, with 12 to 1,500 docs out of half a million, that's just a dot on the map. What's taking so long?

Alex Lickerman: What's taking so long is that it is extraordinarily capital intensive to begin your own practice. Doctors are typically and stereotypically not astute business people and it really takes funds and courage to do this. The statistics that I'm aware of is that in general, when you take a fee for service practice and you convert it to direct primary care, about 10% of your patient panel will stick with you. And so depending on what your expenses are or what you're going to charge, that may not be enough to sustain you or they may feel, the doctors may feel, well what if it's less than that, I can't do it. And so it's sort of a, the phrase the Stockholm Syndrome has been bandied about a lot and I think that we're all captive to a terrible system that we're afraid to let go of because it's what we were afraid of how it could be worse.

Ron Barstop: Well, as a business guy, I have to walk through the numbers with you. Because if you have 2,500 in a typical panel and 250 of those folks follow you, 250 times a hundred bucks a month, if my math is right, is $25,000 and you multiply that out times 12 months and that adds up to $300,000. You can afford an MA and rent an office from a group of psychologists for $300,000. There's no need to set up a flagship beautiful office. You can literally rent a room and see patients in your exam room and start simple and there's not a giant investment in doing that. You can spend a couple hundred thousand also alternatively, rent a nice finish out, have a nice finish out, build a new storefront in a perfect location and there's everything in between. And I've talked to a DPC in Austin and she is a nurse and she has an average startup of about 25,000 per location. So you can do it on a shoe string. You don't have to take out another school loan equivalent to get your practice up and running.

Alex Lickerman: No, that's true. That's true. And I think for folks who are sort of already up and running themselves and already have an office and that's built out and that's a sort of a sunk cost, it is definitely easier. And so for those it may just be fear, or they haven't heard of it or they're worried about what's going to happen to the patients who are going to leave, or I don't know. But you know, the real question though is, I mean I don't think DPC scales based on just individual doctors taking individual patients off the street who want a better system of healthcare. I think what needs to happen and what we're trying to do is actually entice [self-funded 00:29:29] employers to actually sign up their employees with practices like ours. So we get large chunks of patients at once who can actually convert large practices quickly because our idea, for example, is we're looking to open up offices around the country where there is demand and of course that's a large capital expense. And we need large chunks of patients promised to us by the self-funded employers to be able to do that.

Alex Lickerman: And I think the statistics are 50% of all Americans get their health insurance through their employer, so that's a huge, huge population of patients that could be served by direct primary care. And the business case is there. I mean we have case study after case study that shows even when a self-funded employer is going to double or triple or even quadruple their investment in primary care, primary care is the smallest percentage of spending in their healthcare expense. And when they do that, they make that upfront investment. The downstream spending that's over utilized, all the unnecessary ER visits, and specialty referrals and even inpatient hospitalizations dramatically drops. So the business case is there. But getting those folks to make that change is very difficult.

Ron Barstop: Less measurable is presenteeism. You show up to work, and you've got the flu or flu-like allergy symptoms, and you don't really, you're not checked in at work, or you're spreading something around because you're

too afraid to miss work, or you can't afford a primary care visit. And then out of that 50%, there's a very large percentage of those folks who no longer can afford the premium of three to four or $500 a month. And they also recognize that a $1,500 $4000 deductible for family is not something they can even begin to think about. So I call it the tree house, they have the ladders lifted, they can't even play in the game anymore. Those are perfect folks to start a direct primary care practice from. Now you're talking a hundred a month and maybe a catastrophic plan on top or another couple hundred a month.

Alex Lickerman: Exactly right. I mean they're basically, most of America is functionally uninsured, right? They have such high deductibles that they're basically paying out of pocket, and they're a, as David Chase will say, a stubbed toe away from bankruptcy. They have less in savings then is their deductible. So it really, I mean we are a, it's a house of cards, and you know, why is in America the number one reason for bankruptcy, medical bills, I mean it's just, it's really a disaster that our systems become and yet, and yet I am optimistic because there are models like direct primary care that fix a lot of this.

Alex Lickerman: There's other things that other really innovative benefit consultants are doing to sort of try to get at the other dysfunction in our healthcare system. So I think I'm really hoping that employers who are self-funded begin to turn towards this model because they're the ones who will lead this. They're the ones who will turn this into what is still a bit of a fringe movement into something that ultimately will be mainstream. And I think we'll be in a much better place in our country if that happens.

Ron Barstop: Well, I am a DPC client and patient and I call myself a client first because they consider me a customer, not a patient. When I walk in the door, they treat me like a customer, not a patient. When I walk in the door, there's no forms to fill out, no history to re-fill out. It's all been done ahead of time and I just, I got to tell ya, the experience is night and day. What is the most important message that you would want to give employers out there? If you could fly a banner over America?

Alex Lickerman: Direct primary care will give better care to your employees, and it will save you money. There is no reason on earth not to do it. You should be doing it now.

Ron Barstop: It's ridiculous, ridiculously easy as that. And how can folks find you, Dr. Lickerman, if they want to locate your practice and locate you?

Alex Lickerman: Yeah, so we have a website. It's www.imaginemd.net, it's not.com it's dot net. And we created that site really to give people a journey through the story of direct primary care so that by the time you're done crawling on it,

you'll really understand what this practice is about and what benefit you can get from it.

Ron Barstop: Well, I agree, there's a lot of inertia and a lot of fear. Most of the CEOs, when I talk to here in Houston about my experience, don't believe it. It sounds too good to be true and I'm telling folks right now for the world to hear, it is not too good to be true. It's happening, and it's real, and it's going to be expanding to a location near you. And I think you guys are in 49 States now. You might be lacking South Dakota, but I think you're in every other state in America. So it shouldn't be too hard to find a practice.

Alex Lickerman: I mean DPC is, we're expanding out of Chicago, but DPC I think is just about in every state. Yes.

Ron Barstop: Well, I hope when we talk again in a few years, we can make that statement that you're in multiple states and you're all over the country. That would be great.

Alex Lickerman: From your mouth to the universe's ears.

Ron Barstop: Okay. All right, well thank you Dr. Lickerman, we'll look forward to following up with you in the future. Thanks so much.

Ron Barstop: 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.