Primary Care Cures
Episode 86: Clive Fields

Ron Barshop:
This episode is brought to you by the MediSearch Institute. What happens when patients cases become too complex to solve in a typical 30-minute visit? Well, we've all had those super thick, super deep patient history nobody's looked at in a long time and gone back through. Well, I'll tell you what happened is those patients bounce around from doc to doc without getting any answers or making any progress. These patients are trapped and lost in a maze.

Ron Barshop:
Well, MediSearch is here for those doctors and for those patients. Their motto is we solve the unsolvable. Their process is rather simple. Dr. Trent Talbot, the founder, assigns a team of medical detectives, typically three MDs and one PhD to each case. They research the latest breakthroughs and clinical trials and they elicit the opinions of 10 to 15 world-leading experts per case. They purposely seek out experts who will come at each case from a different perspective, the Bayesian method. Altogether, they will put in over 250 MD hours for every case. That means 500 times the amount of brain power that typical doctor can afford to offer.

Ron Barshop:
You know most problems in health care are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance squeezes the docs and is totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost, deceleration of reimbursements. I want you to meet those in this show that are making a difference. With us, Ron Barshop, CEO of Beacon Clinics, that's me.

Ron Barshop:

2020 has been epic for primary care news. Forget the C-19 decimating the independent fee for service primary care model. They never got $175 billion grant, a free ride of the century from Congress like the hospitals. So not all primary care was decimated. Some models are thriving. We're going to talk to one of those today. Let me tell you about Oak Street Health and One Medical. They are both brand newly listed public companies that are in primary care. One is in the value based care for seniors model, and the other is more of a direct care and fee for service hybrid, serving Silicon Valley clients like Google. Wall Street is now fully woke to a $348 billion market opportunity. Although, we don't like to think of it that way, called primary care. And that alone is a sea change because there's lots of focus on what's going on Wall Street for this.

Ron Barshop:

Walmart has just announced a plan B a couple of days ago to their new 10,000 square foot dental vision, hearing, counseling and social workers offering at an end store primary care clinic, a model that's launched in Dallas, Georgia in January. Walmart will now be piloting five senior

focused primary care clinics with Oak street, before mentioned, in Dallas, Texas. And remember they serve 2 million customers every day, so we got to watch Walmart health. Our guest today announced in July, the billion dollar primary care deal with Walgreens. More on that in a minute. So that is all 2020 news. It's my busy year forgetting a pandemic, as if it's side news. Also to add to the story is the London-based Babylon Health has now raised $1,000,000,005 for virtual primary care model and is the primary healthcare system for Rwanda, a virtual care. I don't know if I agree with that, but that's what Rwanda wanted.

Ron Barshop:

There are dozens of virtual care models growing like crazy and raising tons of Silicon Valley cash like 98.6, a former guest of ours, Brad [inaudible 00:01:57] and Crossover Health, which is Scott Shreeve. They serve a million virtually also when they purchased Sherpa and they also offer free, onsite, direct primary care for the employees. They also give Cairo counseling and acupuncture for the likes of LinkedIn, Square and Visa. Acupuncture, hey, the founder is a Cali base doc who's a surfer. What do you want? Okay, so as primary care going crazy with all of this corporate movement, is this a good thing or not? Absolutely. Why do I say that? Because the big hospitals and the big carriers alike are furiously buying, "for no dollars," the 30% of independent primary care clinics left as this crisis forces over 16,000 closed doctor offices, just in the last couple of months, which represents maybe 40 million unintended patients.

Ron Barshop:

We don't know how many of those 16,000 are PCPs or not, but that's 40 million unintended patients if they're all PCPs. So independent fee for service now is brought to its knees. But most hospitals, the buyers along with these big insurers, are volume dependent. Transaction care is the flavor of fee for service that they focus on. Then immediately when they buy a practice, PCP groups price out at two to four times what they were charging the day before they were bought by the hospital with measurably more burnout, more medical errors. We now know that is the third leading cause of death after heart disease and cancer. Now comes also drop, drop, drop, drop, drop. So why do bigs like Walmart and Walgreens, et cetera, why are they a breath of fresh air? Well, simply we celebrate any models where the cost drop and the patients win. Where outcomes improve, that's the triple lane.

Ron Barshop:

You're not supposed to able to get any two out of three of those, or three out of three of those at the same time, yet they do in this model, especially with the doctor we're speaking with today and direct primary care. Let's throw in on top of the triple lane. Remember we talked about cost dropping, patients winning, outcomes improving; what if we have happy doctors to throw in the mix? Now, we've got a quadruple lane, all being accomplished again with these new models. And what if we throw in the employers of the governments who are writing the checks winning the cost war, and now we're at quintuple lane, so we're way past triple lane, which is supposed to be impossible a couple of years ago because of these new models that are out there. This is a future where everybody wins. It's not system owned factory medicine, and it's not transaction care. That model will die of its own weight. It's the modern equivalent, today working in a hospital, working in a coal mine if you're a PCP. Except instead of getting black lung, you get white lung.

Ron Barshop:

These doctors and the providers that work with them are going to flee and are fleeing the big systems. Our guest today, I've known for 40 years when we attended UT Austin together. So for those of you who are aggies, you can turn it off now, but Clive Fields has been on quite a remarkable journey. He's the chief medical officer and co-founder of Village MD, which in 1991 started when he joined his wonderful father Harold at Village Family Practices it was known then. Dr. Fields, Sr. was trained in Scotland and practiced as a family physician in Toronto. So two single payer systems informed him how to practice medicine. That history is important in this introduction because when Clive joined the practice out of Baylor Medical Residency, the father and the son grew it to 13 PCPs with an early adoption, pioneering really, what we now call value based care, but then it was patient centered medical home model.

Ron Barshop:

If you don't know what that means, it's a lot of words. A patient centered medical home is a fancy way of saying the care doesn't stop at the doorstep of the clinic, instead it's brought into the home and the workplace and the wild, we'll call it out of the nest, which we'll call the doctor's office, with care teams and every evolving technology to support particularly older and more chronic conditions. So the single pair models from Canada and Scotland inform Dr. Fields and Clive how to provide what's known as advanced care to these new Texans that were figuring something out for the first time and seeing something for the first time in family practice, a best practice that actually works. And you can actually get paid less money for procedures and testing volume and more money for better outcomes when you go to this new model. So that's the beauty of it. So Clive has beautifully scaled this new model, it's not so new anymore, into what was a mega group. Then in the last seven years, he's now created 500,000 patients and 3,000 doctors practicing in 10 states these past seven years.

Ron Barshop:

After this announcement, this thing is going to take off in July because Walgreens has invested in convertible debt equity, and hopefully a lot of free rent at five to 700 locations, a billion dollars in a minority stake for Village MD and they're now going to leave it to the pros to run their clinics, which they failed at miserably by themselves. So they will be housing, as I said, five to 700 stores over the next five years. These are the best retail corners in America bar none. It's a smart deal. So Clive has won the physician executive of the year by the AAFP, which is the American Academy of Family Practice. He's consistently named one of Houston's top doctors and all the right magazines. Modern Healthcare just named him last year, one of the 50 most influential clinical executives in America. But that's not all, he's a triple threat. So he's an executive, he's a builder, he's also a doctor seeing patients and he teaches family medicine where he did his residency at Baylor Medicine and the university of Texas at Houston. So, Clive welcome to the show.

Clive Fields:

Thank you. Thank you very much for the very complimentary introduction.

Ron Barshop:

Well, you had pioneered something that a lot of people can learn from, and that's what this show is all about is taking best practices and putting it out there. So let's talk for a second about, I have three big concerns for value based care that I want to get to before the end of the show that I'm concerned about. There's nobody better than you to address these three concerns I have, but let's talk about the journey that informed you to expand your model in such a big way in the last seven years.

Clive Fields:

No, no, happy to. So you touched on a couple of really key elements early on in my career, and that was the opportunity to work with my father starting in 1991. His experience in the two national healthcare systems really informed the way that I practice and the way that many of the young doctors who've joined us practice for really the first decade of my career. What that really meant was that we practice what we now call advanced primary care, we call primary care center medical homes, but what it really was was just really good, comprehensive primary care where you went to a doctor and you had an acne, you didn't need to go to see a dermatologist. You went to the doctor and you have back pain, you don't need to go see an orthopedist. We learned to practice that way in really, the late 1990s with Medicare plus choice opportunities from CMS. We started to see data and data was not available prior to that on an individual practice.

Clive Fields:

Actually, the only data you had was the number of patients that you saw that day and that's that's who won, whoever saw the most number of patients. What we realized when we saw that data was that there was something we were doing different and it didn't have to be a lot different, just a little different than our peers to generate a different result. We were able to then move into what we now call Medicare managed and start to see actually perspective payment and payment based on outcomes, not just on the transactions of our fee for service model. Got to around 2000 and we thought we were a pretty big deal here in Houston. We were 13 docs and two locations, and the only person who thought we were a big deal turned out to be us, that without the kind of size and scale and technology and capital and ability to negotiate appropriate payer contracts, that we were likely going to be just another small group or medium sized group that had no legacy and lived no longer than the doctors' individual careers.

Clive Fields:

So took the opportunity to take we'd learned and work with two of my partners, Barry and Paul Martino, and founded Village MD. We founded the company with the sole purpose of helping independent physicians succeed in the transition from fee per service to value based care, recognizing that value based care is not a hundred percent of somebody's business and that you still need to operate in both worlds and will for a period of time. Ron, we've been blessed. We have now grown to nine states and we're working with around almost 3000 physicians.

Ron Barshop:

What is the reason people tell you, "Clive, it seems like such a nice offer to be surrounded by technology and virtual CFO, virtual CMO, virtual fill in the blank C level," you're giving them a wide variety of services. Are they thinking that they're going to make less money? Are they

afraid to take the leap out of the safe comfort- Well, let's not call it a comfortable world, but the safe world they knew before?

Clive Fields:

Yeah. I think there's really two big areas we run into. We run into doctors who truly don't believe that value based care is a movement that will continue to grow in this country, and we run into doctors, and no disrespect, who believe that they can do what we do by themselves. So that slows down the sales cycle in both areas. We are thrilled to see doctors actually band together with like minded colleagues and do it themselves. But many just don't have an idea about the amount of capital and executive experience and how it needs to be extracted to actually build a model like ours or like the two that you just referenced who recently gone public, whether it was Oak or One medical.

Clive Fields:

So that's probably the two reasons people don't join us. It used to be that a lot of docs joined hospitals because they believe that would be the last employer of their life. Unfortunately, COVID has exposed that many of those employers were far more financially fragile than the physicians may have thought and we're seeing physicians now being let go and being furloughed and having salaries cut in some of the largest integrated systems in the country because of the financial and clinical ramifications of the pandemic we're currently living through.

Ron Barshop:

It's just infuriating to see layoffs and furloughs of hospitals that got free federal money. We don't need to go there, but they got money to actually keep people employed and they all had reserves enough to cover these losses, supposed losses. The four biggest public hospitals all reported recently, their second quarter, they did fine without these monies coming in. It was ridiculous. So it's just infuriating that they're furloughing good people that are actually paying the tax bill to fund their free ride.

Clive Fields:

Yeah, I would agree with you. Anytime that you limit access or decrease access to primary care, it's ultimately bad for the communities that those doctors work in because it drives up ER utilization. It drives up inappropriate hospitalizations and specialty work, and ultimately, without any significant improvements in overall quality.

Ron Barshop:

I'm not understanding. The hospitals moving was actually born in Texas, and I'm not understanding how that is primary care, that you go to see a doctor for episodic care, you go to see them for a transactionally care by its very nature and suddenly, that's primary care. That's nothing close to what you and your father started and what you're currently rolling out and across the country.

Clive Fields:

No. We believe that primary care doctors, and that would be defined as doctors who can provide comprehensive, continuous and coordinated care, really meets the definition of a primary care

doctor. So seeing a physician or seeing a patient, excuse me, in a single site and without the ability to see them through the entire continuum of their disease or just their life is not my definition of primary care. So I could not agree with you more in that area.

Ron Barshop:

Okay, good. We're on the same page. Let's talk for a second about outcomes. Now, this gets into the gripe area as long as we're talking about what are some concerns, I think primary care doctors have about the leak. The first gripe I've heard from primary care physicians that are in the old universe is that the value based care model is producing the same cost as the fee for service model, that it's supposed to be less transactions, less volume, less factory medicine-ish, but it's actually, the costs are almost to the penny, the same dollars. Am I off on that?

Clive Fields:

Yeah. The data just does not support that. If you look at some of the data from CMS on the Next Gen ACOs that are reporting literally... or have reported their 2019 data just in the last couple of weeks, there is a consistent reduction in the total cost of care. There's a shift in care from inpatient and specialty care to outpatient and community care. We're actually seeing the total healthcare dollar of what primary care doctor [inaudible 00:14:58] typically receiving around 6% go up almost to 8% or 9%, which doesn't sound like a lot. That's a 50% change in the total spend going to primary care or community resources. So now, what we're seeing is, and what we see certainly within Village, is that a clinical model, not an economic model, but a clinical model that's used to support appropriate utilization, continuously returns the inappropriate economic results, which are lower total cost of care and higher overall quality for the populations being served.

Ron Barshop:

Okay. So that's not the biggest gripe. I'm to escalate these. The second gripe is that, are you managing or are you reversing chronic conditions like diabetes and hypertension? Managing is one thing, but actually turning it around and improving the lives is a whole another matter where they're getting off their insulin and getting off their meds.

Clive Fields:

Yeah. So I think it right now, all we do is actually monitor or our system currently monitors chronic disease. So moving from monitoring to managing to reversing is a continuum that takes years and years, but we've certainly, at least at Village, moved from, yes, documenting diabetes to actually addressing ways to decrease the exacerbations of diseases like diabetes, and heart failure and COPD. I'm sure your audience knows that COPD and CHF, that patients with COPD and CHF account for over 50% of the total Medicare spend. Doesn't mean that spend as a hundred percent tied to those diseases, but it's tied to patients who have those diseases.

Clive Fields:

So it's not hard to risk stratify and identify patients where with education, team based care, with care that reaches outside of the exam room, with patient engagement and education, that you can decrease some of the exacerbations. Would we love to reverse congestive heart failure and COPD? Absolutely. Do we see it with aggressive lifestyle interventions and diabetes? Yes. But

many of these diseases are just by nature progressive, and our goal is to really decrease the exacerbations and the morbidity associated with those exacerbations over the course of a patient's life.

Ron Barshop:

How far are we away, if you had to guess, from a technology solution that allows for the actual reversal?

Clive Fields:

There's some things that will never be reversed. Congestive heart failure by definition can be controlled, but it is a progressive disease. Type one diabetes is not reversible or not currently today. Type two diabetes is probably the one that jumps out at me as the one that people talk about in terms of reversal. We've seen a number of different technology platforms that with aggressive lifestyle management, usually moving to plant based diets, you can see reversal of diabetes. Some of the work done at Baylor about a decade before me, actually showed reversal of heart disease, actually reversal of heart disease and lifespan consistent with cardiac interventions when patients instituted aggressive lifestyle diet and exercise changes. So is there a technology solution? Probably not. Is there a lifestyle solution the same way that lifestyle is driving the progression of chronic disease? In many cases, it can certainly decrease that progression and in some even, reverse the disease process.

Ron Barshop:

All right. Well, I had on my show, Jeanne Teshler, the CEO of a company called Wellsmith out of Austin and I think what you just said might be just a little bit off. She has now reversed 30% of their cohort in diabetes with four different clinical trials. I'll send you the show links. You can listen to it yourself in here.

Clive Fields:

Yeah, absolutely. I'm assuming that there is a significant lifestyle component to that reversal.

Ron Barshop:

Yes. Surprisingly little, but yes. The third gripe that I hear about value based care and this one, I don't know, Clive, if there's an answer for this one, but it's, we have a situation where the big systems are essentially buying up all of the practices that they can get their hands on and they're doing it for essentially no cost. There's not a two times EBITDA or three times EBITDA, or even a five times EBITDA that maybe once was. It's now, "We'll take over your pain and make it go away," and it's of course, they're upping the prices the next day, as I said in the opening.

Ron Barshop:

I'm concerned the value based care is a gigantic bow and they're going to continue to capitate you guys down to zero. They haven't the last 30 years, but I think they're going to capitate you down to zero like they did to the MRIs, make them unaffordable for anybody but big systems. That's my concern is that you may have this many doctors today and twice that next year and five times that next year, but at some point, they'll capitate you down towards not profitable and then the bigs will pick you up for a song and a dance. I'm concerned about that.

Clive Fields:

I think that's a reasonable concern. One of the foundations at Village is the move to a prospective payment model. That perspective payment model is not limited to just primary care services, but to the total cost of care. So for a primary care doctor to actually economically remain solvent in this kind of society and with the cost associated with primary care, the only way to actually do that with the access to we call the total cost of care or global capitation. The idea of me arguing with Blue Cross or Aetna next year about whether an intermediate office visit should be paid at $61 or $63 is already a losing argument before it even starts because it diminishes the value that a primary care doctor can bring to the patients they take care of.

Clive Fields:

So in our model, what we want to see is we want to see global capitation coming through an attributed patient panel to a primary care group, effectively a primary care group that's willing to take risk. Then that primary care group and go out and contract with specialists in hospitals, ancillaries, find the best quality at the lowest possible cost, effectively using the clout of that attributed panel in a way that no individual patient can, but doing it in a way that actually lowers the total cost of care as opposed to increasing the total cost of care, which is when we see when we're there very, very few providers in any given city.

Ron Barshop:

That's all very lovely. I love what I heard just now, but you've got basically on your side, our former guests, Tom Banning, and the others like him that are banded together and the hospitals have the largest lobby in America. When you throw medical devices and others in there, we're talking about a half a billion of money that's in the light and another half a billion of dark money that is not reported to the FEC. How in the world are they not going to legislate you out of existence so that they can just snap you up? You don't have the lobbying power they have?

Clive Fields:

Yeah. I couldn't agree with you more and we'll never have a loving power. I may be naive in thinking of that ultimately, doing the right thing leads people to the top, that to my grave, I believe that what we're doing is ultimately the right thing and when people step back and think about healthcare as a unique type of service, completely different than your TV provider, your internet provider, or the car that you drive, that we should be focused on delivering the highest quality care at the lowest total cost.

Clive Fields:

If you think about the Medicaid budget in 50 states, there's 50 states that are on a one way path to bankruptcy because their Medicaid budget ultimately will exceed their total revenue. There won't be money left for schools, for roads, for police departments and for fire. As that starts to happen, even with the kind of clout that certain constituents can bring to bear, I honestly believe that people in power will start to make the right decisions because they'll have to make the right decisions.

Ron Barshop:

No question about that. I'm excited to ask you a few questions that Lloyd van Winkle, our mutual friend, told me to ask you. He is on the national board of the AAFP I mentioned earlier, and he is concerned that family practice is only able to recruit a tiny minority of the physicians that are getting out of the residencies. What can we do to bump up the salaries, income, et cetera, so that they're not having to work 10 more extra years to pay off that same debt that the specialist are paying off earlier?

Clive Fields:

Yeah. So there's a complete failure of graduate medical education as it applies to residencies right now. Teaching hospitals are being paid to, "produce doctors that are necessary to meet the needs of the communities they serve." But instead, they're actually producing doctors that are necessary to fill the beds and the operating rooms that they have built. So what we need to first see is a complete change in GME funding that actually focuses on what it was meant to focus on, which was meeting the needs of the communities that they serve. If we do that, then we'll start to actually see family practice and internal medicine rise in the recognition scale inside the academic centers where most doctors are trained, which is really the second problem. The idea that race car drivers should train pilots and then tell pilots that they should be race car drivers, this doesn't inherently make any sense, and it doesn't make sense for primary care doctors who work in the communities to actually be trained by the specialists who work in the medical centers.

Clive Fields:

If we can actually change those two things, first being funding, then being the site of training, I think we can start to attract doctors or attract students who ultimately or who initially went to medical school to be a doctor that looked a lot like a family doctor. No one goes to medical school, I don't believe, to be a retinal surgeon. It's just not something that kind of you wake up every day when you're 16 and strive to do. So a change in funding, a change in location of training will ultimately, lead to a different type of recognition, and I believe a different type of compensation as we move to at-risk globally capped populations.

Clive Fields:

The interesting thing that primary care has, which no other specialty has, is the ability to, "attribute patients to a physician." So nobody is attributed to a neurosurgeon or attributed to a nephrologist or attributed to an orthopedist because they can't impact the total cost of care or their total healthcare needs. So the ability to pipe patients through doctors to measure both quality, costs, patient and physician experience can only be done through a primary care doctor. I think that's actually why you're seeing the big feeding frenzy for the acquisition of primary care by other types of institutions. So I actually think that there's... I would challenge Lloyd, and I would say that there's been trouble in primary care in the past. Many people think there's trouble today. I actually believe there's a far brighter future than many recognize and I'm hoping I practice long enough to see that day come to fruition.

Ron Barshop:

What you said earlier about VBC turning salaries into a little bit more attractive offers you're able to make these young residents, that might be the solution. I'm not sure you lobbying or

hoping and praying that you're going to beat the hospital lobby to change GME funding is ever going to happen. Those guys have such tight control over the walls of Congress and state, local, federal. They've got so many lobbyists. There's something like six to seven lobbyists for every legislators in Washington that are federally registered with these healthcare giant concerns. So if it came to market forces like you're talking about, there's your answer. I'm concerned that hoping for a vote or a regulator to change some rule is never going to happen.

Clive Fields:

Yeah. I'll tell you, Ron, the only person who's more powerful than that, that provides care is the person who pays for care. So ultimately, when employers and governance and the federal government and state agencies recognize that they can no longer pay for the system that providers have built, I think we'll see a sea shift in the way that providers are actually paid and treated.

Ron Barshop:

Well, this is very exciting. I'm looking forward to seeing my first clinic. You've already expanded into, I think, five here in Houston on a pilot basis. Right?

Clive Fields:

We have. We actually opened up another five since then. So there's a 10 of our Village Medical co-located at Walgreens currently. I'm currently operating in Houston.

Ron Barshop:

Fantastic. Well, this is such a better model for Walgreens than trying to do it in the back of the store themselves. This makes eminent sense to partner with the likes of you. So very excited for you and for them and what great positioning you have. There is no better retail location than Walgreens anywhere in America.

Clive Fields:

No, we're excited to have them as a partner. We're excited for a lot of reasons, but most importantly, we're excited about the integration of pharmacy services into the management of our patients with chronic disease. Our data continually shows that that type of team based approach drives the best possible results, and the access to their professionals is high on the list of why we actually affiliated with Walgreens.

Ron Barshop:

We are going to do a future show about the role of the pharmacist in primary care because they have been so overlooked for so long as a critical part of the team. They just become bean counters and they hate their jobs, and none of them are real satisfied working for these giant institutions. But now, if they can collaborate with the likes of you and your team, what a sea change that is for them.

Clive Fields:

Yeah. We are excited about being part of that ride.

Ron Barshop:

Yeah. Very good. Clive, I always ask at the end of every show, how people can reach you or Village MD if they want to know more and they want to join your forces, and we'll go there first.

Clive Fields:

Absolutely. So you can certainly find information on us at VillageMD.com or I can be reached at CFields@VillageMD.com.

Ron Barshop:

Great. Then the second question is if you could fly a banner over America announcing anything you want, what would that banner say?

Clive Fields:

Oh gosh, it would be to the 50 million Americans that don't have a primary care relationship, it would be to get one. It's good for you. It's good for your family. It's good for your health.

Ron Barshop:

Very good. Thank you, Clive, and we'll do this again and I can't wait to watch your progress.

Clive Fields:

Thank you, Ron.

Ron Barshop:

So welcome to Just A Hospital Minute. We are adding these segments for one minute at the end of every show to tell you some of the games that hospitals play. If your doctor comes in and visits or any doctor comes in and visits while you're in the hospital bed, if they sit down, they'll be remembered. If they stand up and leave, they're often not remembered. So they're often instructed, "You're going to bill if you sit or stand, but go ahead and sit down. It's better bedside manner." So this is Just Another Hospital Minute.

Ron Barshop:
Thanks again. Thanks again to our sponsor, the MediSearch Institute. I want to read you a note a CEO friend of mine sent me who used them for a rare childhood disease her daughter had. Dr. Talbot's research was thorough. He provided clear paths of treatment and he gave me access to the best physicians. I'm so grateful for his work. That's the MediSearch Institute.

Ron Barshop:

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