Primary Care Cures

Episode 119: Dan Thompson

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

The next-gen of healthcare has five winners. That's how we know. Not only it will succeed, but it's probably the chief reason why it is succeeding as large as it is and I'll get into that. Here are the five parties that have to win: the patients, which I call consumers, because that's what they're called in every other vertical; the payers, which are employers, which are the hero of this drama; the providers, which are the physicians; the population health outcomes; and cost. If those five are all winners, then we have not only triple aim, but quintuple aim, which is really where we're at today with this new model.

Ron Barshop:

We call it Employer Direct Healthcare, because it really encompasses a lot, and it's any kind of care where a payer and a provider skip a middleman to direct contract. That's with primary care, with surgery, with imaging, with pharmacy, with labs. Rachel Means, who was a guest in Show 73, is a fine example of that, and today's guest is, too.

Ron Barshop:

The payer will skip the BUCAs, and the PBMs, and the preeminence of the middles are dying because Jeff Bezos predicted this 10 years ago and it's now happening in healthcare. Some great examples, and there's 25 million patients we have headcounts on with just these companies alone. Premise Health with Jamie Dorset, who was on our show recently has 11 million patients right now. They're the largest in primary care. Paladina Health is probably number two, and they have about a million patients. That's [inaudible 00:01:21] you've heard him speak on the show too. Crossover Health, we had Scott Shreeve and we also had Jay Parkinson, the founders of that, have about a million. Then then 98.6 with Brad Youngren. NextEra Health out of Denver. Madechi is who I mentioned earlier. Santa Surgery, Green Imagining, Redirect Health, Babylon Health, that's going to be on our show pretty soon. One Medical went public last year. These are all examples of direct contracting where the employers skip the middleman.

Ron Barshop:

Today's guest is Dan Thompson and he started the Clinical Wellness Network, which I can't wait to hear where you're at Dan, and also Thompson Risks. Welcome to the show.

Dan Thompson:

Thank you, Ron for having me. It's been a couple of years of honestly, watching you put remarkable posts on LinkedIn. I love your, I'm going to call it the Barship shorthand. I'm now being confused when I read normal English, I start to think like, "Ron would have made a better shorter version." I like the way that you write on LinkedIn, so much appreciated.

Ron Barshop:

Well, thank you. That's why Jeremy, my producer who's listening in called me because he really liked the way we were saying things and he thought we needed a bigger platform. You're going to be show number 120. Congratulations.

Dan Thompson:

Wow, very cool.

Ron Barshop:

Tuned over to a year's worth of shows now. Well, what I'm excited about this network, last time you and I spoke over the phone, you were putting together a lot of different up and down the east and west coast of Florida for the urgent care and other types of medical centers were buying into this direct primary care and you were bringing them, employers and patients, to add to their roles. Is that where we're at right now? Give us an update.

Dan Thompson:

Yeah. This goes back quite a few years. For those that are probably hearing this and don't know me, I've been doing employee benefits, started early career out of grad school, the late '90s, '99, 2000 with Paychecks and was selling employers, and of course, the payroll company bundled normal status quo benefits. Then, I did farm sales for a year, hawking antispasmodic and hypertensive products, and found a pharmaceutical industry, so I had to be just a complete non-transparent nightmare. I went back to payroll. I was in my early 20s at the time. I'm revealing my age, I guess. I went to ADP and then a few years there being in President's Club and selling payroll and benefits. I spent the next 13 years where I became majority owner of a regional employee benefits and commercial insurance firm that did almost 20 million in revenue, 165 employees, and it sold in '18 to a private equity.

Dan Thompson:

The agency did really well with the private equity sale, but what it said to me was it's an opportunity for me to do it my way. I was really tired after almost 15 years grilling to employers and proliferating the big lie of, "Hey, you've got a 30% increase, but I'm sorry to tell you it's because somebody in your group has a really bad condition and we're going to water it down. But because we're the very best and the biggest, we're going to get you a 7%." I've always been the type that asks questions. I got into trouble in Catholic school, probably because of that. But I wanted to really start my own.

Dan Thompson:

In 2015, actually let me go back even further, 2007, I was bringing small employers while I was a sleeping insurance agent, so to speak, not awake to the reality. I was bringing employer clients to doctors. I was bringing doctors out to nonprofit clients and doing physicals onsite and a lot of knowledge learned in the commercial insurance business with worker's comp and OC health and how doctors work with clients. And I thought to myself, "I'm on the employee benefits side. Why don't I bring doctors in to do physicals for just wellness checks, like preventive physicals, check cholesterol, blood pressure." I had doctors, I was negotiating terms with doctors to come in and do on-site work directly with the employers, and I'm like, "Man, this idea, this intermediation as you call it, is something that's very obvious, and that has to be the big change."

Dan Thompson:

You go back to Justin Ford Kimball, in 1920, when he decided that it made sense to do a prepaid membership program for the teachers in the great city of Dallas. I think if I remember correctly, it was $50 a month, that he negotiated with the hospitals so that the teachers could go in and have no other costs than have babies. Just imagine that. It was transparent. Some teachers that had babies went into the hospital and had children and didn't have any costs. It was all transparent and others didn't use it. But the $50 went to the doctors at the hospital, anyway. Long story short, you all know Justin Ford Kimball became the basis of what was the very transparent, honest, Blue Cross Blue Shield Association.

Dan Thompson:

As we look at this, and I'm not telling most of the listeners anything, they don't know, but we know what happened as the insurance business evolved. It went a very sharp, ugly in the mid 1900s, 1960s, low grade in the mid. But these fixes have to be scaled. I love what you're talking about. I love what Premise Health and Medici and Paladina and Crossover and Santo and One Medical, all great organizations. I love the work that they're doing. I love that 25 million people are going to the, around the middle, in seeking services. Not to mention the fact that there's other things out there now like sharing plans. Sedera, we're one of the largest affiliates with Sedera. We help a lot of employers utilize Sedera sharing. I had this idea. I wanted to create a better platform for direct care. Right around 2018, by the time I left that agency and sold that business to start my own, I created a clinical wellness network as the idea of a collaboration between employers, physicians direct, and simply just a membership based medicine approach-

Dan Thompson:

I watched a lot of the legislation occur around the country around direct care. Where it's gone in almost a little over three years now, we have about 1700 providers on our platform. We work with Amazon. We have our own SAS platform now that we'd created. We've worked on this for a while. It's connected to other networks of direct care. We have a referral network of brokers, payroll companies, PEOs commercial brokers, that refer customers to this solution. We're excited about the growth that we're changing the model. I would call it our OS3. OS1 was literally my wife thought I was crazy printing ID cards in the bedroom and hand delivering them and doing the auto debits from the ACH, from the lawyers' accounts to the doctors' account, not keeping any money in the middle because my goal was to try to earn other business with the client. Maybe that's life insurance, maybe it's group health insurance, what have you.

Dan Thompson:

As we've continued to materialize, we've added some great things like direct radiology, drug pricing, no insurance agent, guarantee as your life insurance, no insurance agent in the middle, and things are really turning out pretty awesome. It's a good feeling to be able to bring employers solutions where they get the primary urgent acute care, non-emergent medications directly. We continue to build on that and it's exciting. It's actually exciting to come to work. I don't have to give 38% renewal increases that are not the truth anymore.

Ron Barshop:

What is your typical size client or maybe your sweet spot client? What are you looking for out there

Dan Thompson:

Target market, it's interesting because we have clients that were fully insured, that were anywhere from two to 50, that's mainly the small group marketplace community rated. Depends on the state. Some states are community rated a little bit bigger than that, but sweet spot is in the middle of the 51 to 250. Then, we have some groups in the 500 to 10,000 that are self-funded, that are literally not using any insurance where they have a TEPA with our direct care provider handling the primary care and then we use an RVP vendor like Six Degrees or we put it in a captive model where it's RVP and do some of that work. But those groups are extremely progressive.

Dan Thompson:

Obviously, for any advisor listening to this or for that matter disruptor, this is huge, huge advice. You have two types of buyers. You have the buyer that's HR. People process, all they care about is people and process, and that's fine. Then, your CFO buyer is profits P and L. In order to do it right, you have to have synergy with both sides or you're going to waste your time. I think a lot of people probably are hearing that and going poof, center of the target.

Ron Barshop:

Do you work in all states or are you mostly Florida?

Dan Thompson:

We're licensed in every single state. Thompson Risk, myself, we're insurance licensed everywhere.

Ron Barshop:

You're working in Texas now where I am.

Dan Thompson:

Yes. We do a lot of oil industry in Houston. We have a big primary care clinic. In Texas, we work with Primacare, Dr. J's Urgent Care, Next Care, The Diamond Direct Network and Vital Life Wellness Centers which is in San Antonio. We do a lot of Clean, San Marcos, Austin, Houston, San Antonio, Dallas. Texas is a great state.

Ron Barshop:

Great Now, let's talk about the network count. You said it's several thousand doctors. How many patients are going through this network right now in your platform?

Dan Thompson:

On the individual SAS, since we weren't really doing individuals, we only started that back in August, I would say under a year, a couple of thousand. Changes by the day. We're always sort of re-engineering the pricing because the list of services, some things work, some things don't work, some providers want to offer certain services and some don't. That's unique. Employer account is around 5,000, a little less than I would like it to have been, but we're doing it brick by brick. I think that as we continue to expand and grow it, one of the things people are going to understand is the way we're doing the model is some of the employers that we have, which are a lot of them are in the 51 Lives, they're required to have a RESA and ACA compliant benefits. Well, under current regulations, direct primary care is not considered an ACA qualified benefit.

Dan Thompson:

A lot of the groups we have have traditional insurance that they've had in place. You get about half the employees that want to stay on the traditional insurance and half the employees that want to go to these non-traditional solutions, be it scenario sharing or reference-based pricing type of model where there's no network that's paired with direct care. It's pretty unique. It's an interesting mixture, but I think as we grow the individual SAS side, that's going to grow tremendously because we've got some unique things with social determinants, genomics, and the consumer's intent around what their needs are from a healthcare purchasing perspective that will help us target and identify.

Dan Thompson:

Because I think I should say it like this, , we are more, we have the programmatic and technology solutions for the provider, but one of the thing that we have that nobody else has is the ability to help the practices grow. There's a lot of really good solutions out there that are SAS models for practices to use, but they're handed to the practice. They take their fair cut. How does the doctor grow? Well, you don't see too many guys with a stethoscope and a white lab coat driving around, knocking on doors, and making cold calls. They need help to grow that piece. We were creating some proprietary things that will cause business development and cause business to grow for these because we really would like to fulfill my bee hag of helping a million people. I think we can get there with the right scale.

Ron Barshop:

How close are you now? I'm obsessed with head count.

Dan Thompson:

Well, from a Thompson Risk perspective, I think we have 10 or 15,000 across all of our employer clients, depending on whether you look at the small ones, the middle market, the large. We have a opportunity right now. It's a medical purchasing organization. What I may really want to say about it is about 6,000 employees, 15 states, and we're essentially carving out and letting

the physicians handle employees domestically and get credit for that. Of course, they need catastrophic coverage so it'll be a combination of Sedera sharing, the traditional carrier.

Dan Thompson:

But I think that what's remarkable and maybe what others might want to hear is that since I come from the brokerage space and very successful in the benefits space, I've been known by a lot of very, very high level carrier executives. I've had very, very interesting private conversations with a lot of the carrier level people and they all want to know what I'm doing. It doesn't take a dummy to figure out that they'd like to know what the mousetrap is. You see these characters that are trying to change their supply chain, there's a couple of carriers who have come to me that we can't announce quite yet, but I think we will in the summer, who are saying, "Hey, look. We love your model." Of course, they want to buy it. It's not for sale by the way. But they're willing to do a fully insured, catastrophic plan with enough credit on the aggregate side but don't move over, first time that we're hearing about that in the industry, give us that powerful brand and let us sell a direct care version of their health plan through their broker's network.

Dan Thompson:

Now, a lot of direct primary care docs will be choking on their coffee when they hear that. But I have a very different approach and a different feeling about direct primary care and scale. It bothers me as it should everybody that an individual direct primary care doc opens their doors. "Great. Congratulations. You abandoned the [inaudible 00:17:21]. Good job." But you stopped scaling your practice with 250 patients, with 300 patients. That's not good. How does that accommodate scale when we have 300 million people in the United States? It doesn't. If you do the math, we don't have enough primary care doctors that if they all went on their own and did 350 patients and closed their doors, they'd be in big trouble and that doesn't work.

Dan Thompson:

You have to have these direct primary care practices that scale and have affiliates like the great next Carers and the Diamonds and the Stradas and the Our Health because they're the ones that are incredible. By the way, nothing wrong with the individual DPC shop that doesn't want to scale. Those are good for rural areas. But there needs to be some type of synergy that level the playing field where the pricing is all the same, the list of services are close, and it's scalable because national companies are not going to get into direct care.

Ron Barshop:

But even in rural areas, you have the county employees, you have the local hospital, you have the school district. There are enough people to get scale for a small rural office.

Dan Thompson:

Well, I would agree with that, but I've also spent time with a couple large municipal systems with 20 or 30,000 employees. I literally went in there so full of energy with such a beautiful proposal to do primary care, urgent care, radiology, rheumatology direct. Then, what I get from the municipal decision makers, as you need to talk to these folks and they'll consider it, and I ended up getting thrown to [Ion 00:19:01], Willis or one of those big guys, and then I get-

Ron Barshop:

It's different with the smaller guys so I think you'd find the rurals are more accessible.

Dan Thompson:

No, don't get me wrong. It's happening. A good friend of mine, John Play, in Kentucky. Incredible next gen advisor. He's got scenarios where he's saving small municipal organizations, 40, 50, 60, 100, $200,000 a year, moving them out of the darkness into the direct care. It's an exciting movement, no matter what side you're on. But I think the big thing to look out for is that the carriers are not dummies. They're smart and they're going to continue to build not only coming out of the demand side but build more and more on the supply side too, for buying up physician practices and buying surgery centers and buying up-

Ron Barshop:

United is the king right now, Dan. They've got 23,000 PCPs, the last head count I did. They're bigger than Kaiser Permanente. No, I'm sorry, they're close to 45,000. Kaiser is 23,000. They are buying private practices. Especially during COVID, they accelerated, they picked up because it was a great time to be buying. A lot of doctors were suffering.

Dan Thompson:

There's a lot of interesting movement.

Ron Barshop:

There's an ACO here in town, primary care, and they got a letter, their patients got a letter on the same day that they said, "We're no longer supporting you for tele-health." Then, they sent it to all their patients, and said, "We're now doing telehealth direct with United Health." In some of the others, they said, I mean, it's anti-competitive as can be, but that's that's the way they play hardball.

Dan Thompson:

I think the bubble popped on tele-health a few years ago. Right now it's about as easy to get as each stone about a wheelbarrow. It's almost free now. It's crazy. I remember when it first came out, heavy mid-2000s and I was on the broker retail distribution side. It was like, "Hey, you can move your clients to virtual health and it'll cost the agency a $1.50 a head." Some brokers are doing a really good job. They're charging 20 bucks for it. Think about all that money you can make in the middle. Honestly, that never sat well with me. It was never really my intent to cash and played the middle. I always wanted to do what's right for my clients. I enjoy learning that competitors of mine are charging clients 12 to 18% on their fully-insured premium, and then go into the CFO and telling them that for the first time and watching their reaction.

Ron Barshop:

Let's talk about that. What are you saying to the CFO? You've got 15,000 lives under management with this alternative model, and then a lot more than that with the probably more traditional? What is your pitch to a CFO to use you instead of the traditional big letter houses?

Dan Thompson:

Well, really it comes down to supply chain economics, keeping to being able to analytically be keenly aware of what's happening under the sheet. I mean, your health plan, as far as the codes of all the different things that are happening, I think of one group in particular has about 1,500 employees across a couple of different states and they were utilizing one of the BUCAs and outpatient claims were auto-adjudicated. CFO didn't believe that there was a strong chance that those similar outpatient claims that were happening to different states were actually being paid out at a different reimbursement. When we actually pulled the data, which this particular carrier bought us on, but the analytics company that we deployed had a pretty proprietary process to be able to extract that information. We did get it, they were appalled and left the carrier. Because the client never realized that for specific outpatient procedures, there was a very high chance that they were being paid at various intervals at various times.

Dan Thompson:

Some of the examples here are, we have contracts now with 21 independent radiology practices. I talk to the CFO and I say, "Hey," particularly groups that have a lot of employees that are paycheck to paycheck or middle-wage working Americans, call it 30, 40, 50, 60, $70,000 a year, "when they have a $5 high-deductible health plan and they get referred to a hospital for an MRI their exposure is the cost of the deductible. If you could have a contract in place directly with the radiology group and just pay 250 bucks for an MRI for the same machine that your very same employees stopped paying $5,000 for because they're trapped in your deductible."

Ron Barshop:

Are you selling savings? You're coming in and saying, I'm going to save you 20% upfront?

Dan Thompson:

No, I mean, that's very difficult to do. That's like putting a stamp on yourself with permanent ink. As soon as you say that to the CFO, "You're going to save 20%," you better at least save 20. I mean, I like the perspective of selling value, not on price. There's way too many people in the insurance business because it's such a commodity trap and it's not going to change. Even people that listen to this are still going to go out and try to sell the next cheapest bag of beans or whatever commodity they're selling, whether it's bottled barrels of oil. It's the approach.

Dan Thompson:

Well, put it this way. We have a new site that's going to be coming out in July. Directcaremarketplace.com where people can go to and there's going to be an entire menu of health care services that are direct, no middleman, no intermediary, no carrier. Though I can at least share that there'll be eight specific things in every community that will be able to literally hitch their wagon to this engine and consumers can go through an app and be engaged in complete community health care and enable them to get services like they could never imagined so easily and direct for a fraction of the price of the normal supply chain. We've been working on that for a while and it plays off of everything I've always wanted to do, which is really help people find the lowest cost net healthcare.

Ron Barshop:

Well, let's talk about if people want to find you, what's the best way to reach you?

Dan Thompson:

Probably the best way to reach me is dan@thompsonrisk.com or connect with me on LinkedIn. It's interesting because I've moved from working for a pretty big regional agency to starting my own, and we really didn't get started much in the employer clients for a little while because we were so focused on growing the direct care network and talking to primary care doctors who've been in primary care for 30, 40 years, about 21st century primary care, and being an avid study of what models are out there and seeing them grow.

Dan Thompson:

I would just say LinkedIn is probably the best way. Then, of course, like I said, dan@thompsonrisk.com. We love to share stories about employers that have saved tremendous amount of money moving to these direct models. I think we're really excited about what we're going to be able to do for individuals because there's so many people that have either lousy insurance or no insurance, and a lot of small businesses that unfortunately just can't offer health care to their employees, but they'd really love to. We'll be able to help them do that.

Ron Barshop:

What kind of savings are you seeing out there percentage wise?

Dan Thompson:

Well, I'll give you a good example of the case that we have in Albuquerque, New Mexico. Moderate sized case, about 350 employees. We have them self-funded with a TPA. It's an interesting experiment because we put in place three different plans. We put in plan number one, which the employer almost pays 90% of, where it's direct primary care with reference-based pricing on all the catastrophic and then the TPA manages SPD and Claims that does all of that great work. Plan two is an HMO. Now, we still have the direct primary care, but now we have regular network reimbursement on a leased HMO, self-funded, it costs the employees a little more, for those that are too scared or the non-traditional because they truly get educated about how this works. Then, there's plan three, which is more of a traditional PPO, traditional PBM, no direct primary care, the least amount of employer contribution. However, let's remind that the lining of the plan is that they're meeting the minimum value and affordability and all the requirements of ACA and doing what they're supposed to do.

Dan Thompson:

But utilization, well, first off, it doesn't make any, it won't be surprising to anybody that 70% of the employees went to the direct primary care reference-based pricing model because it was the most subsidized by the employer, but also the most exciting. We're now on its third year renewal cycle and the utilization percentage of inpatient-outpatient emergency room, acute care, all the bad stuff on the first plan is running 73% less than the only 30% of the employees that are on tiers two and tier three. It's fairly obvious that-

Ron Barshop:

70%. Well, they'll all migrate over. [crosstalk 00:29:13]

Dan Thompson:

Absolutely. A primary care doctors who's handling that for us in Albuquerque, she just hired two more doctors. We've helped her scale and grow. Super exciting, actually doing home visits. She does added additional services because of the needs of the group because she's catering to them so much with hormone therapy, testosterone type therapy, anti-smoking. Beyond in depth primary care that she can offer, additional acute care stuff. That's super exciting to see those employees and they are a small muni, a water management district. They're really drinking the Kool-Aid and they've referred us to some groups in Arizona and a couple of places that we're working on, but that's what I want to see. I want to continue to see that kind of success versus just the boring success of selling the status quo, which we do some of, but sometimes you can't. If people come at you and they just want to buy the traditional, you're not going to tell them no.

Ron Barshop:

You can't go to a CFO and you can say, "We can save up to 70% and I can give you examples."

Dan Thompson:

Yeah.

Ron Barshop:

I usually ask a question at the end of each interview. If you could fly a banner overhead, what would it say? I'm going to say, "Use Thompson Risk and save 70%."

Dan Thompson:

If I could guarantee that outcome, that would be great. You can't ever guarantee an outcome in healthcare only because-

Ron Barshop:

Guaranteed 30%. Guaranteed 40%.

Dan Thompson:

Yeah, for sure. I mean, getting in the middle of that, 30-40% is an easy start.

Ron Barshop:

By the way, do you see the biggest savings in the pharmacy side of it? Or do you see it happening on the direct primary care, the surgery? Where's the bulk of the savings occurring?

Dan Thompson:

I think in the larger size groups, it's definitely in specialty meds, no question about it. That goes without saying. But when you get, now that there are these advanced RVP initiatives where there's balanced billing protection, when RVP kind of emerged in the last five, six years or so in those earliest, I was part of that early group of sort of, should we touch this electric socket or not. We have a tendency in the benefits business or at least I do. I think that's why I made my commercial insurance partners nervous. I always like to try stuff. Hey, if it looks like it's going to work and it's got some proven credibility to it, I might be the first one to jump into it. That's the

best way to do. I mean, sometimes you get burning. I lost a thousand life group from putting an analytics tool in place that ended up going out of business. I mean, I luckily ended up getting the CFO back to listen to me and get it back again and they actually went through chapter 11 at one point as well, the actual group itself.

Dan Thompson:

But you live and you learn. You have to fail a lot in order to succeed and it's an exciting movement. I'm excited to come to work every day and think about ways to help clients and think about the people that we serve and think about the people that are in these small and medium sized businesses that are going directly to these urgent cares and primary care doctors because of the model I created to help them. They are completely, these are families who are keeping their discretionary income. I'll leave you with this.

Ron Barshop:

Well, their deductibles went away. Their premiums went away. They now have a raise. They got a $500 a month raise. That's significant.

Dan Thompson:

More than that, I had a guy, a big church that we did, Northern Tampa. They got a 67% increase from one of the BUCAs. Basically it was an invitation to leave. I brought Sedera medical cost sharing and direct care to the table as a substitute. Now, we kept the BUCA in there as an option, even though it was just barely made affordable to comply with their obligation to do so because it's in a list of requirement, an ACA requirement. Compliance is big in our world. We don't mess around with that. Less than two two to 5% of the employees went with a traditional insurance company with did renewal, even with two or three enrolled, but 150 went with the Sedera and the direct care. Just one of the leading pastors of the church who was on the fully-insured plan for him and his four daughters and his wife, family premium decreased by $27,000 a year.

Ron Barshop:

That's a better school district. That's a better house. That's a nicer vacation. It's credit card debt eliminated. It's a life changer. I mean, it's a game changer.

Dan Thompson:

The 67% increase before they met me was going to mean letting go five employees. We saved all five of their jobs, less budget for their school, for their preschool, for their church. I will tell you that the pastor and the CFO ... CFO's, she's such a sweetheart, but they literally care so much about their principal and their teachers and their preschool and their church that my presentation there put the tears because families could be saving that type of money and putting that kind of money back into their discretionary income for things that they can buy for their kids and savings and be able to get a little bit of a nicer car, maybe. For the paycheck to paycheck people, which is 90% of our economy, change in healthcare is necessary. It's no longer a case for change. It's an absolute economic necessity.

Ron Barshop:

It's a good note to end this on. If I were one of the nuns who taught you in Catholic school, I would say you're a very good boy and you've done a fine job and keep up the work of God. Dan, thank you for your time. We don't want to extend longer than we promised you. Good luck and we'll talk to you again soon, I hope.

Dan Thompson:

Thank you so much. Enjoyed the show, Ron. Thanks so much for having me on.

Ron Barshop:

Thank you.

Ron Barshop:
Thank you for listening. You want to shake things up. There's two things you can do for us. One go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.