Primary Care Cures

Episode 138: John Collier

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:

78% of primary care docs work for the bigs. What happens when independent docs capitulate forced into big systems insurance and private equity? Well, know this listener it's more akin to a shotgun wedding than a champagne does to celebration. This is not a victory for most doctors. Costs number one are generated to double and maybe more for sure and pressure is brought to refer to the most pricey, not better places of service. And that means imaging, labs, surgery and primary care owned through these big systems through an outdated volume centric practice called RVUs Relative Value Units. This also hikes the devil sister of burnout, which is two out of three PCPs and medical errors, which is the number three cause of death after heart and cancer. In fact, the CDC says 11 people die every hour due to hospital acquired infections. So this of course to increases with more hospital referrals and there's more dumb tests and unnecessary procedures and dumb test is ordered every 15 seconds for a lot of different reasons and outcomes are certainly not improved.

Ron Barshop:

So this demolition of the independent docs was financed by brilliant lobbying hat tip American hospital association, which helped big systems, double strategic reserves during the pandemic to $175 billion, which six quarters later of reporting we know they never need it. So how does this all fixed? Well, I love Dr. Keith Smith quote, "don't ask Congress to solve the caper when they drove the getaway car." So if not our Congress, how are we going to fix this? Well, we have wealth care and poor care in America sadly, the majority are in poor care. This buyout of independence does nothing to reverse this trend and to help this ever-growing gap. It only adds cost to us higher deductibles for employees and more profits for the bigs. Nobody wins, but the bigs, but we all lend with independent docs, especially if direct contracting because [inaudible 00:02:00] they lower costs. They refer less to unnecessary tests and downstream care and indirect contracting have 40 to 60% lower stays and visits to hospitals and the same for ER.

Ron Barshop:

Overall costs drop for self-insured employers between 20% and 60% in direct contracting with independent docs and surgery centers, imaging labs, and pharmacies. So I live in a future where everybody wins today and today's guest completely agrees with that I'm sure and gets that. And today's guest completely gets that John Collier, who is the CEO of the only primary care provider recognized by the validation Institute for demonstrating significant cost savings to its clients and it's a direct contract with employers. In short, this validation Institute verifies your marketing and savings plans. It's kind of a big deal. Proactive MD is based in Spartanburg, South Carolina, and John has led direct to employer contracting one of the largest hospitals in his region. And before joining Proactive MD, which has 30 clinics, John was the CEO of another South Carolina based direct primary care provider. John, welcome to the show.

John Collier:

Good morning.

Ron Barshop:

So do you have any comments before we get started?

John Collier:

So real quick? So we are actually in Greenville based in Greenville, South Carolina suburb of Spartanburg. And then we are approaching nearly a hundred clinics, not 30. So just under a hundred with the implementations that we have.

Ron Barshop:

Well, that's great. Okay. Well, I led off with outcomes for employers jump. So let's talk about that first. When you're sitting down with an employer for the first time or a prospective employer, what are you touting as your outcomes for your model?

John Collier:

First and foremost, when we sit down with an employer it's really important that the conversation is personal because we're having a conversation about their greatest asset, their people. So we start with that, we start with the humbling realization that we could have the opportunity to take care of their greatest asset and that their greatest asset, their are people, that someone's husband, wife, son, daughter, family member. And so every interaction that we have with employers, our patients, we really want to constantly keep in mind that these are real people. So when we are looking at these outcomes and we're striving for these best in class outcomes, we keep the patient at the center and we keep those real people at the center. But when we get into the data, we spend a lot of time just really getting to understand that their population and knowing that while certainly every population has some similarities, every population is different.

John Collier:

So we get the privilege of working with public sector groups or private sector groups, rural groups, Metro groups, large, small employers, and everyone has a slightly different business case. And so we spend time looking at it from a population health perspective, really stratifying the risk of the population and going into areas of that we know we can impact. And so we're

looking at on the outpatient side, the inpatient side and emergency room visits, pharmacy, specialty, and we dive into the numbers on those areas.

Ron Barshop:

Okay. So let's just talk about, I guess metros, since that's probably going to be your biggest population, what are your outcomes for Metro?

John Collier:

We did a peer-reviewed case study and this was in a Metro area and we were able to decrease their outpatient PMPM pricing by 26%, we were able to decrease inpatient PMPM by 18%, decrease emergency room visits that PMPM spend by 25% and then from a pharmacy reduction take it down my 17%.

Ron Barshop:

Terrific. Okay. That's going to get their attention there. I'm sure going to have a second discussion with you when you started those numbers out. And then what is your care stack? A lot of folks that are scaling in this space are offering mental health, some are even offering occupational health. What is your care stack look like right now, besides primary care and urgent care?

John Collier:

That's a great question, Ron. And I'm at Proactive MD we want to be able to practice full-scale population health and so the core care stack does start with the power of primary care. And so everything we do is built on the cornerstone of primary care and that's your primary care physician and then they have a nurse that works alongside of them. But with something that's unique to our model is every single clinic that we launch or that we start with, the primary care physician also has a sidekick or kind of a Batman Robin approach with a modality called a patient advocate. And these patient advocates are licensed clinical social workers, and they do phenomenal work, working right alongside that care team from a mental health behavioral health perspective, social determinants, from an engagement perspective, really also diving in understanding of benefits plan, being kind of that concierge of benefits, and then taking a step back, looking at other clinical integrations.

John Collier:

And so many times we do see that in an employer setting there certainly we need to offer occupational health services. And we do that on a regular basis. And firefighter physicals, police physicals, preemployment fit for duty type of occupational health. Also, treating and triaging the workers' comp side, keeping those two areas, primary care, and workers' comp very separate. We also will add in musculoskeletal components. So having onsite physical therapy if and when needed, and also even full pharmacy in the appropriate setting, when it makes sense. Constantly looking at the data, looking at the population and again that unique business case for that individual employer.

Ron Barshop:

Okay and do you charge one set pricing or is it a different price for different care stacks?

John Collier:

So as you can imagine, if it's a much more robust care stack, price will increase, but we charge what we would call a comprehensive fixed fee or a PMPM pricing and so we try to keep it one set pricing across the board. But for your standard care stack, it's going to look the same regardless and then that grows with adding other models.

Ron Barshop:

Let's talk about the range. What does it start at and what will it ratchet up to with the full care stack?

John Collier:

Yeah, so that's a great question. So our retail pricing, if a consumer was going to come into a Proactive MD setting, it's $89 per member per month and that is full scope. That's around the clock access to the physician, that's virtual-care, home visits, hospital visits, behavioral mental health support, pharmacy, patient advocacy, but that also with economies of scale and the employer side will come down to an average about $55 $60 per member per month.

Ron Barshop:

Okay. So per member would be a husband and a wife. What if there's a family of three or more kids, is that priced any differently?

John Collier:

That's the adult pricing and then pediatric pricing is set at 25 to a cap of a family of four children. So do a cap there and then the price would hold steady.

Ron Barshop:

And then let's talk about how you handle your chronic care. Cause that's going to be a giant source of savings for employers. If you can help them either manage or even reverse either hypertension or diabetes or some of these other lifestyle diseases.

John Collier:

Right? Absolutely. So, as you can imagine, I know that you've talked to many many primary care physicians Ron. Chronic illness is the bread and butter for primary care and everything we do again, going back to what we were talking about earlier, everything we do is about; this patient is a family member, this is a real person and we want to build a relationship with them. And if we can build a relationship and a deep level of trust, we know that we can help steer and help manage their chronic illness and the way that they transact with healthcare significantly differently. And so we spend a lot of time looking at the data, that's claims data that we have access to that's clinical data and that's aggregating the two together and then building a plan and each individualized Proactive MD care team is looking at their population on a week in week out basis and say, "okay, Mr. Smith hasn't been in several weeks."

John Collier:

We know that when we started by the rest of the population, he's a high risk individual. He has three chronic disease types we need to get him in. And so the physician, the patient advocate and the nurse they're coming up with a care plan say, "Hey, let's get him in for care. Let's make sure we're engaging him". And then nationally, all of our physicians and clinicians are talking on a weekly-basis, sharing best practices and working very closely with that. But going back to the trust side of things, everything we do is built on relationship, is built on trust and it's built on that engagement. And so unfortunately, sometimes you see in these onsite clinics, you don't see as high of engagement as you would like. And so we know for the model to work, you've got to engage the population, not just as a nice supplement to primary care, but as a full replacement, we want to be their medical home. We want to see these individuals often.

Ron Barshop:

I'm going to imagine that a lot of the chronic patients are going to actually be saying, have a care plan in place for the first time in their lives, because they had high deductible plans with the previous regime and they weren't able to really afford to go see the doc, even maybe an afford the medications. Are you finding that some people are just incredibly grateful to finally have no copays, no deductibles and full access?

John Collier:

Yeah, they are I mean. So when you talk to our employer partners and they take poll after poll, after poll having an onsite or near site, direct primary care solution is their number one benefit every single time. And so these employees and their families are besides themselves. They're so happy. And really, that's another reason why also understanding the social determinants of what's going on in the home front is so important. You know, we have found in our patient advocates as, as they've worked to engage a population, oftentimes you think, okay, this is an employed population, they're insured. They have access to nice benefits, sometimes very rich benefits. They should be good to go. But when you can build that relationship, when you can focus on some of the social determinants, things that are going on in the home front that could be causing obstacles to care, we're able to hit that head on as well.

John Collier:

I'll tell you a quick story. I can't stress enough how important engagement is. And so again, on a week in week out basis, our patient advocates and our physicians are working to engage their populations. And so we had a patient who was chronically ill. They had been in for care ones, but then after that subsequently kept missing their appointments. And so that for the Proactive MD way, because we care so much, we wanted to say, "okay, what's going on?" "Why is this patient keep missing her appointments?" And we wanted to be there for her and so the patient after really starting to investigate, well we found out that this patient was actually living in her car at their employer site and had two children with her and so when we met with her, she said, "I'm just worried about feeding my kids. I'm not worried about coming into a doctor's appointment for myself."

John Collier:

And so we were able to spend time, workout some things with these patient advocates being licensed clinical social workers, they have an abundance of resources. We were able to get

housing, we were able to get food and able to secure that side of that patient's needs. And now that trust that we've built, she doesn't miss appointments. We are taking good care of the kids and everyone is doing great clinically, but also mentally and physically on the other side of it as well.

Ron Barshop:

That's a great story. So engaging the employee is such a tricky thing because, I'm going to assume a third of the employees, or some portion of employees are just "I'm healthy leave me alone. I'll call you when I need you for some urgent issue". And maybe some other segment is going to say, "I know I'm borderline diabetic. I'm starting to feel neuropathy in my legs, but I'm not scared yet. So I'm not going to bother you are not going to have you bother me until I know I need you, or I'm not going to work on that smoke cessation. I know I need to do". And then again, there's the population we just talked about, which is, "I am so glad to finally have access that costs me nothing. I can go see a doctor." How do you get that middle group? I'm going to call them the yellow lighters versus the green lighters or the red lighters. How do you get those yellow lighters into the clinic or engage them over the phone, or just have a history, do a patient history?

John Collier:

Yeah and then Ron, then you add to the complexity of that, you add you might have a clinic onsite or near site in this associate with that employer, those yellow lighters in all of them. Sometimes there's this thought, "oh boy is my, is my employer spying on me?" And so you have to even overcome those complexities and so again, relationship, relationship, relationship. And so the way we do that is before we ever start, we put our patient advocate onsite, 60 days, 30-60 days ahead of time, really getting to know the population. We stratify the risk of this population, we have risk stratified engagement, and we're looking to go after those yellow lighters, even beyond, but even even the healthier people. I mean, the reason why our name is Proactive MD is because so much of healthcare is reactive.

John Collier:

And so we want to change the thought of that and, and make healthcare more of a proactive relationship. But I can't stress enough about getting onsite and meeting patients where they're at. So does that, if they're working in a factory, that's walking the assembly line. If they're working in a municipality that means showing up at the firehouses, the police offices, city hall, if they're a school district, that's doing events to get to know the teachers, holding open houses and building that relationship. And then aside from that, working very, very closely with the employer and their trusted advisor, their benefits consultant, their broker to say, let's also build a plan design that's going to incentivize the right care and it's going to help steer patients into our setting. So it's a full scope approach and we do that collectively together as a team.

Ron Barshop:

Yeah, that's great. John, there is a chicken plant in east Texas that had no work stoppage during COVID because they had onsite care. So doctors constantly monitoring their foreheads, making sure someone that wasn't feeling right got off the line quickly and was treated quickly. Do you have any evidence that during the pandemic that having doctors on site was a boon to the production line and to the manufacturing?

John Collier:

Absolutely and we are actually working on a number of case studies there as well. And I can proudly say that not one of our health centers closed down during the pandemic and you know, that highlighted more than ever the need, not just for a clinic, the primary care in general. And so we were able to partner with even several of our chicken factories and work with them and all of our partners should do contact tracing. You know, we built a software that looked at how do we space people appropriately? How do we make sure that there's enough sanitation going on, that there's enough PPE going on that there's education.

John Collier:

And then those that are high risk, that we are constantly checking on them and so the physicians and the patient advocates calling on a multi times a week, checking in on those high risk individuals to making sure they're okay. And then if we had any of our patients that were isolated, maybe they were diagnosed with COVID and then they had to be in quarantine for two plus weeks, making sure that they're doing okay on the home front. Doing fully-gowned PPE visits with the patient advocate and the physician bringing groceries to the house, making sure that that family is okay, because again, that just solidifies that trust and that relationship and you know primary care must go on.

Ron Barshop:

So what states are you in beside South Carolina right now?

John Collier:

We are saturated throughout the Southeast. So what kind of South Carolina, Georgia, Florida, Kentucky, Tennessee, and then all throughout the Midwest as well. And we are growing into the Western regions as well, launching in New Mexico, Colorado, Iowa, kind of shotgun throughout the whole country.

Ron Barshop:

Okay. So the game plan obviously is to cover the 48 states, maybe in 50 states in time.

John Collier:

That's the plan, it's to bring this level of care to all over the country.

Ron Barshop:

And how many providers do you have currently, and then is your model to deal with a doctrine MDDO or do you go with a nurse practitioner, PA model? Or how does that break out work out?

John Collier:

So just over a hundred providers and we are primarily a physician based model, but we do have several nurse practitioners and PAs that take great care working very closely alongside our physicians.

Ron Barshop:

Okay and then how many employees or I should say members do you have at this time?

John Collier:

So we are approaching a hundred thousand.

Ron Barshop:

Okay, great. So the goal is to obviously is to get to scale, as quickly as you can is make sense. And I guess a lot of employers, because they're based in these Southeastern states are going to want you in other states where they have employees in other facilities right?

John Collier:

Correct. That happens a lot.

Ron Barshop:

Yeah. So it's like very organic. Okay. That's wonderful.

Ron Barshop:

So let's talk about the long-term plan. What do you see this looking like in say three to five years in terms of scale?

John Collier:

So around something you see all over our website and something, even it's a little phrase that we trademark and it's true to our culture and our philosophy is "care beyond the loss". And so you've heard me for the last several minutes, talk about the power of primary care and what all the great things we can do in a primary care setting. But we know that primary care does not stop in the four walls of that setting and so what you're going to see, what you continue to see us do is taking the power of primary care and reaching into the care continuum. And so that means building direct contracts, building relationships with specialists surgery centers, hospitals, we are entering into dozens of hospital relationships across the country, and really making sure that we can ensure that our patients, these moms, dads, sons, daughters, husbands, or wives, that we have the awesome responsibility to take care of that they get the right care at the right time in the right place, and then for that right cost.

John Collier:

And so we're constantly looking at quality. We're constantly looking at outcomes of these community specialists or national specialists, national hospitals to say "let's make sure that we are going to do referral. It's going to be in the right place and the right setting", and then opening up communication. And so what you're going to continue to seeing us develop is opening up communication throughout that whole care continuum, giving primary care voice and letting primary care kind of be the vehicle to handhold that patient to the oncologist, if they need that, to the surgeon, to the cardiologist, and then also training and building close relationships with the specialists that if they should be seeing it in a primary care setting, what we'll do is called reverse referrals.

John Collier:

And so they're seeing a cardiologist for hypertension. Well we can do that at the primary care level. We'll bring them back into the primary care setting. And then if, and when they need a cardiological procedure, then we'll get them to the cardiologists that right cardiologists that we've vetted from an outcomes perspective. And so you're going to continue to see that evolution in that evolve and in the power of primary care, expand into the care continuum.

Ron Barshop:

So do you see it as your role, let's say it's time for labor and delivery, which I'm sure happens a lot and obviously PCPs aren't going to handle that. It's now time to make that handoff and they maybe have their OB team already. Do you do anything to make sure that they're not adding complications at the surgery, that they're not creating codes and up coding for COVID and all kinds of ridiculous games that hospitals play. Do y'all take charge of that role or is that the TPA's role to make sure that happens?

John Collier:

So I say it's collective. So we work very closely with that and we train... so if we've built a direct contract with the hospital, then it's definitely our role. And so we are going to be seen as that chief medical officer and if we see these up codes we're going to work with the employers TPA and claims are going to get denied. We also to work with our patients, if you get an EOB, you get something that doesn't look right, bring it back in and let the patient advocate go through your bill with you. And just two weeks ago we had a patient come in who had a colonoscopy and he said, "no, something doesn't look right about this bill". And sure enough it wasn't correct and so we said, we got this, we'll handle it for you. Our patient advocate and physician worked collectively together and were able to get a reimbursement for that patient.

Ron Barshop:

It's interesting. I think the licensed clinical social workers, just being therapists, but I don't think of them as adjudicating claims and working over the billing, but it sounds like you've got some specialty training in there and you're in each of those clinics.

John Collier:

Yeah. So think about these licensed clinical social workers in a normal setting. So they're trained in therapy and the behavioral health side. The ones that are setting have worked in, in hospital settings. And so they've worked on maybe the busiest hospital floor dealing with uninsured, dealing with CMS Medicaid and so when you can put them in a setting where they can just become a master at one plan design, and they're used to looking at resources for patients who have very little resources, but would have put them in an employer setting where they have one commercial insurance and they can really become a master and fully ingrained in that that plan and those benefits they can work magic.

Ron Barshop:

I'm imagining your employers love this, that you're able to bring those costs down as well. So let's talk about pharmacy. In Texas we are not allowed to have formularies in the clinic, but I guess you can in some of these Southern states and Southeastern states, how does buying meds

work? We'll just explain how that works. How's that process work? So you can bring the pricing down from the traditional PBM pricing?

John Collier:

Right? So most of our settings, we have an onsite dispensary. So that's about 200 or so generic pharmaceuticals the physician and the nurse can dispense right there to the patient. Compliance goes way up so that diabetic, we can hand them their Metformin right there. But there are certain settings that if the volume is high enough, if they have multiple thousands of members, it may make sense to do a full pharmacy. In that setting, we will build out a full retail pharmacy, have a staff, a pharmacist, and in some attributes become almost a replacement for their PBM. And that's an amazing environment when you can get the physician, the patient advocate and the pharmacist working kind of as a triad, working together to educate that population in those individual patients.

Ron Barshop:

And when you can create your own dispensary, you must be able to bring the costs of pharmacy way down from, these giant prices. Have you looked at the cost savings when you do have a full pharmacy?

John Collier:

Yeah. Like I said we can predict 17% to 20% reduction of what they're spending before and that's conservative, but yes we can bring it way down. And also really, we've built software and, and so we call it Proactive IQ is our population health software that we've built in training our care team and building out pathways. So when they go to prescribing medication, they can see " is this in-plan, is an unplanned" "how much this is going to cost the patient" "how much it's going to cost the employer." "Are there alternatives?" "Are there other things?" And so constantly putting parameters in place to get that care team, to get those physicians thinking, maybe a patient came in and saw a commercial and wants this pharmaceutical, but there's another great alternative. And because we have that relationship because we've developed a deep relationship, we can have a unique influence on educating the patient and say, "Hey, let's try this first and then let's go from there."

Ron Barshop:

All right, well, so what are you most excited about when you meet a new employer? You must have a very high closing rate because it seems like America is migrating to these plans. We have, by my count of just people on this show John, 30 million people are now in these types of plans. These subscription per member per month plans, they're direct contracted, and they're all different flavors, but most of them seem to be growing so fast that, and I don't think really the world knows about it because there's no association, there's no books about it. You don't see many articles. There's very little academic research other than your internal research that you're doing that is certified by the validation Institute. But there's very little work being done to actually sit down at a table with all of these folks and talk about an association. I think that might be the next step.

John Collier:

Yeah. I tell you Ron, we are in an exciting time across the board from an employer perspective. The pandemic was hard COVID was hard, but let me tell you, it accelerated so many fronts. It accelerated virtual care and the need for that. And the openness to that, it accelerated conversations that I had been trying to have for decades verging my whole career to think about value-based care. Employers are embracing it in a way that I have not seen, hospitals are embracing it and then independent physicians.

John Collier:

And so I'm very active in the direct primary care space and I want to see this space grow and grow and grow. And I've seen the direct primary care movement just continued to explode. And so you do have the large direct primary care players that work in the employer arena. I would say we are like that ever side premise you have those groups, even groups on the MA side, but even individual doctors, there's probably nearly we're approaching close to 2000 independent doctors who have converted into a direct primary care type model and that continues to grow. And I talk with family practice residents or internal medicine residents, this the number one question, "how do I get in direct primary care?" "How do I think about value and not having to be on the hamster wheel of our views?"

Ron Barshop:

Okay. I love for the doctor that there's no burnout in this population. You're talking about these 2000 docs have the happiest conventions I've ever seen in my life. There's no burnout, there's no suicide ideation. And I'm going to assume that's the same for your hundred docs and providers. And I'm also going to assume it's the same for ever side and all the others that are in this game. Let's talk about virtual. I just had on my show, Babylon health and I've had a [inaudible 00:30:34] on my show and they are a virtual only model. Their doctor-to-patient ratio is one to 3000 because they're not offering, in [inaudible 00:30:43] case employers they're not offering [crosstalk 00:30:45] but in Babylon health which is a Medicare population and really a capitation model, there are one to 18,000 ratio of docs per patient. So again, each model has it's virtuals, but how do you feel about the coming on of artificial intelligence as a decision-maker for docs and as the I guess the HR data entry for docs?

John Collier:

Our patient promise is we are only and always about our patients, our clients, and we promise to always fight for their greatest good and part of fighting for the patient's greatest good is looking for ways to continually better serve them. Our job is to continue to innovate by continuing to improve and so I am thrilled and I'm excited to see more and more technology, just like I said COVID, it was tough. It was tough nationally and globally, but it's certainly accelerated a lot of innovation and a lot of openness to using virtual care and also other technologies, AI and other items. And so I'm certainly excited and it's definitely a vital part of what we do. You know, our job is to be nimble and to meet the patient where they're at and in virtual is a great way to do that.

John Collier:

Virtual services, leveraging RPM services, working with our specialty partners. And so when we are working with the specialist, how do we come together? I'll tell you one more quick story. So

what we saw in COVID, we had a lot of patients that were comfortable coming into the primary care setting because, in direct primary care, we keep low volume. They're not waiting in the waiting room so they felt safer. But what we're seeing is a lot of our patients said "well, I'm not going to the specialist. I'm just not going to go to the hospital", but there were patients that were ill, that still needed to see their oncologist or still needed to be seen by a different specialist.

John Collier:

And so what we did with our hospital relationships is we provided virtual care inside our setting, where you had your family physician sitting right next to the patient in there. And then you would beam in that oncologist and having an open conversation right there and help still give them the care that they need in a virtual environment. So again, being nimble and being creative on how do we make sure our patients get the care that they need.

Ron Barshop:

Hey, John, how do folks reach out to you if they want to send you a resume, if they're a doctor or they're an employer and they want to talk to you?

John Collier:

Yeah. So Proactive.md on the career side that we have a careers page. And then my email is J Collier as J C O L L I E R jcollier@proactive.md. I'm also on LinkedIn.

Ron Barshop:

And if you could fly a banner over America, what would that banner say?

John Collier:

Primary care changes lives.

Ron Barshop:

Good message. John, thanks for your time. And we'll look forward to keep keeping up with you and watching your growth.

John Collier:

Thank you, Ron. I appreciate the time.

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.