Primary Care Cures

Episode 148: Darshan Kulkarni

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:

So pretty much, most of the content you'll see in articles about fixing healthcare is like trying to repair termite and mold infested house with a terrible foundation and a leaky roof. Now, just buy a new house, side stepping the big middles is the only way to drive employer costs down and improve outcomes and eliminate friction for the consumer and the docs, into a world where we all win, where all incentives are aligned and everyone has a possibility of getting better, better health, better income, better revenues for the companies that participate. So having more take home income, more EBITDA, have five star consumer experience, a A plus work environment if you're a doctor or nurse. It's all real folks, this is seemingly like I'm talking about Valhalla, but the bar is set so low it doesn't take much to fix healthcare. After all, it's a rotted and misaligned incentive house.

Ron Barshop:

There are almost no incentives aligned with healthcare that depends on volume because fee for service is not only alive and well as more primary care trends corporate because the hospital's got a giant check to buy as many suffering primary care practices as they can possibly get their hands on. The numbers are staggering in the last 18 months of this panic, this COVID pandemic that we've had. And when I say a panic, because doctors had basically zombie revenue for five months in a row. There's also no incentives aligned with healthcare that has alignment with sick care. That means to get more heads in beds, do you win when there's more sick than healthy people?

Ron Barshop:

An article recently published in Forbes talked about a hospital investment that Cone Health made in a company that was reversing diabetes over four different clinical trials, 27% of the people reversing diabetes. Guess what that does to heads and beds? When you're at a 3% margin, that's not good. The investment was stopped. Also, there's no incentives aligned when consumer friction takes 21 steps to fill a prescription, 51 steps to see a specialist. That is called friction. There's no incentives aligned when you have navigation confusion for the patient or non-

transparency for us consumers on pricing, which is changing. Or we have high inaccessible deductibles, which I think is the number one problem in America because 85% of insured patients never burn through their deductible to get to the actual, quote unquote, insurance. And there's no alignment of incentives when PBMs play shell games with the rebates and kickbacks and where there's [inaudible 00:02:33] for special interests that are big, when there's hidden brokerage fees. There's 17 different hidden broker fees in a typical health insurance plan for an employer. 17.

Ron Barshop:

There are captive broker nondisclosures, meaning the broker tells you they're going to bid the market, but they really work for one carrier and are beholden to them, or they get in trouble. And avoidable referrals into big systems via RVU incentives. So the day a doctor, a primary care doctor, sells, has an independent into a big system. They suddenly have a kick at the back of their chair from the man who wants them to refer more patients to their imaging centers, their labs, of course their hospital and other outpatient services like surgery centers. So this is all not aligned incentives. And all employers want is the same thing. They want the same thing in Sacramento, Dubuque and Trenton. They want a true attraction and retention and engagement tool, which is what direct contracting gives them.

Ron Barshop:

If you've listened to this show, direct contracting is where you contract directly with a PCP. And there are scalable national groups that are doing that in all 50 states now, not just independent mom and pop DPC Kool Aid stands. And control over spiraling costs and reduced costs, the average reduced spend is somewhere between 20 to 60% when they engage in this direct contracting model. And the employer wants claims free of gaming by the big systems because 80% of bills have errors. So at least have somebody adjudicating your claim, whether it's a third party administrator or a transparent advisor, like we had Rachel Means on our show and Katy Talento, that is something that employers want. They want it simple. And they also want simple reporting, not giant spreadsheets that are unreadable by anybody but a CFO with a mathematics degree. They don't want noise from their team, employees that are complaining the plan doesn't work for them. And they want advisors truly aligned with them, not bigs.

Ron Barshop:

So this is again describing direct contracted digital first care, we can call it cash pay healthcare. We can call it near site or onsite care. We can call it virtual primary care. There's so many different flavors in this Baskin and Robbins, but it's all subscription based, per member per month. It's all cash pay to this ecosystem of docs, labs, imaging, and pharmacy, which we're going to talk about today. It's a future where everybody wins, the consumer, the doctor, the nurse, the employer, and cost drop in outcomes increase. Today we meet a guest who is a expert on pharmacy, not only what's going on in the macro, but down into the nitty gritty of the legal aside and the medical and clinical side of what's going on in pharmacies. Darshan Kulkarni is a PharmD and an attorney specializing in pharm regs of every Stripe and color you can imagine because he not only helps startups, but he also helps the big pharmas. And he has a podcast that's called DarshanTalks. Hey Darshan, talk to us.

Darshan Kulkarni:

Hey Ron, how are you? Good to have you on and thank you again for inviting me over.

Ron Barshop:

Your habit is to say, "Good to have you on." This is my show, buddy.

Darshan Kulkarni:

I'm so used to being on the other side of this microphone.

Ron Barshop:

I know, I know. Welcome to being in the hot seat for a change. You have no idea what question I'm going to ask, but I'm going to ask some pretty typical questions that our audience I think would want to know. My understanding about independent pharmacies is that they're getting so much pressure over the last 20 years from the PBMs who are only growing in power. And frankly, two of them are pharmacies. How is that happening and what's going on in that space?

Darshan Kulkarni:

So generally speaking, what you're seeing is a certain amount of vertical integration and the idea being, and it's not just two, it's several of them sort of coming together and saying, "We don't want to just be in the pharmacy business, we want to actually control the entire process." And that includes owning the PBMs, that includes potentially having their hands in GPOs. That includes just a variety of different ways they want to engage. For example, CVS came out and said they want to get into clinical research. CVS came out and said that they want to get into mental health. CVS obviously has its minute clinics.

Darshan Kulkarni:

Pharmacy is sort of changing their roles from being the place you get your prescription, to owning the entire ecosystem. And that raises some opportunities for pharmacies, but it raises some flags for physicians, and quite honestly, for some independent pharmacies as well, who are getting blocked out and don't have the opportunity to engage in the same way that they probably want to and engage with the patient in a way that the patient's ready. It's become a little bit of a lowest cost structure where all the pharmacists I talk to continuously complain about the fact that they're being held to these really stringent metrics that they simply cannot perform to. And you're seeing burnout, which is similar to physicians and almost everyone in the healthcare ecosystem.

Ron Barshop:

Aren't there some fees charged to independence that the larger pharmacies that don't have to pay that force them into not even being able to offer certain kinds of generics?

Darshan Kulkarni:

Yeah. So there are these fees, they're called DRR fees. And there are some other fees as well, which really get into this idea that certain pharmacies get more preferential treatment, and the end result is that they cannot compete. And you'll see that happen really often, especially when you've got these large PBMs that have their own mail order pharmacy that will often just simply go, "You know what? You don't have to pay a copay if you're talking about a mail order." But

you may have to pay that same copay if you were going to a pharmacy next door. It's a way for PBMs to push one format of the other.

Darshan Kulkarni:

And I imagine, again, I don't work with HMOs. However, it becomes a way to save money. However, the downside of that same structure is that it becomes very difficult for these smaller pharmacies to compete. And as a result of having a much harder time competing, they're having to sell out. And they're often selling to these same to the CVSs of the world and the Rite Aids of the world and the Walgreens of the world, because they're the ones who buy it. And that feeds in and off itself and takes away the choices and options that a lot of patients may have wanted.

Ron Barshop:

Let's talk about that for a second. I want to talk about the minute clinics for sure. Before we get into my other question, the minute clinics aren't offered by CVS. But VillageMD, which is a great primary care group out of Houston, signed a deal with Walgreens. And they're now going into 700 clinics across the country for Walgreens. So it's a different model. Walgreens is basically saying we tried, we can't do it. You guys know the business of value based care better than we do, go for it. So what do you think about having, well let's talk about VillageMD first, about having a full service primary care offering in the back of the Walgreens versus the minute clinics? Do you have any take on that?

Darshan Kulkarni:

I'm not completely clear as to the distinction as to how they're operating differently and what is difference in the business model. However, I can comment in general about just the idea of having minute clinic or minute clinic like structures around the pharmacy. I think pharmacies have generally struggled with the idea of space and they've generally struggled with the idea of privacy. I worry a little bit as a patient in terms of can they get the privacy to have the discussions that they want to have in the back of a pharmacy?

Darshan Kulkarni:

Having said that, I think that what it does offer is opportunities to access care at times that that maybe it wasn't as easily available because as we all know, sending people to the ER is significantly more expensive. It's often just easier for someone to go in and go, "You know what? I just need this one thing," and it's a very clear, defined problem that I can go to a minute clinic or the urgent care and get some assistance along the way. But I think the key there is coordinating with your primary care physician, making sure that your care is being appropriately coordinated. Otherwise, you have these dangling chads, for lack of a better term, that are being left all over. And is that giving you as a patient, the best options for treatment?

Ron Barshop:

Daron, what do you think about having the proximity answer to that question, which is that pharmD can now physically be in the same room or consulting physically nearby the MD and the DO? They're right next to those NPs, they're they're on site. Is there any advantage to having a consultant pharmacist who's no longer just a pill counter, but now is actually part of a team?

Darshan Kulkarni:

I think that as a concept, I think it sounds great. It sounds like it would be, be really, really useful to be able to have your, quote, unquote, drug expert right next to you as you are helping a patient. I think as a concept, it sounds amazing. At a practical level though, I would question whether that happens as often as you'd want it to, in that these pharmacists are often overworked. They're still trying to meet their COVID quota, the vaccination quota. They're still trying to meet their prescription filling quota. And at the same time, they're still trying to make sure that they're dealing with all of this when they're understaffed. So with all of that going on, are they providing the care that I as a patient would necessarily want? And I'm not sure that they feasibly can do that.

Darshan Kulkarni:

Having said that, if executed properly, I think that that becomes a great resource. I think it also provides the opportunity as you continue, to get into more medication compliance issues and addressing them a little bit cleaner. I think on one hand, the advantage you have is that if they're right next to you, you might decide that I can just go to the next booth over and fill my prescription. The downside of that, however, is what if you wanted to go to a different place? What if you wanted to fill your prescription in a different pharmacy? And there might be some more implicit pressure that you have as a patient that you had not previously considered. And that gets into these issues of directing your care to specific people. And I think a lot of these pharmacies take special precautions to make sure that it doesn't sort of become a directed effort.

Ron Barshop:

Like a pill mill.

Darshan Kulkarni:

Exactly. But I think that it's a risk that does exist.

Ron Barshop:

You know what? I went to go see when it opened the Dallas, Georgia, next to Atlanta, Walmart healthcare offering that was brand new. It was their first one. And we've had a non-med who's their medical director, now he's out on his own with DPC, on the show twice. But I did the math afterwards. I called two national experts, one who is a national expert with Atrium Health and another who has a giant primary care group in Arizona about the numbers.

Ron Barshop:

We just ran through the economics of a 10,000 square foot, primary care clinic and the math wasn't working because they offer everything. They offer behavior health and ophthalmology and blah, blah, blah, goes on and on. But the important thing is that the pharmacy is right next door and it looks like a fricking Star Trek set of a movie. It's extremely modern, there's lit up drawers. I'm sure you know what I'm talking about because you've probably seen it. But it's kind of a state of the art 21st century pharmacy where nothing gets confused anymore and there's no mix up. It was impressive. But when we started playing with the math, what does the average pharmacy fill? What is the average margin on a pharmacy fill at Walmart? We started saying,

"Oh, that's where their economics are making sense." They're doing more durable medical goods and more pharmacy sales because of the clinic in the Walmart.

Darshan Kulkarni:

Yeah. It becomes another driver, and that's the big advantage. It's the same reason why they introduce pharmacies to grocery stores. It became a reason people go there and that you can sort of upcharge on everything else that's in that location. It's a similar concept, obviously, in this specific instance is directing people to the pharmacy and where you already have your margins built in. But I think that that's the future, the commoditization of healthcare. And I think that's what worries me as we start getting into these next phases.

Darshan Kulkarni:

And what I'm thinking about specifically is this idea of what does Amazon look like as it gets into the pharmacy market? Google and Apple just came out and said that, "We can't figure this thing around health out. We might still have some healthcare offerings, but we're closing down a system that we had built around healthcare." And what that tells me is this is a difficult nut to crack. Even if you have billions of dollars, well technically trillions of dollars together, there are too many people too entrenched to give up what's already existing.

Ron Barshop:

Amazon has hired a company that is crossover health. It's going into all of their fulfillment centers, but they've also opened five of their own clinics, one in Dallas, Texas, and four across other states. And they just quietly soft trial ballooned 20 other cities that are all the obvious major metros that they're going to soft launch in 2022. So Amazon's in the primary care business solidly. And PillPack, when they purchased that, what is your thoughts on PillPack? I used it and it helped me stay organized with my nutriceuticals I had to take a couple of years ago.

Darshan Kulkarni:

I like the idea of PillPack. I remember, I think it was Walmart and Amazon was simultaneously trying to buy PillPack. And Amazon bought them out. I think Walmart was trying to buy, if I remember correctly, for like seven or 50 million and Amazon came in the last minute, bought them for a billion if I remember correctly. And I think it was an all cash deal, if I remember correctly, which I thought was super impressive. But the part that I thought was really impressive is the systems that they have, which takes me back to a point you made earlier, which, oh, isn't this cool, this 21st century pharmacy where you're going to have no mistakes? And the truth is, I guarantee you, there are still a ton of mistakes. Having been on the other side of that counter, I can tell you everything you hadn't considered will happen and you're going to get those mistakes. So all the lights in the world don't prevent that, especially if you've got people working quickly.

Ron Barshop:

I know there's not an easy answer to why Darshan, but does it have something to do with pharmacy burnout? I met with a pharmacist when I was in Atlanta, met with two of them, and they both were massively burned out. They'd lost their sparkle.

Darshan Kulkarni:

Yeah.

Ron Barshop:

And they said that when you go through these meat grinders with these big corporate pharmacies, they burn you up alive and you're basically an accountant. You're no longer a doctor and you've left what you were trained for and what you're excited about and you've just become another number in the factory.

Darshan Kulkarni:

I'm not sure it's a one to one correlation, but I definitely think it's a factor. Being burnt out means that you aren't paying as much attention. You're just a pill counter, not unlike the robot right in front of you that's going to count out 1,000 pills faster than you ever can. And what you're often doing is just literally putting them into a packet and giving them to your patient. The value that a pharmacist has, the value I went to pharmacy school to learn about was, is this medication right for you? And working with physicians, working with DOs, MDs, with NPs, with PAs, to make sure that the patient is getting the medication that's right for them. And the right medication may not be the one that's the cheapest, it may not be the one that's the easiest to take, but is the medication the patient will actually end up taking. That gives the right safety and efficacy that was planned.

Darshan Kulkarni:

And that is hard and that requires time and it's not reimbursed. And since it's not reimbursed, pharmacists are being basically told, "I need you to stay behind the counter. I need you to [inaudible 00:18:58] and that's what we expect from you." That I think speaks to the idea that how do you ensure accuracy at a time when, as you put it, that sparkle is gone? How do ensure that you are taking the time to care for your patients when the company you work for is saying, "I need you to care less for the patients and care more for your productivity and for your productivity scores"? And I think that's the balance.

Darshan Kulkarni:

I don't necessarily even blame the companies because they're looking at metrics saying these people can do it, why can't you? I think there needs to be a conversation, a better conversation as to how the needs of patients can be met. And I think that as we start having those conversations, hopefully as tech companies like Amazon get into that space, they may discover that there are more opportunities here than have been previously planned. For example, having a Siri, and I'm trying to avoid using the Amazon term because my digital assistants will go off. But having those digital assistants help you with compliance, help you with figuring out if this medication is right for you, help you coordinating your care between the pharmacy, the physician and the other stakeholders. And I think that's the future, but that's not where we are today. Right now, we're in this chasm of depression for most healthcare practitioners I talk to.

Ron Barshop:

Yeah. So it's apparently with pharmacist as well, although I'm not seeing the metrics on that. So what is the most common medical error that occurs in a pharmacy?

Darshan Kulkarni:

I'm not sure I've seen the latest statistics or anything like that, but it's everything from wrong medication to wrong patient. And again, it depends on how you define the word error. It could be wrong dosage to we billed it, but the patient didn't pick it up. So you didn't actually pull it back. And then the patient got the medication anyways, and now you've got other issues coming out. So it can be a variety of different things. And none of those are pleasant, none of those are ideal. And then you've got to make that phone call to the patient going, don't take this. Or if you've already taken this, have a discussion about what the implications are.

Darshan Kulkarni:

Sometimes it gets even more problematic where you've given the wrong drug and now you've got to go, what's the impact of a levothyroxine in a patient who has no problems with their thyroid? And the answer might be nothing, because it's a single dose or it might be, was a really high dose and this patient, we maybe need to have some other discussions that go along with it. We can take it even further, going into a pediatric patient giving tetracycline, and what are the implications of that? So all those need to be considered and each of those is different and the implications are different.

Ron Barshop:

What is your take on GoodRx? Is this a good thing? Is it hurting pharmacists? I know it helps consumers. They could get the lowest price for maybe a mile away or two miles away. What are your thoughts on it?

Darshan Kulkarni:

So again, I don't have a horse in the race. I come at it more from the perspective of a consumer than as a pharmacist because I don't work in a pharmacy right now. But most pharmacists I speak to are not the hugest fans because their argument is that GoodRx batters them with the price and they don't get appropriately reimbursed. I can see that logic being true. And what makes it even worse is that the way it works is that the patient will come in after the fact, after everything's been filled and say, "Oh look, I have a GoodRx card." And the implication and the impact of that is the patient's filling medication twice basically for the same medication. So that's something the pharmacy has to consider. You've got to reverse the first charge, reassess the second charge and basically fill the medication twice. So pharmacists are not the greatest fan sometimes of GoodRx, but I think also pharmacists do recognize that especially in larger chain stores, they recognize that this is the best interest of patients in many cases.

Ron Barshop:

Have you seen anything out there, Darshan, that helps people with their medication compliance? I've seen numbers as low as 6 to 16% of people take their meds on time as they're supposed to.

Darshan Kulkarni:

I have not. I haven't recently looked at numbers, but I know that compliance is a major issue and I recently had a diabetes scare. I was trying to figure out if I have diabetes or not. And one of the things I realized is that I take medications when I want to. I take my medications HS as opposed to daily. And the implication is it's 12 hours different. But the point being, I don't take

medication the way the physician intended. I happen to think that I still know what I'm talking about, I could still handle it. But the fact is that that still would fall into that category of you're non-compliant in the way that was intended. So A, you've got to look at the numbers and evaluate what the impact is.

Darshan Kulkarni:

But the second part of it is also, if you are taking those medications, if you are using those medications, you need to make sure that you're talking to the physician and then them evaluating whether there's an impact. Most of your listeners may not be pharmacists, may not be physicians. And then those cases, they have to understand what is the impact of a situation like this, where your patients are taking medications as and when they want to.

Darshan Kulkarni:

But I know it's a problem that pharmaceutical companies, for example, have spent millions trying to solve. I know companies that are in the business of trying to solve the problem, using everything from Bluetooth to wifi, to tele signals, all to make sure that you take your medication on time. But the problem is that the impact seems to be significant from a statistical viewpoint, but not significant from a monetary viewpoint. I'm making up numbers here, but you said six to 16. You bring it up to 18%, yes it's significant, yes it may even have a monetary impact, but it's really not dramatic enough for a company to go, "This is a solution." So compliance remains a major issue.

Ron Barshop:

Okay. I want to talk about partnering with DPC. We have a lot of listeners that are direct primary care. And Carl Schuessler was on our show. He's a benefit advisor of the highest order out of Georgia and he partnered with Lee Gross in Arcadia, Florida. They took on the poorest, it's the poorest county, if not one of the poorest in Florida. And they had lost all their industry, but the hospital was still the big industry there.

Ron Barshop:

And when you lose a hospital, everything starts creating, people really have to move to the city, they don't want to. But the hospital started partnering with a local pharmacist. And of course, Dr. Lee Gross and the school district and the county and the city, and they were able to cobble together a membership model so that they could get great pharmacy pricing. The pharmacists loved it because now they had a steady customer and the largest employer. The school district, everybody won. It was basically about a million, six, savings, which is how much they lost in the COVID panic. So it was literally a lifesaver for this hospital. So do you have any experience or do you have any thoughts on direct primary care in the neighborhood partnering with a local independent pharmacist who's also in the neighborhood?

Darshan Kulkarni:

I've had some exposure and conversations with people, but I haven't actually delved into the actual model itself. The overall perspective seems to be that they like the idea of it and the execution of it. And I think it enables some of those direct to patient contact and impact they wanted to have. So pharmacists like the idea of really making that change, they're making that

difference, not being seen essentially as someone who works at McDonald's and is expected to fill the order exactly as quickly as someone at McDonald's. And again, I'm not trying to dis someone at McDonald's, I'm trying to say that hopefully your medication gets a little bit more care than your burger.

Ron Barshop:

Okay.

Darshan Kulkarni:

Yeah. I think they generally seem to like the concept of it.

Ron Barshop:

Two last questions. It's why in a riot, do the rioters go for the pharmacies every time. They loot the heck out of those things. And in Chicago, or maybe Philly, they looted 40 of them. It's like a magnet for looters.

Darshan Kulkarni:

Because you get the Oxycontins which have a street value significantly higher plus it's easier to carry out.

Ron Barshop:

Okay.

Darshan Kulkarni:

Plus there's a pent up thing of blaming pharma and saying that if I can get the medication, which can be in many cases, super, super expensive, yeah, it becomes a better bang for your buck. You pull the Oxycontin, pull hydrocodone, it's easy to pull that and sell it on the street. There are two ways to address that for the most part. One tends to be, and this is true for pharmacies, you're required by most boards of pharmacy to do one of two things. Either keep all your controlled substances inside a vault. But if someone's coming at it with a jackhammer or something else, that vault's going to hold only for so long.

Darshan Kulkarni:

The second option is actually surprisingly a lot less cumbersome, but a lot more effective, which is you have to intersperse your medication, your controlled substances throughout the regular medications. So unless you knew that hydrocodone could also be called vicodin, which some do some don't, you wouldn't necessarily intuitively go to V to look for hydrocodone. So that helps not lose all the drugs. But then again, I don't think rioters generally are going, let me be strategic and surgical about which medications I'm going to take. They usually just go with the bag and just pour things into a bag and then figure it out from there.

Ron Barshop:

The second question I have is, it seems like a lot of scripts never get filled. I don't know what the numbers are, but I've heard pretty high numbers. What in the heck do you guys do with all those unfilled scripts?

Darshan Kulkarni:

I'm not sure necessarily they don't get filled. I think they don't get picked up.

Ron Barshop:

Yes.

Darshan Kulkarni:

So the distinction obviously being the first being filled, but you just return them back to where they were. It's one of those things that's why you have pharmacy school interns. And you'll get them, and I remember doing this, every week, my pharmacist would have me look through the bins and pull out all the medications that weren't picked up for say two weeks, that are two weeks old, and then return them. And that's what we did. So it ended up becoming a way of recycling the medication. Obviously, one of the key portions of that is that you have to make sure that you reverse the charges. And again, I represent pharmacists every so often around the issue of billing compliance. And sometimes pharmacists will bill, but not reverse if the patient didn't pick it up. And now you've got a situation of is that an issue of fraud and dealing with that.

Ron Barshop:

Okay. All right. That's interesting. Is the medicine returned to the general population with all the other pills or are there different expirations on different batches? There are expirations on medications.

Darshan Kulkarni:

Absolutely. So these medications are generally from different batches, but at a realistic level. First of all, I think that most of the prescription bottles have the expiration date because you're pulling it off of the serial number and stuff. So it does tend to carry the same expiration date. You might have different batch numbers that go along with it. But generally speaking, you can return it to the same pill bottle, depending on what you have going on. Again, going back a couple years, this wasn't a big issue for us. I remember you either just pull the pill bottle and just keep it inside and you're just going to give it back to another patient. Because generally speaking, you have enough of a turnover that it's not a big issue. You'll be able to sell it within the next 24 hours, generally speaking. So it's not a meaningful impact. But sometimes it is and you have to keep an eye out for it.

Ron Barshop:

I know the answer to my question where I ask it, do you ever have people come up when they find out that you're in the business and say, "Hey, can you hook me up with that little blue pill, or how about some ivermectin on the side, buddy?"

Darshan Kulkarni:

I think we've all had those experiences. It's sort of the same thing as can I get some legal advice and can I get some medical advice, in your case? We all get that question, and then you get the lawyer answer of, and the answer is no, because I don't work with as a pharmacist anymore. But yeah, you get those, you get them pretty routinely.

Ron Barshop:

All right, Darshan. I'm glad your diabetes was just a scare, not the real deal because that is not something we want for any of our worst enemies. So if you could fly a banner overhead with one message for all of the people, what would that message say?

Darshan Kulkarni:

I think that that message would probably say, listen to me on DarshanTalks or you can all also reach out to me if you have questions about pharmacies and the life sciences industry, anything from medical devices, clinical research or anything else.

Ron Barshop:

And I might add that you belong to a pharmacy network of podcasters that are universally pretty high quality. I really listen to your old podcast, Mortar & Pestle. Is that what it was called?

Darshan Kulkarni:

It used to be called The Mortar & Pestle. Yes, absolutely.

Ron Barshop:

Yeah. Really good podcast and the young lady you had take over, very sharp and your old podcast was great. Your new podcast is great. I would commit, folks, to listen to that if that's a subject they're interested in.

Darshan Kulkarni:

Thank you.

Ron Barshop:

Darshan, Thank you. How do people find you if they want to connect with you?

Darshan Kulkarni:

Absolutely. So you can find me on Twitter, Darshantalks, that's Darshantalks, or you can go to our website, Darshantalks.com or you can find you on LinkedIn at Darshan Kulkarni.

Ron Barshop:

Great. Thank you very much for your time and we'll catch up with you again soon, I hope.

Darshan Kulkarni:

I look forward to it. Thank you again, Ron.

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.