Primary Care Cures

Episode 149: Dr. Omar Matuk-Villazon

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 PCPs and big insurers sure have an odd relationship these days. You're in network, but they are competing for your patients now, and they want to hire your colleagues away from you and your nurses. And they are, or will soon, offer virtual primary care in your city, at least three of the five biggest announced they would do that last month. Aetna, CVS is expanding their medic clinics into primary care clinics as hub spots or Health Hubs, they're calling them, and as a central gross omnichannel strategy. We'll talk later about omnichannel strategies, another show.

Ron Barshop:

How does this latest insult of your insurance company that's supposed to be paying you, your payer, competing with you, how does that impact your love/hate relationship with them you already have? Well, it's no picnic out there, but you already know all this stuff that I'm about to say today. I'm just going to spell it out. But not to worry, there's a clean way to exit this game. And there's a clean way to win without a big fight or a struggle or lost sleep, because there's an enormous shift away from all of the headaches created by how you're paid as a doc.

Ron Barshop:

20,000 plus primary care providers have chosen to direct contract with employers and consumers, that serves 30 million employees, and about 10% of them are independent, and you can read about them on the various direct primary care websites. But 90% work for startups that are the biggest of the bigs. In other words, they are growing fast and there's companies that have been on this show like Premise Health and Everside and Crossover Health and Medici. And they get paid on a per member, per month basis by employers, not by insurance companies, not by bigs. So their panels are much smaller, 500 to 850 is pretty typical for these direct contractors.

Ron Barshop:

And if they are doing virtual only like Medici, or say 98.6, who's also been on this show and helps Walmart, they're going to have a larger panel, but they'll still be the same employees you'll be talking to consistently. So you will have a panel, you're not going to be talking to random

people every week, every day. So peer virtual is a little bit different, but when you have bricks and mortar, you have a panel that's much smaller than what you have today, 1500 to 2,500. So it's not volume centric care anymore when you go virtual first or digital first and bricks and mortar.

Ron Barshop:

Anyway, the good news is that the employees, you'll know them, just like you know your current patients, it's just different. So it's scaled in every state, all 50 states, there's 30 million patients that are currently being served, likely more. That's all that we've counted on this show.,And this show hasn't had every one of the companies on it. Nobody's really tracking it, so we don't know, but I'm guessing 30 million is a pretty safe bet.

Ron Barshop:

So the best part, the direct contract movement rejects the CPT coded, bye book, the ISDN codes, adios, because they're paid, as I said, by a monthly subscription per member, per month. So some out there will code year one, if an employer signs up, just to prove out the direct contracted savings net, which range 20 to 60%, and the range is wide, I'd say 20 to 60 because some the employers direct contract all at once. They rip the bandaid off or they run and some walk, they ease into it and rip the bandaid off, slowly.

Ron Barshop:

So for example, employees would be offered a PPO, HMO, and a DPC option, and it goes slow approach. Not everybody moves immediately out of the PPO and the HMO they've had so long, sometimes for decades, because it's a name brand and they know it and trust it, even though the DPC option, direct primary care option, has no copays, no deductibles.

Ron Barshop:

Well, that's sounds strange for some people and I want to dive into that, well until they hear from their friends that it works. And they may have to leave a doctor that they've had for many years and some people don't want to do that. Other go slow strategies that employers use is instead of direct contracting with the entire ecosystem, I call it the five fingers, which means primary care, pharmacies, surgery, specialists, imaging labs. Instead of contracting with all of them, they might just contract the pharmacy initially to get those initial easy, low hanging fruit savings and make their employees very happy. So it's an evolution from newbies at the game, if you're an employer, but some just like to run fast year one and dive right in there in the new economy, which is what Rosen Hotels did in 1994 and they're the probably prime example of an employer who just ripped the bandaid off and never looked back.

Ron Barshop:

We also had Paul Johnson Drywall, PJD, on one of our shows early on and it's our most downloaded show, but they just ripped the bandaid off and never looked back. And I did the same thing myself with my company, much smaller. Okay, back to doctors because that's how we started this rant here, is opting out of sick care is a very real possibility for you as a doctor. With who? Well, listen to my past shows, I just named five or six companies and all the CEOs or the chief medical officers that these companies have been on this show and will be on again,

because we're keeping up with them. So here's what wearing a hot fur coat of in July feels like when you feel like you have to be in this legacy carrier industry is you have to live with pre-authorizations and prior authorizations. Really? The consumer friction of sky high deductibles, we have to be 70 to 80 million, are basically functionally uninsured.

Ron Barshop:

So lot of patients can't finish what they start with you as a primary care provider and they're priced out of reach. In other words, that their primary care and meds, because they simply can't afford these sky high deductibles. 40% of people are in sky high deductibles and 40% of people have ill liquidity. So about a half of your patients, possibly more, because we had 85 million last year that carried medical debt and we have 70 million if you do the math on 40% of workers. But somewhere between 70 and 80 million people are basically functionally uninsured so they can't finish what they start with you sometimes. And that's got to be frustrating.

Ron Barshop:

Also, administrative dweebs and pretend white coats are judging you and denying you for care you've been giving for years to patients that you know well, and they're completely out of touch with the dire needs of some of these patients of yours. And the EHR is not designed to help you, it's designed to help the insurance companies, and it's certainly not designed to help the consumers. So we would have an answer to COVID and cancer treatment and everything if we had full access to all this great EHR data. We'd know what exactly works out there, and we don't.

Ron Barshop:

How about charting at night? You like that one? That's my favorite one that I hear from docs and the volume pressures, you're constantly under more pressure to see more patients in the old legacy, hot fur coat in July system. And then also, I hear from a lot more doctors, they have a fear of speaking out about a lot of things, about what's going on in COVID and masking and whether they should use alternative therapies. And there's a constant also pressure of chargebacks, but for one typographical error in a giant chart. So I don't think I'm being over dramatic by calling this fur coat in July and all this insanity I just described and a merry go round is maybe, we can and evil. It's clearly not consumer or physician centric behavior, when insurance companies are poking you in the eye by competing with you for not only your people, but for your network, for your patients.

Ron Barshop:

It's a dirty finger in the eye as well. It's not just a finger in the eye. It's an insult. So we are still the bastion of freedom in this country, but it just doesn't feel like it navigating this minefield of rules that the bigs have set up. It's more akin to authoritarianism, isn't it? They take away your voice. They take away your autonomy. They question your training. It's a very important calling, and it suddenly it becomes drudgery and primary care is not supposed to be about that. So opt-out is an option from the manipulation, from the mistreatment, from the muzzling, they are begging you to come into their bosom further, but you can opt-out too.

Ron Barshop:

So I'm living in the future as a consumer of this product, that is a future where we all win and you can too. And today's guest completely gets this because he did something very interesting and it's a first in America. I'm introducing you today to Dr. Omar Matuk-Villazon. He's a pediatric [inaudible 00:08:00], who has led multiple initiatives of the brand new U of H Medical School in Houston, Texas. And it was created to add diversity to our positions here in Texas and it's done a great job.

Ron Barshop:

So as its chief medical officer, it isn't enough that he created from scratch and is running a brand new program, but he also started a DPC free clinic. I can't understand how that matches together, so he's going to explain it to us today. A DPC free clinic is part of his responsibilities. It's the first ever, as I said, in a medical school. Why is this important? It's important in my opinion, and I want to hear his, because now medical students don't just have to round in a hospital, which isn't really primary care anyway, it's hospitalist medicine, it's different. But now, they can get experience in a direct primary care practice too, and a free clinic to boot. We're going to hear all about that. Welcome Omar, to the show.

Dr. Omar Matuk-Villazon:

Thank you Ron. As I was listening to you, I was thinking, "So why will the students want to become primary care doctors these days?" So just to clarify something, the clinic is not free. So patients are actually paying and I'm able to explain that better because we want to make a model that is sustainable.

Ron Barshop:

Okay. Well explain, how did y'all get this idea to get this started and where did you learn about DPC initially, because this is unusual for a medical school?

Dr. Omar Matuk-Villazon:

No, absolutely. As you said, I'm a pediatrician, so I was working for a large federal qualified health center in Houston. As pediatrician, I was seeing all the parents, they were asking me for care and I realized that a lot of them didn't have access to healthcare insurance. Just in Harris County, I think the last data that I saw, 1.4 million individuals are either underinsured or don't have access to insurance. It's really, we have a high need. I'm assuming other parts in Texas are the same. I did an MBA. And in the classes, I met individuals that they tell me, "Hey, there's this thing that CMMS is just putting out about direct contracting." And that caught my eye. All these primary care first initiatives and DCF contracts. And I was trying to think, "So how can we offer this for people that don't have access to the insurance?"

Dr. Omar Matuk-Villazon:

So, that's how the idea came up. I met the Dean of this medical school, a wonderful family medicine physician, Dr. Spann. And he liked my pitch. And he invited me to join the school two years ago. And with his support, we have been able to do this. We got funding from the current healthcare trust, a local healthcare foundation, to really start this clinic in a specific area in Houston that has around 40% of uninsured in Gulftown. And this aligned very well with the medical school, because the idea of this new college of medicine is to educate a diverse group of

physicians, that want to decide to stay in primary care. So DPC makes a lot of sense just from the experience, the way you practice medicine, to really try to have students become passionate primary care doctors. Because as you were saying on your intro, you start thinking the reality that no one will want to do primary care, right?

Ron Barshop:

Well, primary care is still a noble calling and it still can compensate well without all the stress, but you have to think about it differently than going to work for a big hospital or going to work for a big practice. You don't have to do that today. And the beauty of what you're doing is you're going to let these medical students take a round to go see exactly what a primary care clinic can run like when it's direct contracted. So I'm going to assume that when people come in that are uninsured, they're going to be paying a per member per month. Are you sticking with that formula?

Dr. Omar Matuk-Villazon:

Yes. The innovation here is just maybe the market and the place where we're doing, but we have been open officially, let's say two weeks, unofficially a couple of months, but people will be paying $60 per month per person. We're working on a family package right now. People will have access to full spectrum primary care services. We have like a traditional DPC. We have POC labs. We have direct contract with the labs. We have made some discounted rates of a specialty and diagnostic services with a local hospital. So patients have access to that. But mostly people are paying out of pocket. We haven't gone through the employers at this moment. We're just marketing to patients and the demand has been tremendously, I can tell you that.

Ron Barshop:

I'm so glad to hear that Omar. When I think of the care stack that is offered by more experienced DPCs that have been out there 5 or 10 or 15 years, they're offering not just traditional primary care, but also urgent care, of course. And they're offering some form of dermatology where they can do probably 15 or 20 different skin procedures. Some are offering behavioral health. Are y'all planning to get into mental health, or you going to stay away from that for now?

Dr. Omar Matuk-Villazon:

No. That's a medium term strategy because we have a strong psychology department here. We don't have that yet for the members, but the long term game is to do a truly integrated behavioral health practice. I haven't worked out all the kinks, but that's definitely on the books.

Ron Barshop:

It's really a beautiful thing when you build primary care from the ground up of what the patient needs, mental health is almost always going to be part of it because it's just such a big part of the telehealth availability. There's so much you can do by phone, by digital. You don't really have to go in all the time. And I was looking at a study today that most of the telehealth today is actually mental health consults, much more so than the, what I use it for, which is I need to renew my medications, or I just have a question or I'm trying to get an appointment at a lab. But it seems like that is a really good opportunity for primary care to redefine itself.

Dr. Omar Matuk-Villazon:

It is. Last year, this was not on DPC, but the clinic we have here, I can tell you the mental health component probably was 80%, the telemedicine, and has a stay like that. The rest has come to the presence. But I agree with you, that's a big component. Also that I may add to the concept there, the fact that the doctor has time to spend with the patient. I don't know if there's a study out there that will reduce a lot of the mental health issues because people can speak what they are having and feeling. And I think that has a lot of value that we just need to account and make sure that we show that that makes a difference.

Ron Barshop:

So let's talk about that. How many providers will you have at your new clinic and then what's the patient panel? So it's going to be per doc, per nurse.

Dr. Omar Matuk-Villazon:

Yeah. Right now, we're just starting. For now, it's going to be one, we anticipate to have between 750, that's the goal. We put support staff so they can practice on top of the license and help the family medicine doctor that we hire, and she's a wonderful doctor, very experienced. So she can really do a good population, healthcare management of the patient that she will own. As we are, we see a lot of demand, then we can start hiring more doctors. Something that Dean really wants to do is he really wants to only hire physicians. And I think I fully support that. That has a lot to do with showing the student that can be done and really putting the value back to the doctor as the leader in the primary care space. As you are mentioning, we have all these companies, which are wonderful. I know some of the people you have bring to your show. But as a medical school, I think we need to put the doctor back on the center so that they can serve the patient again.

Ron Barshop:

It's interesting, there's now DPC with PAs in some states, because they have full scope. There's a DPC in Austin, run by nurses, strictly nurses. So there's different strategies for doing this, but I agree with you, the training of 10 to 15,000 hours per doctor, makes a lot more sense than a nurse who may have 500 hours or 2000 hours or a PA who may have 1500 hours. But again, I like pairing extenders with doctors, but to have them run their own clinic, unless they're extremely experienced, it's a little scary for me, I don't know.

Dr. Omar Matuk-Villazon:

I respect deeply my nurse practitioners and PAs that I have worked during my life. I think they're tremendously value. But if you think from an educational perspective, I think even from people you want to look up or you want to admire, you want to learn, I think having doctors make sense in a medical school. Maybe in the future, we will expand with PAs or nurse practitioners. But I think we are really committed to show students and to hopefully create a marketplace in which they can later work.

Dr. Omar Matuk-Villazon:

If you think we want to train these students to be community advocates, to do population health, to train on this risk/value based care models. But when they go out, what are the options that they have? It's either I work for a big hospital. I join one of these startups. I join one of these big

medical groups. So I think just showing them, "Hey, look, this can be done. If we were able to do this in the medical school, you can do this or even more." So hopefully inspiring a new generation of doctors that have my entrepreneurial mindset, I don't know if that makes sense.

Ron Barshop:

Yeah, no, of course. We had Fun Health on our show and that physician is a good social media, he's knowledgeable in social media, knows how to build a practice, has opened his second clinic and he just started a couple of years ago. The Bear brothers in Kansas, what they're doing is they're established and they just keep offering more and more services for free. So they keep buying more equipment and saying, "Now we're going to do this procedure, that system and we're can offer bariatric," is what they offered last year.

Ron Barshop:

So it's nice to see the evolution of DPC, but I think some of the fear doing it straight out of medical school is, can I attract 3 or 400 people? Because I did the math. If you take 750 in a panel times 60 bucks, that's 45,000 a month and you don't need more than a staff person or two, you don't need a billing or coding. You don't need people that run preauthorizations because there's none of that inside the model. So it's a much cleaner, simpler staff.

Dr. Omar Matuk-Villazon:

Yes. And just to add, and some people in your show have said, the way you practice medicine is also different, because you are now truly focused on fixing the problem. Even from a value proposition, if I'm a patient and I know the doctor won't be thinking of billing or even investing time on, as you said, coding, documenting in a certain way that benefits more the billing part, not necessarily the patient care, even training students to do these things right.

Dr. Omar Matuk-Villazon:

There's a couple of articles that this reduces burn out. And also I will say, it will increase satisfaction. And patient quality, I haven't seen any large dataset that says that this [inaudible 00:19:25] patient quality in terms of quality of care. Well, we are looking at the university to hopefully create that data. So we can show that, "Hey, this model not also is better from a financial perspective, but from an employer, what actually keeps you healthier." I think if you are able to demonstrate that, then this model can take off because this is the right thing to do.

Ron Barshop:

Yeah, well you can't show from a scratch clinic like you have, but in clinics where they take over a practice, they show that hospital visits drop anywhere from 20 to 40%, that hospital stays drop anywhere from 40 to 60%, that the actual amount of medications drops as people start getting healthier. The amount of urgent care and emergency visits drop dramatically because now they don't need, 90% of the time, to be in the emergency room.

Ron Barshop:

They can go to their DPC or call them and instead of charting at night, your doctors will be communicating by a synchronous texting or voice. So it's a different animal when you're instead of charting for insurance companies and might actually dealing with issues that the patients are

wanting to deal with. So it's a very exciting new idea and I hope more medical schools follow your lead. This is a great example of what can be done to give medical students in primary care, a new view of the world.

Dr. Omar Matuk-Villazon:

Yeah. Hopefully we make it right. And just to add to your point, I read one article that it reduces total healthcare utilization, kind of thinking besides emergency healthcare visits and hospital admits. I think from an employer perspective, that's where the data mostly is coming from. The challenge on the population we want to serve is if you think about more from a social determinants of health or public good perspective is we're going save money to all these big county hospitals, big not for profits. It would be hard to quantify the savings, but we are truly committed to do this 5, 10 years and hopefully make an impact in the region.

Ron Barshop:

Yes. I'm excited for this. Have you heard about the new Robinhood DPCs that are propping up in California?

Dr. Omar Matuk-Villazon:

Yes. I think they just released, talking about that, it was what, two or three weeks ago, that they released an article, right? DPC With a Touch of Robinhood.

Ron Barshop:

Yeah, and what's happening, now I know your neighborhood well, you're in not a borderline neighborhood, your neighborhood is definitely going to serve your market. But some of these neighborhoods in California have very wealthy neighborhoods right adjacent to very poor neighborhoods. And so they are using a set of 60, maybe 100, 120 a month. And the wealthy people, they're saying, "60 of your 120 is going to pay for another patient that's not going to have any cost at all, or maybe it'll help, $5 a month." And so they call it Robinhood because they're taking from the rich and giving to the poor and the rich are happy to do it. It's a form of taxation, but one they happily pay.

Dr. Omar Matuk-Villazon:

I think it's a fascinating concept. Just thinking from a broader societal perspective, how do we consider healthcare as a public good? And who needs to own these memberships? And now that we know that this model actually saves money from the emergency and unnecessary hospitalizations. So yes, I remember that story you are sharing. It was a very good story.

Ron Barshop:

It is. How are you getting the word out Omar, and what can we do to help?

Dr. Omar Matuk-Villazon:

Thank you for that. So right now we have what we call a soft opening on November, because we're having a full-time family medicine doctor joining us on January the 5th. So all the big push

will be after January 5th. And I think just spreading the word, especially after that day. So right now, I don't have the capacity to keep up with demand, but by January we will.

Ron Barshop:

Okay. Well, we hope to get this issue done on or before your opening date, so you can use this with your social media to get the word out. So we're in full support of what you're doing and excited about it. So Omar, I'd like to wrap this up by asking a question, as you've heard before, if you could fly a banner overhead, what would it say?

Dr. Omar Matuk-Villazon:

Become a primary care doctor.

Ron Barshop:

Okay. I love it. And how do people find you Omar if they want to reach out to you and learn more about this clinic and about you and your new medical school?

Dr. Omar Matuk-Villazon:

I'm very responsive on LinkedIn or if they also want to follow me on Twitter is @omatuk. I'm also responsive on Twitter.

Ron Barshop:

Okay, great. And congratulations on starting a new school, and it's a very exciting idea of what you're doing here. Thank you for doing it.

Dr. Omar Matuk-Villazon:

Yes. And it's a team effort. I cannot take absolutely whole credit. It's a lot of people behind me that are doing a lot of the work. So, it's really a team effort.

Ron Barshop:

Well, very good. All right. Well you have a great day and we'll catch up with you in maybe a year or so and hear what's going on.

Dr. Omar Matuk-Villazon:

Yes. Thank you so much.

Ron Barshop:
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