

# Primary Care Cures

## Episode 153: Robert Palmer

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:

Acute labor shortages are all in the headlines these days as thousands of cities, and towns, and states, and school districts across the US are facing the most acute labor shortage in a generation or two. Regional and local governments have an even tougher time than businesses because they can't compete with our private sector wages nor can they offer remote work. They rarely can. And they faced a historically unprecedented wave of early retirements as The Silver Tsunami has decided to opt out early. And younger opt outs are happening too thanks to COVID.

Ron Barshop:

The biggest problem for private employers is same, same. Chronically, about 800,000 people shy of the needs. Municipal school, state, county, labor shortages by comparison are exceeding about 780,000 slots today. Supply chain disruption might vary for the first place problem for employers, but most of them are saying they can't get enough help out there today. And this show can't help supply chain, but we can talk about labor shortages because there's an elegant and clean answer for most of these labor shortages.

Ron Barshop:

The smart solve in Silicon Valley is the early adopter, because technology has chronic shortages pretty much all the time is, drum roll please, direct contracting. You knew I was going to say it. With all five fingers of the healthcare hand, primary cares the foundation. That's the thumb, we'll call it. The specialties and surgery centers, the independent imaging and the labs, wholesale pharmacies, we've had a lot of those folks as guests on our show, all five of those. Then you got to add in a catastrophic stop loss as a rapper to protect against the scary stuff like cancer, heart, and more like that mental health and a great TPA to adjudicate claims and to steer call in members to world class solutions like today's guest, we're excited about.

Ron Barshop:

Direct means skipping the bloated wasteful metals who muck it up for the employer or the doctor and the consumer. We all three have been hammered for decades by the bigs as they have been

profiting very handsomely. And now we are the winners and not the losers anymore when we go direct. So offering essentially free healthcare, which means no premiums, deductibles, copays, or co-insurance. Not free, no tricks.

Ron Barshop:

A tier candidates will turn up and rose for interview when free healthcare is the headline in your opening. It's the number one reason candidates give for accepting offer, and it's the hop reason or two while they'll stick around too. Freedom from the tyranny of premium deductibles and copays is called, a raise. For singles, that's averaging \$400 to \$500 per month nationally at a minimum. For families, that's \$1,400 to \$2,000 per month, at a minimum.

Ron Barshop:

We're talking about \$6,000 to \$24,000 as a raise. The first true raise in decades is not absorbed by the tape form of healthcare, as Warren Buffett calls it. For almost 25 years wages have been flat. Thank you, healthcare. And that's called a personal recession and its length is unprecedented in US history. Our previous guest, Dave Chase, elegantly calls this, healthcare stole the American dream.

Ron Barshop:

Unfilled jobs will be filled by better candidates than ever before. I've lived it firsthand four years now since we offered it, and no one leaves either. The latest study on this is, two thirds of all employees would forego bonuses paid time off vacations if they had excellent employer-sponsored healthcare. And imagine if it were free.

Ron Barshop:

Well, that's a wake up call for mayors and governors, but really for directors of all healthcare plans, CFOs with spend authority, treasurers, finance directors, not only is offering direct contracted care smart, but cities, states, schools and counties, can save 20% to 60% off their overall spend by skipping these bloated sleepy middles.

Ron Barshop:

So free healthcare means using that 20% to 60% to eliminate the employee contributions. You get it? Employers use these savings to pass it onto the team. We had a guest Rosen Hotels, a previous guest twice with 6,500 employees who basically only have \$5 copay. So they have some skin in the game for their healthcare and their executive exercise.

Ron Barshop:

Rosen Hotels, a previous guest with 6,500 employees have basically only a \$5 copay, not only for their workouts, but for all of their healthcare needs. And now the 6,000 room Orlando Resort has zero debt. They've been doing this since the mid '90s. They also will give free college to all of their employees and to all the graduates of the two poor school districts in Orlando. And the matriculation rate for these school districts used to be in the 1% to 2% to 3% range, now college matriculation is on par with the richest school districts in Orlando with 65% to 75% range.

Ron Barshop:

Healthcare is the second biggest line item after labor cost. So with serious savings, that only helps these larger causes, but it also goes right to the bottom line, if you wanted to. Walmart has saved \$1 billion a year the last two years this way using direct contracts and steering teams to centers of excellence like today's guest company.

Ron Barshop:

They had thin margins. They'd have to open up about out 1400 stores to drive \$1 billion to their bottom line. They used a quarter of that \$1 billion, \$250,000 million to offer free college assistance to their employees too who qualify. So when Amazon is your worst nightmare, \$1 billion from being smart in your spend is a huge lift.

Ron Barshop:

800,000 municipal state and school employees and retirees of New Jersey enjoy some of these direct contracted relationships. Chris Deacon, a guested on a few shows of ours ago, a couple of months ago, who led this effort told us that they found \$1 billion [inaudible 00:05:32] in savings to finally fully fund their pension plan. No one has done that in decades in Jersey. And they also gave a month reprieve on all employees funding their healthcare spend. So not pre-health care, but at least 1/12 off. That's never happened before in New Jersey history, a premium vacation.

Ron Barshop:

The state of Montana was the first state, and now the health plan has a surplus in savings using direct contracting of about \$120 million a year, which contributes more to their bottom line than all the other state categories of savings combined, by far. And with easy, free frictionless access to primary care, chronically sick people that work for you are finally properly attended to which is about 85% of the healthcare costs they trapped in maybe five to 10% to 20% of your employees. Diabetes, heart, cancer, asthma, et cetera. These lifestyle diseases are early on reversible.

Ron Barshop:

Cracking that code, diabetes and lifestyle reversal are two companies one of which has agreed to be on our show. You're going to hear from Virta Health's chief medical officer in a future show, and they're the real deal. And that's called the tease. What shrinks with frictionless access to primary care are way fewer ER visits, way fewer hospital stays and visits, dumb needless tests, which happen every 15 seconds for a lot of different reasons, and less medication usage and even better compliance or adherence when they do have to use the meds. And way less overtreatment.

Ron Barshop:

There are way too many surgeries on knees and backs and more much better handled without surgery we learned from our previous guest, Catherine Ramin Jacobson. If you remember, she wrote the book Crooked. It's the defining book on crooked orthopedic racket. And her hundreds of citations alone are booked themselves. And her publishers said they can't put them in the book, they have to put them online. It's over 400 citations. In short, what shrinks by 20% to 60% in every category, I'll just name, with free primary care is volume-centric sick care.

Ron Barshop:

That fee-for-service model that we know the bigs are addicted to like crack, is old and haggard but it's not going anywhere because, remember, they own 70% of all the urgent care centers as feeders to their heads and beds. And they also own 70% of all physician practices. So volume-driven profit-centric sick-care heads and beds is alive and well and it ain't going away.

Ron Barshop:

800,000 opening is in government, 800,000 private untitled, it's forcing change. Other states are waking up and starting this direct contracting journey include the Virginia's and Kentucky. My beloved progressive Texas may even wake up and dabble soon I'm told. And half a dozen other states are looking into it because they have to. Why aren't more doing it?

Ron Barshop:

Well, last months, I wouldn't agree to be on the show, but one state plan director who I spoke with said they couldn't direct contract even though the state would save an easy \$1 billion with a little bit of work, billions, with an S. Why? The governor and lieutenant governor were in the pocket of bigs, who, let's face it, write ginormous checks to politicians, and their giant job creators too in most states, even if a lot of them are fluff administrative jobs. And until the last selection cycle, 2020, big healthcare outspent combined the next four lobbying categories, which is Defense, Wall Street, Silicon Valley and Energy.

Ron Barshop:

Imagine that. Now, six school districts in Texas are dipping their toes in direct contracting, including the largest Houston ISD, just hired our recent guest, Dr. Juliet Breeze and her urgent care centers, and they direct contract primary care. El Paso was the first in the game, and there's four or five others that are now getting started. Florida and Colorado schools are all over this slowly, but surely. And one Colorado school district gave the first raise they've seen in decades to their teachers, because they had extra money to spend. So we have a big school district in Florida, that'll be on the show soon again, another tease.

Ron Barshop:

It's spreading, and we know for a fact that 30 million Americans are direct contracting through their employers. On my count, just from guests on this show. So it's got to be more. And by the way United Aetna, all the bigs are getting into virtual primary care as of last month. So 30 million's going to be a much more bigger number, but it's hard to estimate right now. There's no association. There's nobody counting this. What to end city and state labor shortages? Your own labor shortage to your company, start offering free healthcare.

Ron Barshop:

You can pay for it with the savings and it's close to a no-brainer. It shaves your number two cost center, the health spin, and with those savings, it shores up your number one labor. Today's guest, I'm super excited about. He's literally the wizard behind the curtain on a lot of things we see in standard care today. Robert Palmer's an MBA. He's also a CEO, a founder, and a data scientist. He is the CEO of PotentiaMetrics, and of several other companies he's founded and sold. And he has over 20 years developing analytical models for healthcare payers and providers, life sciences, professional sports, financial services, private equity and manufacturing.

Ron Barshop:

But he's best known for really developing these really cool models to define the individual, clinical and economic outcomes for say, cardiac surgery and cancer, number one and two killers in America. And also home healthcare. He developed outcomes models that are used by the largest medical technology companies you've heard of, and top academic centers you've heard of. What does that mean, outcomes models? Well, before minimally invasive cardiac surgery blew up, to become the standard of care, someone had to model the massive savings, massive outcome improvements based on evaluating, comparing massive data sets that are out there. And it's not just intuitive, that guy is today's guest, the wizard behind the curtain on that. No more Frankenstein scars by cracking open chests these days.

Ron Barshop:

So what heart has gone through in the last 30 years ... I'm told cancer's about to go through with precision medicine in the next 30 years. Another example. Robert has worked with Medtronic to define the reduction of complications associated [inaudible 00:11:32] for using cerebral oximetry in cardiac surgery. That's how much oxygen goes to the brain. We don't want too much in a surgery.

Ron Barshop:

Another example, personalized cancer care. What works best for you personally? Chemotherapy? Surgery? Radiation? Diet? A mix of these? None of the above? Or one of the above? Everyone is going to respond differently based on a ton of personal factors. And this is a guy and the company that now laser-beams to you and your doc. The best approach based on massive data to a [inaudible 00:12:01] guesswork and shotgun approaches. Throwing the kitchen sink of cancer is not a good idea. "Don't worry about the cancer," they say. "We all know the radiation of chemotherapy will get you first." Well, Robert Palmer's defining work has been published in Harvard Health Policy Review, Becker's Hospital Review, and he's received a ton of honors and award, including from the American Cancer Society, Predictive Analytics World Conference, and South by Southwest in Austin.

Ron Barshop:

He taught at Washington University for seven years in the famous entrepreneurship program there. He's of YPO, Young Presidents' Organization, and he's currently the education chair for the healthcare network. And he's our only guest that's good enough to, as a teenager, be able to hit regularly within number one ranked, [Jimmy Connors 00:12:44]. Welcome to the show.

Robert Palmer:

Thank you. A really nice introduction. I appreciate it.

Ron Barshop:

Yeah, you bet. Well, do you have any comments on what I said before we get started?

Robert Palmer:

Yeah. Many of the topics, I couldn't agree more. The biggest challenges I've seen in healthcare, now reviewing literally millions of patients outcomes, is that the elephant in the room many times that isn't discussed is the frequency of procedures. We talk about cost savings or making the current system run better. But in reality, about 30% of what we do in healthcare isn't helpful and therefore harms the patient. So if we would right-size the system according to what treatments provide the best outcomes, we could go a long way to solving a big problem we have in healthcare today.

Ron Barshop:

Well, hallelujah to that. Robert, your dad's story compelled you to start your present company. And to introduce that story, please tell us how you came to partner in St. Louis with the Washington University School of Medicine.

Robert Palmer:

I attended Washington University Business School there, and I was developing models for cardiac surgery. As you, referenced, with modeled the outcomes of patients that were treated with minimally invasive approach surgery versus conventional, and looked at the reduction of infection longer time in the OR, more complexity on the procedural side, but downstream patient benefits.

Robert Palmer:

Over time, as you've indicated, that's become more of a standard of care as I believe it should have been. And while we were building those models, I was using cardiac surgery dataset, which include, really granular information on patient comorbidity, the complexity of the procedure, outcomes of other patients.

Robert Palmer:

And during that time, my dad was diagnosed with metastatic prostate cancer, and so quickly shifted personally to, "Okay, what outcomes information is available for my father so that we can make a more informed treatment choice for him?" And I had assumed that in cancer there'd be more data, that the models would be more advanced, but shockingly I found very little inform that was relevant to my father who had at that time metastatic prostate cancer. So it really based upon a personal need and then our personal need turned into the needs of millions of others that are diagnosed every year that are looking for an answer to a seemingly simple question. What are outcomes for individuals similar to me based upon different treatment choices?

Robert Palmer:

And that's really where we set our sites in providing the information because these treatment decisions are so complex. You have personal values and preferences enter into the discussion, as well as clinical outcomes. And so just providing transparency so people that can make the best choice for them is really where we focus.

Ron Barshop:

It seems to me like there's unlimited variables with your dad, age, health BMI, diet, exercise, true heart age, true liver age, versus his actual. How do you actually narrow it down to know, is he

part of an avatar that fits, here's what we ought to do as a treatment protocol for him in cancer with this metastatic cancer.

Robert Palmer:

And that's a great question. A great way to pee up a exceedingly complex environment that we enter into. Just looking at the factors that impact every patient with cancer, so age the other diseases, their overall health, the stage of their disease. Those are critically important factors that can start and frame the conversation. And then you can also look at some additional factors that would be genetic factors, mutations, the availability of targeted treatment.

Robert Palmer:

And so with all those factors combined plus the personal preferences and values conversation, I would argue impossible to create a mathematical model that would direct someone towards, "This is what you should do." But what you can do is solve part of the puzzle and say, "Here are some elements that are important for you to know."

Robert Palmer:

Some of these other components are really up to your personal judgment, personal values, as well as your understanding of the limitations of all the models that we have in place today. For instance, in our models, if we quote a 50% survival rate for individuals similar to you, it's important information for you to have, but what we can't target today is tell you, "Are you in the 50% of survivors? Are you in the 50% of patients that didn't survive?" What we can do is quantify the risk and at least put people in the right neighborhood with that which is greatly needed today, but also being frank with people and describing the limitations of what we can provide today as well.

Ron Barshop:

Okay. The standard of care now for stage three, not metastatic or stage two, it might be, first surgery, try to excise the cancer, then you're going to radiate. Maybe you'll do that before, then you'll throw chemotherapy at it. And then you'll tell them to get on an exercise program if they have any energy left at the end of all that.

Ron Barshop:

I think what you learned from your dad's situation is that, his protocol that he went through as a standard of care was wrong for him. He would've had a much longer or somewhat longer survival rate had he followed the data that you have now.

Robert Palmer:

Yeah. We believe that to be true, and the data that we have also indicates that for my father. The treatment he received, radiation, hormone treatment, chemotherapy, each one of those had a negative impact on his functioning and as a derivative in his quality of life. What we found with my father and what we didn't want to realize is that, he was frail when he was diagnosed with cancer. Even though he was 70 years old, if you looked at him and told you he was 50 you'd believe it. He jogged for five miles, the morning of his diagnosis so his physical activity was high, his physical conditioning was great.

Robert Palmer:

Didn't smoke, didn't drink, never had. It was really compounding to us that he even received this diagnosis. And our assumption is that the time was well more or less be better, whatever we can do to slow the progression of the disease down is going to give him the best chance.

Robert Palmer:

But we didn't take into account was the effects of treatment. In his case, pulmonary embolism, a side effect of the chemotherapy, radiation caused scar tissue into the urethra, he couldn't pass urine, he had to cath himself. Introduction of staff infection through cathing himself. Surgeries to remove infection. Incontinence in and out of the hospital more than not. After a year of very low quality of life, pneumonia ended. He started at about 200 pounds and towards the end of his life, he was down to about 140 pounds.

Ron Barshop:

[inaudible 00:20:42]. Wow. So people are using your consulting, I guess we call it, to have a higher quality of life, maybe an extended quality of life. You're not going to end the cancer, but you're certainly going to look at all the factors and give the best outcome for the least amount of stress on the body.

Robert Palmer:

Correct. [inaudible 00:21:01] one of the big challenges when we were in this group, less than 5% of adult patients can accurately describe their prognosis. There've been multiple studies done around this, and it's not because the physicians don't share with them information around prognosis. Many times patients don't want to hear it, or they may hear during treatment that your tumor is responding to treatment. And immediately they think, "Well, I was terminal, but now my tumor is responding, therefore, I'm now being treated for cure." Which is a wrong assumption, and therefore, these patients many times, will self direct more care than they would otherwise, if they knew that what they were dealing with from a long term perspective.

Robert Palmer:

So when you speak with patients and ask them the question, "Would you like to spend time in the ICU?" Of course, "No." But large numbers of cancer patients end up spending time during the end of their life in the ICU because of side effects of treatment in large part. Understanding that there're benefits, and there're trade-offs associated with each one of these decisions, and just eyes wide open because there is no math, as I indicated that can solve for each one of these and direct people to what they should do, rather, here's the best advice of your physician. Here's the best evidence that we have. Here's the trial information. Here are the guidelines, which we believe are incredibly important, but the additional element needs to be brought into play.

Robert Palmer:

What are outcomes for individuals similar to me so that you and your physician, your family members, your caregivers can sit down and solve this incredibly challenging decision, and be at peace with it, and have confidence in the decision you made?

Ron Barshop:



Basically 1% of all employees at a typical employer, are going to get cancer. I guess a lot of them are younger employees. So they might have blood cancers that are imminently treatable anyway, and have a super high survivability rate. Are you still going to consult with those folks who are going to use the standard of care, basically with a 95% survival?

Robert Palmer:

I think every patient should be aware and go in. There is the tendency towards everyone. Patients to lean into, "Well, let's do more for this than last." If you look at the outcomes of patients that have early stage cancer, the adjuvant treatments, many times don't provide much survival benefit, and yet, they may have side effects and longer term trade-offs that the patient may or not be aware of. For instance, a young woman diagnosed with breast cancer would want to have deep conversations with her clinicians about, "If I choose this treatment, what's the effect on my future ability to have children? What about downstream potential damage to my heart valve or secondary cancer?"

Robert Palmer:

All these are future derivatives of the decision that they're making today, that may temper their fear of the current state versus getting treatment a that would put them in the cure basket today, versus in the recurrent basket tomorrow.

Ron Barshop:

Okay. Washington University was your primary source of the data for your metrics and your outcomes. Have you gone to other treatment centers for cancer to get their data as well, to partner with them?

Robert Palmer:

Yeah. We always had multiple center data in our model, so it's important to have a large sample and also an understanding of how patients are treated in different areas of the country. Working with large academic centers is a great value. We do see benefits for patients treated those centers as far as it's outcomes, and they see more complex patients, for example. But the reality is that, patients with cancer or any complex disease, greater than 80% of them will get care within 20 miles of their home. So we need to provide a cross-section of data, which we do, which shows, what are outcomes among smaller hospitals, among larger systems, urban areas, suburban areas, rural areas, all taken into account.

Ron Barshop:

Okay. Let's talk about for a second, randomised clinical trials. They aren't just quick enough for the patient who's got cancer right now, to answer these specific questions, nor is it efficient, as the risk-adjusted data analysis. Is it?

Robert Palmer:

Yeah. Some of the challenges with the evidence that the guidelines are based on today, randomized controlled trials, is that they're really a limited data set going in. The trials are largely designed to answer different questions, than patients are concerned about, when they're looking at their treatment options. Randomized controlled trials are looking at whether a tumor

shrinks or grows, based upon a treatment. Meanwhile, the patient is asking, "Okay, the drug caused the tumor to shrink. What does that mean, with respect to my survival? Can I continue to keep my job if I go through the treatment?"

Robert Palmer:

[inaudible 00:26:36] many time to disconnect there. Then other major disconnects with the data, is if you look at the participants in the trials, they tend to be younger, healthier, less racially and ethnically diverse than the patients that are diagnosed with cancer. If you look at the average cancer diagnosis age, it's 70. And if you look at that subset of patients greater than 60% of those patients have multiple comorbidities, and those two aspects alone would preclude the lion share of patients that are diagnosed from participating in the trials. Now, are trial's evil? Are they set up wrong? No, they're there to look at the differences associated with different treatments, and there isolating factors that may confound their outcomes. I would do the same thing, so that what we're trying to crosswalk here, is looking at the efficacy versus the effectiveness question that drug companies have on one aspect and patients have on the other aspect.

Ron Barshop:

The other natural source, I thought, other than going to these academics, [inaudible 00:27:49] would be EHR data, but you don't think EHR datas have any value, because it's really designed for insurance companies, not for evaluating cancer risk and outcomes.

Robert Palmer:

Yeah. The EHR data in many cases has limited value. It gives us a good understanding of how patients were treated, what treatments they received. It doesn't provide us information on, the why they received the treatment they did. And in large part, it's coding for dollars. Over the years, I've done this incentives matter, and what's reimbursed is largely what's coded for, and what isn't reimbursed, there is an incentive to do it. Understanding what that data set is designed for in large part billing collection, it's not there to answer clinical questions.

Robert Palmer:

That's where the importance of registries comes into play. And working with these specialty groups that help define the variables captured in the registry, so that understanding what's captured, when it's captured, what's measured, for instance, definitions around what renal failure is, so that we're not solving for variation in definition, instead, we're able to solve for variation and outcomes.

Ron Barshop:

Okay. Robert, with large employers or small employers contract with you, and then what are they going to save per cancer patient once they engage you?

Robert Palmer:

We contract direct with the employers, and then we can provide our platform to their employees when they're diagnosed. We can do that on employee, per month basis or on an individual basis, as employees present with cancer. In general, with our models, we expect to see out of \$30,000 savings per diagnosis, among patients that are self selecting the best treatment for them. In our

case, the economics is a derivative as it is in everything and healthcare of the decision that the patient makes. But what we've found and others have also mirrored this analysis is, when it informed that the risk and rewards of treatments, many times patients will opt towards a less invasive approach then, if they didn't have the information.

Ron Barshop:

Okay, 1000 employees is going to yield basically a \$300,000 savings, which obviously pays for itself with you guys, and now covers not only that employee's \$20,000 spend by the employee, but another half an employee as well. So it's economical for sure.

Robert Palmer:

Yeah. And the intangibles are there as well. Quality of life, functioning ability to stay on the job are other factors that are important measures that individuals are trying to balance when they make these treatment [inaudible 00:30:59] decisions, and that's also a role that we can help them with.

Ron Barshop:

Okay. Before we sign off, the time has just went by here. Robert, what is the way that your wizard behind the curtain has helped professional sports teams, got to ask. With the Astros in the ... Hopefully after this is online, the Astros have won the world series. But how do you help professional teams or how did you help professional teams?

Robert Palmer:

We've done work with one of the large leagues, and I'm under confidentiality on this. But one of the largest leagues in United States, and helped them optimize behind the scenes positional data that was captured, automated, so that we could look at how patient or how the players interacted with each other. And for the first time we developed models that we could value every player on the field for every play. The impact of what historically wouldn't have been measured from a defender perspective, we were able to quantify versus just players in the field that were in scoring position.

Robert Palmer:

It was a new approach. I know there's a lot of discussion around Moneyball, and I get that. It's a great approach. We came at it a little bit differently and more from outcomes perspective, thinking about it in terms of, "I really adapted the approach that we'd taken in cardiac surgery and cancer." For example, and adapted those risk metrics, so that we could take into account many variables that intertwined, versus historically focusing on one or two variables that are active in a given play at a given time.

Ron Barshop:

Did it result in less injuries or better recovery?

Robert Palmer:

We didn't end up putting it in play. There were some political challenges behind the scenes that were going on at the same time, but it was more along the lines of valuing each player so that you would understand who to put it into play, what size of contract that you would want to give each player.

Ron Barshop:

In three to five years is my final question. How many employees would you be serving in three to five years, if you hit your numbers?

Robert Palmer:

We're looking at both domestic and international markets. So in three to five years, if we start seeing the uptake that we expect, we should see North of 20 million lives being assisted with our tools.

Ron Barshop:

And you've at this since 2014, so you're not a spring chicken, you all know what you're doing.

Robert Palmer:

Yeah. Yeah. It's been a long and bumpy road, especially going through COVID, and the effect that COVID has had on cancer diagnosis is significant. Some of our customers have seen greater than 90% reduction in testing and therefore diagnosis. One of the elements that we're going to see over the next few years playing out is, patients that should have been diagnosed this year, being diagnosed later. And by definition, they're going to be having later stage disease.

Robert Palmer:

And the later stage disease can be significantly more expensive to treat. That's going to have an impact on our whole system of care. Cancer is the most expensive diagnosis in healthcare already, and that's where the normal distribution of stage presentation diagnosis. But now we're going to be ratcheting up the stage of diagnosis and that's going to have a significant impact on cost for everyone.

Ron Barshop:

I will say my last question. Do you see these orphan drugs being used in precision medicine as essentially, or eventually replacing either radiation or chemotherapy or both?

Robert Palmer:

My background is economics. I'm hesitant to comment on clinical. That's a [inaudible 00:35:01].

Ron Barshop:

Call.

Robert Palmer:

Yeah.

Ron Barshop:

Okay. All right. First of all, people want to reach you, Robert. How do they find you guys?

Robert Palmer:

You can look at us up online. Our company, [potentiametrics.com](http://potentiametrics.com). Our cancer platform is at [my-cancerjourney.com](http://my-cancerjourney.com) and we'll be happy to respond to any employers who'd be interested or any patients that would want to use the platform as well.

Ron Barshop:

That would be my first stop, God forbid, if I get cancer. If you could fly a banner overhead in America to say one message, what would that be?

Robert Palmer:

I think the message is, we really need to turn the system on its head with respect to, how do we even begin with treating patients? I think it's important that patients present with their values, their goals when they meet with physicians. And the physician solve based upon the patient preferences for what treatment is best for this individual versus, "Here's the course of treatment that we usually follow, and we're going to adjust that course down the road based upon you pushing back."

Robert Palmer:

There's a nuance there and it's a really important one. If I could encourage listening to this, if your loved ones, your friends have any serious diagnosis, sit down and create a roadmap of what's most important to you so that when you meet with your physician, you can begin with that and empower the physician to help you in ways that he may not realize that you want help with.

Ron Barshop:

Well, you are, if not the first guest, one of the first guests out of 140 shows that I can actually grab lunch with. And I think we're going to make plans to do that when we hang up here, because we live in the same town, San Antonio.

Robert Palmer:

Yeah. Fantastic. Looking forward to it. And what a great place it is.

Ron Barshop:

Yes. All right. Well, Robert, thanks for being on the show and, well, keep up with your progress.

Robert Palmer:

Thank you so much for your time, and thanks everyone for listening.

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](http://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.