# Primary Care Cures

# Episode 154: John Canion #2

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 rig 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.

Ron Barshop:

Welcome to the New Healthcare Economy.

Ron Barshop:

All right, there is no dynamite more effective than a fixed from the edges. Federal Express, charter schools like KIPP Academy, the largest in the country, have completely upended and unnerved bloated bureaucracies that seem unassailable. We will never fix healthcare, but we're rebuilding a new model from the ground up. And it starts by rejecting the bloat, the dumb rules that were designed by bureaucrats, the volume centric game board of codes designed for bigs, not us. In fact, if EHR were designed for us, we would've solved what works for the pandemic, toot sweet, no mucking around. We know what therapies break through for autoimmune disease and cancer we don't, because the game is rigged for bigs, not for us. We don't even own our own data, nor does our doc, which is insane. Direct contracts are skipping bloated middles like FedEx did, like KIPP Academy has in the charter schools and accomplishes the same.

Ron Barshop:

The [inaudible 00:01:54] and the bigs cannot compete in the long run with this model. Amazon has a real chance because of several unique advantages. The new retail primary care, though are doubling down on the bigs, ICD 10 and CPT Bibles, albeit with value-based ACOs, but they're just doubling down on a broken house. So why would anybody code indirect contract in, because it's a cash pay. So now it's back to charting care plans and basic centric focus, not bigs payment models. Direct contracts allow all of us to be winners. There are 30 million consumers who are using it, and that's strictly based on the people who have showed up on my show via self-funded employers who are financing this new model, this new movement. That's just to count, as I said, from the CEOs and chief medical officers we have booked on 140 to 50 episodes. There has to be more than 30 million.

Ron Barshop:

There are 60 transparent and bundled price surgery centers that are emulating the original one, Surgery Center of Oklahoma, which was created in 1993. They have never, since 1993 raised their prices in hundreds of different surgeries. And so in 30 years, they've in fact lowered many of their prices, in 30 years. Find that in a [inaudible 00:03:12] healthcare. Again, it's designed for self insured because the surgeons there make two to four times they will at a cash pay center than they would at a traditional legacy center. And the patient has no surprises, no facility fees, few complications with the most experienced narrow niched specialists on the planet. Employers are basically capping their surgery risk with cash pay excellence. In fact, every specialist, not just surgeons offer discounts for cash. They win with no billing, no coding, no chargeback, no denials, as do the independent imaging. [inaudible 00:03:52] imaging.

Ron Barshop:

They have 1400 locations that are 20 to 60% off the system own centers. So place of service matters, independent versus system owned. Most of them are system owned. Labs, they all discount for cash. You can get all your labs for cash. And pharmacy is literally a race to the bottom. We had script [inaudible 00:04:15], and they offer one to three cents per pill on 85% of all generics for $140, your membership fee. So that's 90 cents to $2.70 for a 90 day fill. Do you even need a pharmacy benefit manager at $3 every 90 days for your medications? And remember, generics are 90% of all the drugs that are sold. Almost 90% of all scripts are generic. So the other 10% of branded, that stuff you see on TV ads, those advertisements cost money. And specialty drugs like chemo, drugs. And even though these specialty and branded drugs are only 10% of the sales, they represent 75% of the overall drugs spent in America.

Ron Barshop:

Does that make sense? So that's why generics are 90% of the medication sales out there because they're ridiculously cheap. And if you can get it at the cheapest wholesale source, who needs a PBM. So direct primary care is a subset of direct contracting, the mothership. And it will continue to see market share, continue to shift away from the legacy model, thanks to eliminating friction of money, friction of time. Friction of all the navigation aggravation is another way to say it. Not only for the docs and consumers, but for the employers too. And the tyranny of unaffordability, we've talked endlessly about the underinsured and the functionally uninsured on this show, which is probably about half of Americans that simply can't afford their medications or their care.

Ron Barshop:

So also costs drop 20 to 60%... Never hopefully get tired of hearing that one, and the outcomes improve measurably with a trusted primary care physician in your digital first pocket, if you will, and measurably with shorter stage, fewer visits and this expensive treacherous downstream rapids, we call sick care today. It's a future where everyone wins.

Ron Barshop:

I am thrilled to introduce back a guest who made so much sense you can't just listen to him once. John Canion is a nurse practitioner who speaks the truth. I've had... I'm not going to say countless. I've had several guests on the show that I could not publish the show because they spoke privately the truth to power. And then when it came to turn the mic on, they couldn't tell

the truth. John Canion is a truth teller. He is a former teacher at a couple of excellent nursing practitioner schools. And so he knows what's going well and what's not going well in nursing. And this isn't a tell-all, this is a fix-all prescription. John, welcome back to the show.

John Canion:

I have a realistic view of life, so I try and break stuff down from a non-emotional standpoint and look at pieces from an objective standpoint. And when, for instance, if I hire somebody, my interview process is brutal.

Ron Barshop:

I'll bet you have them chart a patient. I'll bet you have them file a claim. I'll bet you do it all.

John Canion:

Well, they have to know how to document. They have to know how to approach a patient. I make them do an assessment. I go over clinical scenarios with them to test their knowledge, because this is something that in my mind you have to do right now. Or it's somebody I know and have already trained.

Ron Barshop:

Okay. Yeah, you don't want to work alongside somebody who is going to mess up all the hard work you've done with a patient.

John Canion:

And this is one example I give for that. One of the last emergency departments I went and worked in, I walked in the first day and the doctor says, "I can't believe we hired a nurse practitioner, y'all suck. I'm going to have to go see every patient you see, y'all are the worst. They should've hired a PA." And my response to that is, "Well, I don't know who you've been working with, but it wasn't me." A month later that doc's one of my best friends and he wants to work every shift with me. So it's a significant difference in how you approach things too. So I don't know.

Ron Barshop:

All right. Is there someday... And I'm getting back to questions and I'm supposed to be signing off here, but is there going to be someday when we're going to see GI specialists that are nurses or brain surgeons that are nurses or neurosurgeons?

John Canion:

There was actually a nurse practitioner who started doing uncomplicated surgery cases in Britain. 15 years ago, nurse practitioners were doing EGDs and colonoscopies without intervention. So they were doing screening EGDs, colonoscopies, they were doing heart catheterizations. I don't think that that's outside the realm of possibility. I think that probably what's going to happen at some point is you're going to get nurse practitioners who are GI specialists, going to be doing screening colonoscopies. And because everybody who's 50 needs a screening colonoscopy for colon cancer, and there's just not enough gastroenterologists to do it.

John Canion:

So what you may see in the future, if people are a little more aggressive in their thought process is have a board certified gastroenterologists sitting in a GI suite, having four NPs doing screening colonoscopies. And if one of them has a problem, they have a doc come in and snip the polyps or clip the bleeder or do whatever intervention needs to be done.

John Canion:

That may be a future that we see rather soon. And it just all depends on reimbursement. That's the problem. The problem is again, scope of practice. The reason that they're not doing that now is 10 years ago, insurance companies couldn't figure out how to pay them, how to reimburse for it. Like, "We don't know what to do because you, F&P have been trained to do this. John F&P has not been trained to do this. How do I know who can do this and who can't?" And there wasn't really a good definition of that at the time, which is why my thought processes of doing the specialization.

Ron Barshop:

I got to brag about my son. He's a gastro, and he's going to be working with a really prestigious group that does a lot of work with the Yale medical students when he gets out of his fellowship very shortly. And he's at one of the Harvard hospitals now. But I gave him a business model I thought I could make him a lot of money without having to use nurses or anything. I said, "If you just work on little people all day long, you can see twice as many people because the GI tract is half as big and you could set up your practice as a specialty and then we start..." He said, "Well, dad, I did the math and there's not enough of them where I lived to make it work. But it's a great idea otherwise." So I said, "Well then just help short people. Nobody over five foot."

John Canion:

Yeah. That works until you're on call, right?

Ron Barshop:

Exactly.

John Canion:

When you got to take ER call and then you get whatever walks in the door and you've got a mess of patients to take care of. Yeah.

Ron Barshop:

Yeah. "Sorry, we don't have any scopes long enough for you tall guys. We can't help you. We'll send you next door." He didn't like my idea. All right. Well, that's what dads are for, is to be the difficult. All right. So if you could fly a banner over America with one message to this subject, what would that message be?

John Canion:

We need to revamp the entire NP education system. Period. It needs to be revamped and it needs to be... the education... the clinical hours need to be increased. And 15 years ago, we didn't know

as much about medicine as we do now. We're significantly more progressed, we're going to keep progressing, we need more hours to keep up. We really do. And my thought on is that I want the people who are trained behind me to be a thousand times better than I was when I graduated.

Ron Barshop:

Shoulders of giants. John, thank you for your candor. I think if I would've talked to some guy from name brand school, I would get the defensiveness you talked about. Because there is a lot of that when I start talking about these subjects online, on LinkedIn, people get very upset. And we're not saying nurse is bad, doctor's good. We're saying light training, bad, heavy training, good.

John Canion:

Well, but the question is, and this is something that the docs are even talking about is how much training is necessary? If we can do it with 8,000 hours, why are we doing 30? If we can do it with 10,000 hours, why are we doing 45? And that's the real question. At what point do we say we've had enough training? And that's something I think that... I don't know. I don't know the answer to that.

Ron Barshop:

I think it might be state by state. I think let's say Indiana might be a lot more kind than Idaho next door, or practically next door. And-

John Canion:

Well, I'm talking about the base training for residency or when you're in medical school, how many hours do you really need? How many hours of residency do you really need? Do you really need a three year program or is two year good enough? Or should it be two and a half, or should it be one and a half?

Ron Barshop:

Well, we know you don't have to memorize all those anatomy turns because you've got this thing called Google, it's really incredible.

John Canion:

That's right.

Ron Barshop:

And do we really need to know the Kreb cycle and all the intermediate molecules?

John Canion:

Right. And while you're looking at that, at what point... while it's great foundational education, at what point do you need to be more specific to your role? Would it be better to reduce the number of hours of training if you know what role you want to go into from the beginning? Like if I come out of school and know I want to be a dermatologist, I accept it into dermatologist section, do I really need to go through four years of medical school? Could I do it in two and a half and

get what I need to be foundationally an expert in dermatology and focus on dermatology just from the beginning? Get my base of course, base education and then year and a half focused into dermatology and then spend two years as a dermatology resident, would that be enough? I don't know.

John Canion:

Those are definitely conversations worth having. I don't know that we need to, as nurse practitioners go up to 40,000 hours of training, but I also don't suspect that 500 as a minimum is enough. It's obviously not enough, we need more. I need to know that when you walk in to see me, you need to be confident enough that I'm going to treat you as well as the physician does.

Ron Barshop:

Would you advise your children to get into nursing?

John Canion:

One of them, yeah. I wouldn't advise anybody to become a nurse practitioner right now. I wouldn't advise anybody to do that.

Ron Barshop:

I'll tell you something interesting. One of my dear friends, his daughter won a national award. I'm not going to say because it'll identify her. But she won a national nursing award and she cannot advance in her hospital. And it's a good one because she'll step over people with more seniority with less quality than she has. I'm afraid to talk about it, but she will literally have to leave a good hospital because she is ready for management and they're not going to give it to her because it'll upset the people that have been there longer.

John Canion:

Here's the thing. This is a value. You have to value people as an individual. Any corporation that pays people based on a scale and that's all they pay you on, is making a massive error. For instance, the way that I do is I like progressive scales. So you have a base rate and then you're able to make more money based off of RVU production. So in an urgent care, the most I've ever made on an RVU base is 166 an hour. Whereas, the average NP makes 55 to 65 in an urgent care.

Ron Barshop:

Wow.

John Canion:

And the reason that we did that is because I can produce, and I know how to generate money for your business. So if you want me to come on and work for you, I work for you, but you have to reimburse me at a rate that's-

Ron Barshop:

Measuring up with your skillset.

John Canion:

Exactly. And there's some people who are on the lower end of the skillset. And this goes for administrators as well. If you have an administrator in your hospital who is rating people just based on how long they've been there, that's not a good way to evaluate people. How long somebody's been there... I can sweep a floor in a room, let's say a bedroom takes me four hours. Well, the next guy takes him 10 minutes. And you're going to pay me more just because I've been there longer? Doesn't make any sense at all.

Ron Barshop:

This has nothing to do with what I've heard you talk about before, but it seems to me that we are in this pandemic... because we haven't even used that word yet, the P word. In this pandemic, we're running a lot of good people out that are nurses that have proven they're beyond a shadow of a doubt excellent at their job because they have natural immunity and they don't do well with jabs, or there's 100 reasons. They might be immunosuppressed. But there's a bunch of reasons why some people are not getting a vaccine, and I'm not trying to get red or blue here. But I'm just saying, it seems like a lot of nurses, if they don't meet certain deadlines, they're not going to get that job at that hospital any further. Are you seeing that in San Angelo?

John Canion:

It's the most ignorant thing I've ever heard. We're not dealing with that here. And here's the why. The literature shows... and you have to be objective when you look at this, this is not a plus minus whatever. Literature shows that the natural immunity is as good as, or better than the immunization.

Ron Barshop:

The Israel study said 27 times better with 700,000 patients. It's 27 times better, not a little better.

John Canion:

Well, there's some other literature that is wishy washy, but the quality of that literature may or may not be... I'm not going to get into that. I'm not getting into specific studies because we'll be here all day. But there's literature that shows the natural immunity is fine. So why are you trying to... it doesn't make any sense. You have to have a hepatitis vaccine to work in medicine or you have to prove that you have a Hep titer. Why not let these people prove they have a titer? If they have a titer, then they're fine. It doesn't make any sense from an objective standpoint to try to enforce that. If it was me and I'm the king for a day, it would be immunization or titer, you can choose. But you have to show that you have immanency.

John Canion:

And again, there's literature coming out from the pharmacy companies saying that you may need an updated injection because it's not providing long term benefit. Whereas the literature's showing that the natural immunity is providing longer term benefit. So I would treat it just like we do anything else. If you can prove immunity, then you're fine. If you can prove you have titers, that's fine. If I go into work at a different hospital tomorrow and they say, "We need your Hep titer. 'Well, I haven't had a Hep shot in, I don't know, 15 years.' Well then we need a titer to make sure that your Hep is up. 'Okay.'"

Ron Barshop:

I'm going to imagine in San Angelo, Texas, you're not going to have the same kind of pressures you'll have in the big city where they think they can replace those... Nurses are not easy to replace, especially with five years experience. But I guess it's not going to happen in smaller towns in Texas like your town because it can make a huge difference in the revenues if they lose one ER slot of a nurse, right?

John Canion:

Yeah. Even when you look around the country right now, they talk about hospitals being full when in fact it's bed capacity, not nursing staff. So they have bed capacity availability, but they don't have the staff to take care of them. And there's a lot of things for that. I know 25 nurses who went and did the emergency COVID staffing, where they paid a lot of money to these nurses to do COVID staffing. 23 of them retired, 23 out of 25 retired. Because they were second income earners, they were all female. And that's just the statistics. 23 that retired were female, the two that didn't were male.

John Canion:

The 23 that retire were all second income earners. And once they paid off their debt, they didn't need their income anymore. So they said, "I'm not working anymore." And the two that I know that are male, one of them has already gone back to work and he's just working as a traveling nurse. And the other one hasn't gone back to work yet because he's made enough money that he's just taken off for six months. "I don't have to work. I'm not going to."

Ron Barshop:

The hazard pay paid for it. Why do we have half of all nurses, and I'm talking about the whole alphabet suit now, drop out after five years? What is going on there?

John Canion:

Are you talking about drop out of the profession?

Ron Barshop:

Out of the profession.

John Canion:

Out of the profession?

Ron Barshop:

They step into something else.

John Canion:

There's a lot of reasons for that. Income is the first one. A lot of people aren't making very good money doing this, they thought they would make more. They're not making good money and the stress and they have unsafe staffing ratios. You put people in positions where they are going to make mistakes. And the literature's pretty clear on that too on staffing ratios. But there's not very

many states that have adopted safe staffing ratios because it costs more money and you don't have... Nursing is going to be the biggest cost in any hospital system from a cost standpoint because it's the largest portion of your workforce. So you want to keep that cost to a minimum as an administrator in order to increase your revenue. But the flip side is if you go with safe staffing ratios, you reduce your malpractice risk. And it reduces what we talked about in the beginning. All those medication errors, all the medical errors that happen, a lot of that can be attributed to unsafe staffing ratios, which isn't... we're getting a whole lot of different topics here.

Ron Barshop:

Well that's okay. This is our second visit with you. You came on the show earlier in the year, and now you're back for a second interview. This is John Canion, an NP who speaks the truth to the truth of what is going on well, and not with nursing. John, you need to write a book. It doesn't have to be a thick book, it could be 12 pages, but you really do need to get your ideas out there I believe.

John Canion:

I've got that on a list of things to do. I've actually got a format I'm working on, but it's... for instance, we talked about trying to get this set up. I've got 24 shifts I'm working this month trying to cover for COVID and all that. So I'm working 24 days out of the month. And those days that I was off, reason we couldn't do it earlier is because I was on vacation. It's the only time I could take vacation.

Ron Barshop:

Yeah. Do you see the burnout in their faces at the end of the day when they are just completely gone, they're not there anymore?

John Canion:

Oh, absolutely. And they're overworked underpaid. You look at a model where you have somebody who is supposed to care all day about every patient and it's difficult when you deal with difficult patients and you're put in difficult circumstances. For instance, we're running a 21 bed ER and we're holding 22 admissions because we don't have enough nurses upstairs to move the admissions up. So they've got whole units closed because they're not hiring people. And they're not hiring people because the nurses have done COVID staffing and realize they can get paid more money. So they don't want to come unless they're going to get paid.

John Canion:

And the hospital's not willing to pay them so they're not willing to bring them on to help out the staff that's just getting absolutely brutalized. And I talk from an ER perspective, because that's my home. You get a nurse who normally takes care of five patients in a shift when the safe standards are four in an ER. And then you add on top of those four patients, now you have four or five have additional hallway patients who are stuck in a hallway bed that you have to take care of as well. You get to where you're staffing critical patients at a level that they should not be staffed at.

Ron Barshop:

Do you feel differently... So one of the reasons the burnout factor of half the nurses going out of the profession is, it's emotionally draws too much out of them to care about every patient every day, every minute. And the second reason is I'm told it's such physical work that you guys sometimes feel like glorified janitors.

John Canion:

Well actually they are janitors sometime depending upon where you work. But nurses are one of the top professions for back injuries. And I can't remember, probably 10 or 15 years ago they were the number one profession. But I don't know if that's still the case, I haven't looked at that literature in a long time. But they get back injuries all the time from heavy lifting. We as a country are not getting skinnier.

Ron Barshop:

Yes. Do you have a sadness about the families can no longer join their COVID patient family members? In other words, it must have been a little bit of joy to see mom or the kids, or grandma and grandpa sitting down with the families and they're all glad to see you and you're walking in and you're like...

John Canion:

I think that's absolutely the worst thing we ever did by far in a way. It's not even close. That is absolutely the worst thing as a profession we ever did. And I don't know that the literature supports what we did at this point.

Ron Barshop:

Let's just add a giant dose of loneliness to their misery. It's just... Yeah.

John Canion:

Horrible. And you're killing the family too because the family can't be there. You want to be there when you're loved one is hurting and sick and doesn't feel good.

Ron Barshop:

Yeah. Their stress is already high enough.

John Canion:

Yeah. It's horrible. And then you got to look through a window at somebody, come on, man.

Ron Barshop:

Yeah.

John Canion:

I think that as a profession and as a country, we handled that exceptionally poorly. I get at the beginning when we didn't know anything, we didn't know anything about this at all. But if it's me and I was king of the world at that time, we don't know, "Well, here's what's going to happen. If

you want to see your loved one, you're going to get in 100% suit and we're going to put you in a viral suit and we'll let you go in the room."

Ron Barshop:

Do you have any theories on why nations like Taiwan, Japan, South Korea, Australia... let's take Australia out. Let's just say those three nations, their death rate per 100,000 is one 10th to one 20th of that of America, UK, Canada?

John Canion:

Obesity.

Ron Barshop:

So it's obesity. So they're eating better?

John Canion:

Yeah. They're not as fat as we are, man.

Ron Barshop:

Okay.

John Canion:

We're one of the fattest countries in the world.

Ron Barshop:

All the hypertension and all the comorbidities.

John Canion:

The biggest comorbidity for death with COVID is obesity. Nobody's talking about it, but that's it. If you're morbidly obese, you got to a, what is it? 75% higher risk of mortality? I don't think it's that. That may not be right.

Ron Barshop:

Well, but it's high, it's dramatic.

John Canion:

It's high. If you're obese, you got a significantly higher risk.

Ron Barshop:

Especially if you're under 60. The over 60, we get that. Unlike the pandemic of 1919, that was 20 to 40 year olds. This one's 60 plus year olds. But except it dips down to parental age, mom and dads when they're not well.

John Canion:

Yeah. Comorbidities and obesity are the big ones. And the one good thing about this... it's hard to say there's a good thing. But the one good thing about this is it's not killing kids in any significant number. And when kids get sick with this, they don't die from it unless they have significant comorbidities for the most part.

Ron Barshop:

Yeah. I just saw the math on it. The odds of losing your child to COVID are the same as getting struck by lightning or getting kicked in the face by a horse or a cow. You're right up there with, it's just so unlikely that you can't expect it to happen. And by the way, natural immunity is in that same ballpark. It's under one per 100,000 that are dying from these... Like car accidents are 30 times more likely than a child dying from COVID.

John Canion:

Yeah. It's interesting, isn't it?

Ron Barshop:

Yeah.

John Canion:

It's very, very interesting. So the question there is why are kids wearing masks?

Ron Barshop:

I don't understand it. It doesn't make any sense.

John Canion:

Why are we encouraging children to wear a mask when one, they're not going to die from it, two, if they get exposed to it, they're going to get natural immunity from it? So I don't understand the... the literature doesn't support this at all, what we're doing. It just doesn't. Objectively, I can't find a reason for us to have any children masked. So we know that kids are not vectors, they don't transmit this very well.

Ron Barshop:

Do you feel the same about the vaccine for children? Should we dare talk about that subject?

John Canion:

Well, from an objective standpoint, I don't think the literature supports it. Why am I giving a vaccine to a child for a disease that is not going to affect said child in a significant fashion? Do you vaccinate your kids against flu every year?

Ron Barshop:

No. Well, my kids are adults now, but I didn't when they were kids. No.

John Canion:

Why not?

Ron Barshop:

Because they got the important vaccines when they needed them.

John Canion:

Yeah. And the flu is unlikely to cause lifelong debilitation, and it's also unlikely to cause death. And this kills kids at a lower rate than flu does. So to me it makes zero sense unless somebody is high risk, it just doesn't make sense.

Ron Barshop:

Yeah. The way I summarized it is, don't go play lightning storms when it's thundering outside. And don't... if your kid has to work on a farm, just stay away from the trampoline stuff because that's where you're going to get hurt by a cow or a horse. And by the way, if you're going to be a kid COVID, you're in that same category. I can't think of anybody I know that's been struck by lightning. I don't know of anybody that's been killed by a horse or a cat... well, maybe secondhand. But...

John Canion:

Well, I'm in Texas. I know a few people that have had cow and horse injuries.

Ron Barshop:

Yeah. I'm in San Antonio. I'm in your sister city [crosstalk 00:30:18] because we're spelled... a lot of people confuse our cities together alphabetically.

John Canion:

Yep.

Ron Barshop:

Well, what a pleasure talking to you. Last time we were on the show, I asked you... and I'm going to tell you how you answered the question. If we could fly a banner overhead, you said nurses need more education. In light of today's topic, what would be your banner overhead for America to see, if you were able to do that?

John Canion:

Oh, for vaccinations? How high risk need them. There's no doubt. The bottom line for COVID which nobody wants to talk about, everybody's going to get this. I think everybody's going to get this.

Ron Barshop:

It's a date with destiny.

John Canion:

If you want to reduce your mortality and you are over 18, getting the vaccine is a good idea. If you want to reduce your mortality and your under 18, not really much you're going to be able to do.

Ron Barshop:

Well, I have a good strategy that worked for... I don't know if it's worked for me because I may have had it and not known it. I may have been asymptomatic, but I lost 40 pounds.

John Canion:

That's definitely a good thing. Obesity is massive. We need to become a thinner nation.

Ron Barshop:

Intermittent fasting folks. Eat six hour windows, it's magic. You watch, two pounds a week, at least me. Well this has been a great second talk. I'm glad we got you back on the show again, John Canion...

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 podcast and subscribing and leave us a review. It helps our megaphone more than you'd know. Until next episode.