Welcome to Concierge Medicine Radio. We’re joined today by Dr. Josh and Dr. Doug of Atlas MD out of Wichita, Kansas. Dr. Josh and Doug are leaders in the Direct Primary Care Movement and they’ve both spoken at conferences. I heard Dr. Doug at the DPC Conference in Washington, D.C. recently. They both published an excellent newsletter and podcast which we’ll link up to refer when you check out about Direct Primary Care. And then I’ll be in the show notes but I want to start and have Dr. Doug and Dr. Josh talk a little bit about their practice, Atlas MD. So, kind of walk us through how it’s structured and how it’s kind of—where it fits in the DPC model.

Dr. Josh: Happy to. This is Dr. Josh and…

Dr. Doug: Dr. Doug.

Dr. Josh: And again, thanks for having us on. So, we both co-founded Atlas MD Concierge Founding Practice which is ironic because we still—we call ourselves Concierge Medicine but we follow into the Direct Primary Care category based on pricing and value. But we started September 2nd, 2010 with the idea that insurance complicates more things than it helps.

We wanted to get to a high value, low cost membership model and we set our prices: $10 for kids, 50, 75, or $100 for adults through the age ranges for unlimited home visits, work visits, office visits, and technology visits. So email, webcam, cellphone, texting, Twitter, Facebook, Skype because we can all integrate that into our software. Then, no co-pays for anything. Any procedure we can do in the office is included free of charge, so stitches, biopsies to injections, EKGs, Holters, barometry, audiometry, urinalysis, cryotherapy, DEXAs are all included. And I’ll let Dr. Doug explain the meds and labs.

Dr. Doug: So in order to further prove value, we can utilize the free market to find some very valuable medications and lab pricing for patients. And because we operate the clinic based on the membership model, we didn’t feel the need to make extra money on medications or labs. So, medications, for instance, we can buy a wholesale and all but in just a very few states, four or five states, physicians can dispense to their own patients and that’s exactly what we do.

We buy in bulk, so Prilosec, for example, I can get 1,000 Prilosec for $58. So that means I can treat someone’s heartburn for about $2.5 a month versus them getting it over-the-counter and a lot of times, even with good insurance, your co-pay is going to be more than that. So saving money there. Many other medicines are a penny a pill. Lasix is actually less than a penny a pill because 1,000 pills is $9. So, I can dispense that at cost to the patient, take very good care of their health, and save money at the same time.
We’ve done the same thing with labs. We’ve worked with a local lab here in Wichita, but also just integrated Quest Diagnostics into our software so national pricing on blood work is what we’re aiming at. But a blood count that might cost somebody 30 or 40 dollars or even more depending on where you go, we do it for less than $2. A lipid panel is $3. A thyroid panel is 4. Hemoglobin A1C for 6. So you’re talking about doing your lead screening blood work for 12 to 15 dollars.

**Dr. Josh:** Which is just fantastic. And so, that’s how Atlas MD fits into that Direct Primary Care space is—I would say the key difference between Concierge and Direct Primary Care is typically the price. Our goal of keeping our price as low as possible and our value to our patients, our customers, is the highest possible. Now, it makes it very easy to sell the idea of a membership to a patient who’s not familiar with that because we can say, look how much we’re saving you on and then their visits and their co-pays and free procedures. But really, the objective savings for meds and labs can be multiples of their membership costs per month. So, some patients make money to come into our—

**Dr. Doug:** And we can even save them on things like CTs and ultrasounds. Again, because we go to imaging providers and essentially have them bid against each other for our business and they can build a clinic and then we build the patients. So a CT head is $175, MRI knee or extremity joint is $400. So, we can save part of it there, but fundamentally, when we started Atlas MD, what we looked at was, what is it that’s causing health care, especially primary care to be so broken? And it’s the insurance as a payer model.

Physicians working more for insurance companies than for the patients so you get back to a regular business model and healthcare isn’t always has been a business. Get back to directly caring for the patient and they pay you directly and you take insurance out of the equation as far as a payer but one of the things that’s helped us be successful and help save patients significantly is working to find insurance plans that work.

**Dr. Josh:** And that might feel a little weird, a doctor’s office who is singing the praises of not taking insurance is also talking about how to work with insurance. I want car insurance, home insurance, life insurance. I can only die once or twice so I can’t abuse my life insurance, but a health insurance, we’re trying to use for everything. We’re using it too much. So we want to solve both big pieces of the healthcare equation: healthcare through the clinic and health insurance as well.

So we find a lot of our growth comes from helping employers transition from expensive bloated insurance plan to a trimmed up, efficient insurance plan. It still covers everything the employees want to be covered: [unclear 00:06:46] heart attacks, the scary stuff but now you can carve out insurance for co-pays or labs or medicines that cause a penny a pill because that’s just an inefficient way to pay for that.

**Dr. Doug:** So to help make sense of what we’re thinking and how we see it, imagine for example, you use your car insurance to pay for gasoline, oil changes and tires.
Well, your premiums are going to be higher. When you go to the pump, you’re not going to know what the price is because it’s not listed anywhere. The person at the pump next to you is going to have a different price because they have a different plan. When you get your explanation of benefits in two or three months, you’re going to see how much your insurance did or did not cover. The insurance company’s going to dictate where you can get gas, what grade of fuel you can have, and if you wanted to take a trip out of town, you have to get a pre-authorization.

**Dr. Josh:** No one would stand for that. You wouldn’t want that plan if we tried to sell that to you.

**Dr. Doug:** So why do we accept that in health insurance? So that’s the thing. With Direct Primary Care, the primary care is covered, by definition. So why insure it?

**Taylor:** I was going to ask you for some examples of the high value and cost, and you just gave me back two dozen. So you’re ahead of the game there, but I was really struck at—I just kind of walked around the office. Some of the things that you’ve been having talks with a lot of other guys saying, you can see here, Concierge, there’s one patient room per doctor because of the patient, like, you’ll only need one room per doctor to be able to provide the kind of service—I walked in and there’s a DEXA scan machine in a primary care office which I’ve never seen before in my life. I think there’s a surgical laser and so—

**Dr. Josh:** Medical laser and ultrasound and all the other testing equipment. We wanted to add as much as we could in terms of value for the patients.

**Taylor:** And talk a little bit—because that’s a totally different paradigm that just kind of ever existed or at least in recent memories of just the medicine before this, providing this level of value to patients. So from a physician’s perspective, how are you able to do that economically? Just talk a little bit about how that works because of your model.

**Dr. Josh:** So, I think the hurdle we saw before we launched was a lot of doctors—we’ve been watching this space since 2000, 2001. And so a lot of what did work and what didn’t and so we wanted to bring the best practices into our model. One of those, that the cost of the membership was too high and the things the doctor did was too low. So we can opt to do an autopsy, a direct care clinic that closes because of those reasons. You’re not offering meds or labs or procedures for free or discounted prices and if you charge too much on the membership, it spoils the equation.

I like going to my gym but if it costs $300 a month, then we’ll go. And so, there’s a sweet spot there. So for us, we said, what all can we add that would make it easier for the patient? Why don’t I have a co-pay when I go to the gym? And I don’t need to charge a co-pay in this model. The membership side’s profitable enough. So I want patients to say, here’s the idea that you can use as much as you want: unlimited texting, unlimited gym use, for a flat, predictable rate that gives the consumer a lot of peace of mind that if they are sick and they needed more and they don’t have an unplanned hit on their budget.

**Dr. Doug:** And that’s something that co-pays are designed to disincentivize care if you only get so many visits per month. Some clinics have set up a model where there’s a monthly fee but there’s five visits a month. Anything more than that, there’s an extra fee involved and you have to wonder, okay, well am I sick enough this time to use one of my five?

[http://conciergemedicineradio.com/01/](http://conciergemedicineradio.com/01/)
You’re going to have to decide whether you are or not and it puts a barrier to care, much like saying that I have unlimited text messaging versus you could say I have 5,000 texts. I’m probably not going to send 5,000 texts a month but I’d be thinking about it every time I do versus saying unlimited and I just don’t think about it.

**Dr. Josh:** The chance of patients abusing it has essentially been zero since we’ve never had [unclear 00:11:03] patient from that. So then, we just move on. What other value added can we include to increase our chance for success? So unlimited visits is nice and then your co-pay is nice. Procedures that we do in the office, probably because we never had a clinic outside of residency, we weren’t stuck in that old mindset. But EKG pads cost us 3.5 cents each. Pretty sure I can absorb that as the cost of doing business. Urine dip sticks are 10 cents each. So those aren’t abusable things for most patients and they’re so cheap, why not throw it on?

**Dr. Doug:** And something I think really gets people’s attention is when they have—let’s say, you have an infected toe and now it needs to come off. They’ll ask us, “Okay, well, do you know any podiatrist that I can go to?” So yeah, I know several but I can do that as well. “Really? I didn’t know you could do that.” Oh yeah, no, I can do that and a lot of other procedures that people don’t really realize that primary care doctors are well-trained to do but they’re not used to it because their doctor never had the time to do it and it’s something that—it allows physicians and practitioners to get back into the habit of being able to do the things they were trained to do and finally have the time.

It’s the same with treatment of chronic conditions. Some primary care doctors, you try one or two blood pressure medicines, you’re still not under control. Let’s send you to the cardiologist. Well, there are several more classes of medicines and other things, sitting down and talking to you about your diet and your exercise and getting to the root problem and actually trying to really take care of the patient because you do have the training but the missing component was time.

**Dr. Josh:** And the luxury of time. And so, if I could save you $100 because I can do your joint injection or your toenail removal, why not? The model is already set to be sustainable and profitable at a higher income level just off the memberships so everything else is just a benefit to the customer.

**Dr. Doug:** Well, shopping around for the best prices and knowing that, locally we could, if we did a biopsy, we do it for free. But pathology, we’re not pathologists. We need to send that off. So locally, we’re getting it for a little over $200, about $225 but we found a…

**Dr. Josh:** Cole Diagnostics at Boise, Idaho.

**Dr. Doug:** Yeah, so Ryan Cole, a very wonderful dermatopathologist, but we can ship it off to him for less than $50. So, why would I not take advantage of something like that to save the patient? Essentially, they’re being charged four times more for the same thing. I’m still going to have a pathologist treat it but why not save them the money?

**Dr. Josh:** Interesting. Henry Ford said, if A plus B equals C and C’s profit, then all you have to focus on is A and B. And I think physicians have long been taught to be critical of business, assuming a good business and a good medicine can’t coincide. Well, in this model, all we do is we focus on A and B. If we provide really great cost-effective care, then the profit side of it will come.
So, the rewarding size is, if I want EKG, I don’t have to charge you $30 more. I can get—so for my professional satisfaction, when I'm providing very good care, I'm removing barriers for myself as well. We can do a complete rheumatology workup for $12 while the normal would be $200. Well, if I'm curious about rheumatoid conditions, I want that information so I want to make it as easy for the patient to get that information. Why would I upcharge my medications? I want to get you to the best outcome for your migraines.

So if I'm making one of the medicines unnecessarily affordable, I'm hurting myself professionally because I'm not able to get you the best outcome. So now, we really pick a very bold stand set. The new version of doctor-patient adequacy is embracing sound business to get a better product for our customers, better health so that—I can get your Imitrex for almost $95 less than you were paying. I am benefitting your life financially, medically, professionally, so that is—it’s a combination of good medicine and good business that yeah, I think doctor’s logic, maybe wrapped their head around in a new way but the more services I can add to the clinic, the more I can do for you. The more I do for you, the more you stay. I’m on 600 patients who stayed with me for 20 years. That will be a great medical experience.

**Taylor:** You guys have this more eloquently, then i’ll sum it up but it’s—the crutch of this is taking the insurance and third party payers out of the equation and that’s what allows you to have a DEXA scan and offer all these value added services out of a primary care facility.

**Dr. Doug:** Not only does it allow that, but for far too long, when a physician sees a patient, they document based on what insurance has dictated in order to justify the charge. So there are several levels of charges and I won’t get into the details, but several levels of charges and then I have to have so many bullet points for so many things in my note that support what I’m doing. Well, unfortunately, as EMRs have come out, people have gotten click happy and they’ll just start clicking through the note in order to generate a higher level charge to justify what their billing.

Well the problem is, sometimes you click in the wrong place and you’ll have a male that has normal adnexa. Well, that means their ovaries are normal. Hopefully, he doesn’t have ovaries, but unfortunately, that’s what the note says so now, you have a medical error that—or a documentation error that could potentially be a liability just because you were trying to click through the note and bill something out, whereas I can actually document only what I need to.

[http://conciergemedicineradio.com/01/](http://conciergemedicineradio.com/01/)

Documentation really is only to serve for what happened, and in case I’m not around for whatever reason, other people know what happened. That’s all it’s for, but insurance billing right now as it stands, I’ve gotten five- and six-page notes on people for consultations that really only about half a page worth of information is really helpful. The rest of it is just fluff and bloat to justify insurance documentation.

**Taylor:** You all ran through a lot of these already, but just to kind of sum it up for us, what are the cornerstones in your opinion of the more value part of the equation?

**Dr. Josh:** Right. I think there’s definitely a recipe here and we don’t pretend to have the best recipe but if you’re making pancakes and there’s several things you must add and there’s a lot of things that you can
or don’t need to add but there’s certain things you shouldn’t do. And so for a successful Direct Primary Care practice, we feel that it has to be very reasonably priced and probably cheaper for children because you can do less for them, cost savings wise but older adults have more meds, more labs, more services so you can save them more money per month. But unlimited visits, little to no co-pay, as many procedures included in the membership as possible and then the whole for meds and labs.

Does every clinic need a DEXA? No. I mean, we are fortunate to be able to provide that. An EKG and a stethoscope is probably all you really need but if you can do the meds, then you're getting an opportunity to save not just the patient a ton of money on their healthcare, but also their employer. 30 percent of insurance premiums can be related to prescription cost. And also we can’t stop all prescription costs, biologics for rheumatoid arthritis or oncology meds but the vast majority of them, we can. And so, a lot of those things are the essentials to providing the maximum level of care for the lowest price.

**Taylor:** Sir, if you're a physician and you're sold on this model, you see value. You think it’s the future. What are kind of the first steps towards making that transition?

**Dr. Doug:** Well, there'll be other several. I think the first—we’ve helped transitioned out several physicians. Some that are just tired of the—they’re just tired of practicing like they’ve been forced to. Some are ready for outright retirement but don’t want to leave medicine. So the first thing is looking if this is something that’s going to be right for you, if you want to be available to your patients and overall, take better care. I know some people, their hurdle is, well, if I cut down—I have 4,000 patients and I cut down to 600, well, what happens to all those patients? I'm going to lose some. But for some of those doctors, if you go to an employee position…

**Dr. Josh:** Or retired.

**Dr. Doug:** Well, if you retire, you lose all of them. If you go to an employee position, then your insurance, who you accept my change and therefore you might lose some of those patients anyway so at least with this, you have complete control of who you do or don’t have as patients.

[http://conciergemedicineradio.com/01/](http://conciergemedicineradio.com/01/)

**Dr. Josh:** So once you’ve made up that—your mind to move into this model, I think step one will be to find an example of a doctor’s office doing direct care the way that you want to do it so that you can base a successful—your model on a successful model.

**Dr. Doug:** And it’s been said, if you’ve seen one Direct Primary Care clinic, you’ve seen one Direct Primary Care clinic.

**Dr. Josh:** Right. There’s a lot of variation. And that’s a good thing and a bad thing. I think one of the reasons the model has struggled to get traction until recently is there was a lot of doctors doing it inefficiently, but now the number of doctors doing it successfully is growing so the traction is growing.

**Dr. Doug:** And we have more of a consortium of those doctors that have been successful talking to each other and helping those that are kind of stuck or just starting out. We want to help everyone. Physicians
have a grand tradition of helping each other so why would we want to compete ourselves into oblivion this early in the stage?

**Dr. Josh:** So, good artists borrow; great artists steal. Look, to borrow or steal a model from a doctor who is doing something similar. I obviously talk with them. But that way, you always have a good base to say what all I’m going to do and what is my pricing going to be and then you talk with docs like ourselves. We offer all of our consulting for free, map out a conversion, some timeline. We recommended eight- to 12-week conversion. Less than that is just stressful on the staff because it’s very quick. More than that and it’s hard to keep it on the top of my mind of where it is for patients but sending out a series of three letters.

The first one is just an introduction saying here’s why I’m changing and we focus on the why. So tell patients the emotional side of this. I’m changing to provide better care for you. And the next two letters explain the model more and then schedule a series of town halls so that you can talk with your patients with wine and cheese after hours, something or they’re brought as the case may be and educate them, inform them, educate your staff so that as those questions come up. So those are some of the first steps.

**Dr. Doug:** And to design the pricing, you have to look at first and foremost, what are you looking to make as income? Being reasonable is very important. Sometimes you get stars in your eyes and say jeez, if I saw a thousand patient at $500 a month, then god, I’d be making millions. Well yeah, you would, but you’re probably not going to be successful and you get there. So be reasonable on an income and then figure out what your overhead is. Add those two things together and essentially divide by the number of patients and the number of months and you’re going to get—for us, when we did it, it came out to a 50-dollar average for 600 patients. So that gave us 360,000 total income minus any overhead. And again, remember with a lower volume clinic, your overhead’s going to be lower.

We have a three-physician clinic with almost 1600 patients and we have one full-time and one part-time nurse and that is our staff. So your overhead is going to be lower than what you’re used to because you have—just have less overhead staff.

**Dr. Josh:** But your profit and revenue will be higher. And so, that’s the equation to get you and anyway, we recommend you give kids out for cheaper because that is a lost leader. It’s going to bring families in and help grow your practice. I think some mistakes are overpricing kids. Well, they’re sometimes more work. They sometimes are, but kids eat free at restaurants and they’re cheaper prices at the movie because they’re trying to bring in the family. So price it correctly is a big part.

**Dr. Doug:** And of course, as anyone that’s run a successful business knows, having good staff is invaluable. You’ve got to wear more hats in a model like this which we certainly enjoy. We answer our own phones. But you’ll find that we staff Orions but they play the role of the front office person that is talking to patients as they come in. They’re helping draw labs. They’re functioning as a nurse in the room with us with the procedures. They’re answering phone calls about what the model’s all about.

**Dr. Josh:** And occasionally, they are therapists. Patients have gone, I just want to talk with the nurses a little bit because they need a friendly ear and that’s also a benefit.
Taylor: And where did you all find your staff? Because obviously, that’s an important part and it’s not [unclear 00:24:51], perhaps a traditional system aren’t going to be as well suited to work on this model.

Dr. Josh: One, we actually just hired through traditional means and one of our nurses who actually knew our most recent physician addition Dr. Michael. So they have worked together previously so he brought her along.

Dr. Doug: And she was looking forward to a change of pace and the nice thing here, you’re not just funneling patients through like a patient mill all day. You’re actually getting to use some of your other skills elsewhere and there’s quite a bit of camaraderie and it’s incredible and fun.

Taylor: When we say traditional means, is that like monster.com or you just…?

Dr. Josh: Oh, I think we did a social media request for applications in LinkedIn and probably took 20 applications, interview five or six of them and settled on.

Taylor: So you found them through LinkedIn?

Dr. Josh: Mm-hmm.

Taylor: And you all touched on some of these in terms of common mistakes you’ve seen other people in transition make. Making sure you set reasonable pricing, hiring the right staff, or some of the other kind of common errors.

Dr. Doug: We found that again, dispensing medicines and if possible, to do repackaged medicines but this not dispensing has been a barrier for some people. Having temporary staff, trying to—in order to have good staff, you’re going to need to pay them out. Of course, you’re going to need to incentivize them to really do everything they can to make it work. So sometimes trying to find staff from temp agencies or people that kind of come and go, your patients never really feel like they have much of a connection whereas if you have staff that stay here, the patients know them. You get to know them. You get comfortable with each other.

Dr. Josh: Plus they’ll answer the phone. They’ll provide the pitch and the explanation and again, making sure that you offer a lot right off the bat. I think some doctors—it’s almost like selling your house. We’ll overshoot the price and if it doesn’t sell, then I’ll lower the price but if it does sell at a higher price, all the better. The problem is, we’ve all seen that same house that’s now priced to lower price. Why are they lowering the price?

Dr. Doug: And you’re hoping they keep doing it. You’re hoping that they just keep lowering it so they’re going to jump on a price much lower than they intended to sell it.

Dr. Josh: And you get one good chance to make a first impression, right? So that if your first impression is that you’re expensive and unaffordable, that’s what patients will remember and you will have to do even more work to rearrange yourself as affordable and explain why you’re changing.
Dr. Doug: And part of the reason that this movement has worked, Concierge. We’re all familiar with the offices that you walk in and it’s got Italian marble and things shipped over from other countries to make it gorgeous but very expensive. And to some, that’s fine. To others, it’s ostentatious. It’s a turn off. You need to look at your market. In healthcare, the nice thing is, your market is everyone. So, you need to have—one of the things we’ve seen is people go a little either too high or too low in how they set up their office so it can be a turn off both ways if it looks either too expensive or too cheap.

Dr. Josh: Well, we tell Doctor all the time and we have a nice office. We like to think not too nice. We have iPads in the waiting room but that’s not what makes it successful. So, you can do this on a shoestring and a stethoscope but there’s a difference between looking affordable and looking cheap. And so you want to make sure that if you're starting in a small office, a great book of The Lean Startup, you don’t have to have a [unclear 00:28:36] and begin. They’re buying you but have that full value proposition. Have a wow factor. Again, and that’s the—they say, well, make me a piece of meal and do your meds later or labs later or I'm only going to do two days a week. That makes it hard to do a successful start.

Dr. Doug: And something else that you need to keep in mind as well, Walmart will hire any honorably discharged veteran that needs a job, whether they need the help or not. They can do that because it’s a giant company and it’s something they want to do.

So, in the beginning, of course, you're going to need to be successful but once you're successful, you can start doing some sweat equity for patients that can’t afford care or even just charity care. You can give away services but you have to make sure that you're successful first. If you're trying to do too much of that too early, and you don’t survive, then you can’t help anyone. So you definitely can do charity care in this model and we do it. But again, you have to make sure that you're successful first.

Dr. Josh: And then one tip to be successful is the conversion. The docs who have the most success are the ones who do two or three months of legwork to market their practice, sell it to their existing patients, do a nice transition. So day one, they might have two or three hundred patients already signed up. So, that’s what our emphasis with a lot of docs converting a practice is there’s no reason to do this and lose one. If you do this well and have set up so you're ready to build Day One of the new model, a lot of our doctors are making more money the first month in this model than they were in the previous insurance-based model.

Taylor: Let’s take into that a little more. The marketing and sales pitch, in particular, is something I hear from a lot of physicians. That’s not something they were trained to do. They’re excellent physicians but the business side is a bit woo-woo. So, you mentioned doing town halls, sending out a conversion letter like four of the physicians you’ve had at Day One have had 300 patients. What have they done or kind of essentially taken to get to that point?

Dr. Josh: Yeah, it’s really interesting because I think the best doctors to transition don’t realize that there’s a best doctor. They’re the ones who have been doing Concierge medicine in an insurance model and suffering financially for it. So there’s a doctor who’ve seen 15, 20, 25 people a day and providing great care and giving out [unclear 00:31:12] but only making 100, 110, 120,000 a year. We talked to docs making 70 to 80,000 per year or two but they’re providing excellent care.
So these docs often are too, oh, I couldn’t do direct. I need a DEXA. I need a gorgeous lab in the town. No, no. They’re still buying just you. So that conversion of marketing have the type of care, the high touch care that they do is the key to being successful. So now, you can do this with very little cost to transition because you’re going to tell your existing patients, there’s a great TED Talk for all doctors to watch to want how to start movement and to start with why.

I love that one! It gave me chills with it. We have the best why of all products sold to patients and to people. It’s their health. It’s their life. If Steve Jobs wanted to make an iPhone that made your life better, then surely a doctor can have that same passion for medicine to make your life better. So in that first letter, you share that passion. Don’t do a dry, boring kind of business letter. Tell patients that you’re changing because the current system won’t let you take great care, that it’s providing you more roadblocks. It’s making it expensive and distancing you from your patients. So if you show your passion for helping them, they’re going to see that and how it benefits them.

Then, in the next letter, you can talk about the financial structure and how it all worked and get into more specifics. Starting with the great first letter, almost like getting into med school, is a great step. Having a well-rounded value proposition all ready. Again, unlimited visits, no co-pays, free procedures, meds, and labs. Now you can start with the most well-factored right out of the gate so you get a great first impression.

Most of us are probably good at talking to people because it’s what we do everyday. But if you’re not a good public speaker, the rub in medicine is always know what you know and know what you don’t. So if that’s not your skill set, I’ll look for someone that can maybe work on commission or a marketer, a sales personnel nurse who has a good public speaking skill set. But it’s going to be relaxed. And so the other option is, reach out to your colleagues. This is how we learn how to do knee injections because our [unclear 00:33:40] shows us. This is how we consult in and educate ourselves and all kinds of things. Business should be no different. Use those same skills and lean on your colleagues to find out how they transitioned, and adapt that to your practice.

Dr. Doug: The really nice thing is, the bigger Direct Primary Care gets, the more accepted it is. Even the top branches of government are recognizing it and it’s recognized by the AAFP now as more than just a movement but really is a viable practice.

Dr. Josh: More and more mainstream everyday, making the transition that much easy.

Dr. Doug: Yeah, the more patients that know that, the easier I think they will be that the first people to—the early adopters of this, and really, you’re kind of pioneering the way for the rest of us that we just want to see how it goes but we’ve transitioned companies that we’ve helped transition into this. The employees that come in in the beginning love it and then when they go back and talk to their co-workers about how they got an appointment the same day or the care that they got, the people that didn’t sign up initially started to trickle in because they saw the benefit. So the more that happens nationally, the easier it’ll be for physicians and patients both to get into this kind of medicine.

Taylor: Yeah, I think one thing you said that I think a lot of physicians had trouble wrapping my head around is this—what their marketing really is, is that they’ve been providing amazing care for their
patients for the last five years. I mean, there’s some stigma around marketing especially with physicians, it’s kind of like this deceptive, manipulative thing they’re going in. That’s not even knowledge. They’re providing great care and then they’re showing other people, I’m providing this amazing level of care and I want to provide that to you, too.

Dr. Josh: I think physicians have a real love-hate relationship with business, and for good reason. We’ve seen it done wrong so often. But we have better phones that ever existed which are helping people do all kinds of things but because of good business. In my med school, and I’m sure like many others, they thought us to be critical of business and maybe your best example is a physician who came in wanting to learn more but very critical of the model because he understood it to be concepts.

When we told him again the value proposition, look at all that you get for $50 a month for an adult, $10 for a kid. It’s like, oh, okay. So that concept of I can eat good or sleep good. I can’t be proud of the profits I make because I’m making it off sick people. It’s a fallacy.

Dr. Doug: It’d be like a mechanic feeling bad about your car breaking down. It’s just what they do.

Dr. Josh: My car breaks down regardless of the mechanic and I’m happy he’s there to fix it. So it was really interesting that within 10 minutes, we can convert that doctor who was very critical to be a supporter once he understood the value. Now, you’re less selling and more educating. I feel great about every dollar I make because I just saved you $00 on your price. So I helped you. For $50, I gave you unlimited office visits, your medicine, and now, you have $50 back in your pocket. I’ve made it like that. I feel that that’s the true do-no-harm.

I would feel worse now in a traditional model if I can save a patient $100 on their Imitrex in our model and in our model, and then I go to a standard model and send him off to a pharmacy, they’re $100 worse off than wear in a standard—so this is actually, wants one physician to grasp how they’re really benefitting their patients now. They can see how the standard system is harming.

Dr. Doug: Well, in some of the things even like email. Traditionally, physicians have email patients because there’s no way to be reversed for it but you’d be surprised that the things patients will tell you in an email about their depression or some other life events that they may be too embarrassed or shy to do so in person. So, I’ve come to know some of my patients very well just through email because that’s a much preferred means of communication for them than in a traditional practice; they never would have had that opportunity or that outlet.

Taylor: I think one of the words you used was education. My background is actually marketing and sales, consulting. And I could see why it’s diverse education based marketing. And so I think when the service or the park you’re providing is actually really high quality, you don’t need to deceive people or spin it or put all these fluff on. You’re just educating them about how it works and then when they go look at the market and see the options that are available, it’s just to [unclear 00:38:21]

Dr. Doug: In fact, 90 percent of what we do is education. But once somebody understands what and why we’re doing what we do, it sells itself.
Dr. Josh: Yeah, and actually, that’s a lot of our advice. People will ask, what’s the best way to market? Well, there’s a single best way where we’ve seen every company do it. But everything works very well in our city. It has worked well in other cities for key reasons. But the best business model that sells itself will lead to patient referrals. And that word-of-mouth, that transferrable trust, is your best avenue. But if you’re selling snake oil and you know it’s snake oil, then yeah, you feel really bad about it. If you’re selling a great product that you really believe in, there’s nothing to feel bad about.

I get the exact same pitch to someone who has very little money or who has a whole lot. They get the same exact [unclear 00:39:14]. You come in, you’re a guest in our home. You get the same level of care. This is a tier so you maybe—if you’re poor, but you’re a patient, you pay your bill, you get 24/7 access to be just like the very successful business person does. So, in that sense, I know I’m providing great care that’s the same to all people regardless of their background.

Dr. Doug: And you need to make sure it’s consistent to stealing from Dale Carnegie’s How to Win Friends and Influence People. There’s an old saying that says, “Twice I did good and that I heard never. Once I did bad, and that I heard ever.” So you need to make sure that again, like the Starbucks experience, when you come into this office or when you call me on the phone or when you email me, it’s going to be an experience one way or another. We can decide whether it’s going to be a good experience for the patient and it’s going to be something that they’re going to boast about in a good way or we can go the other direction, slip a little bit and a little bit of bad press goes a long way especially these days of Facebook and Twitter.

If somebody has a good experience, you’d be amazed. You get somebody in with a migraine and treat them quickly, and they’ll boast about how they just came in to the doctor with a migraine. [Unclear 00:40:34] but at the same time, if they have a bad experience, you can have quite a bit of a bad response to that pretty quickly. So just making sure you’re consistent in what you’re doing is very helpful.

Dr. Josh: I’ll piggyback on that because you’re right. We don’t want the patients to have a bad experience, but at the same time, I think a lot of doctors overshoot and say, well then, am I just the whipping boy for people who’ve paid for membership and they can have whatever medicine they want, whether weight loss or ADD meds or pain meds. No. You’re still a professional.

I don’t know my car well enough to tell the mechanic what to do on it but if I’m—he should—the correct thing for him to do is to do what’s best for my car, not what I think is right for my car. So if the patient wants antibiotics, I’d rather then be upset and leave than practice bad medicine. My degree, my professional integrity is not for sale. I’ll find 600 people to fill the clinic who want my style of medicine.

And so in that way, it’s a lot nicer than the standard model where docs are really falling victim to depressed gaining scores and how that affects the reimbursement and being countered, demanding that they do a little bit more pain meds, a little bit more antibiotics to keep people happy. We practice great medicine. But we have the luxury of time to explain to the patient why wouldn’t I give them their antibiotics, or help them lose weight or work through their anxieties and other meds. So you don’t want a bad experience but at the same time, you have the luxury of protecting your integrity now more in this model than the standard model.

CONCIERGE MEDICINE RADIO

http://conciergemedicineradio.com/01/
**Taylor:** Yeah, the things that come down for me is trusted adviser and I think with people I worked in the past, that’s always kind of the role I’ve tried and put myself in and it’s like, I want to be the trusted adviser. And sometimes, that’s like, tough love, right? I want the best outcomes for you, so how do we get those? And sometimes that means saying the things that they don’t necessarily want to hear.

**Dr. Doug:** Well, just like being a good parent. Parents can’t always be their children’s friend. At some point, you’re going to have to be the adult in the situation. And it’s same with your physician. I mean, I have a good reputation and rapport with my patients but there are times that if you need to be stern about something, talking about their weight or diabetes or blood pressure, I can’t always just say nice things if what I need to get accomplished means that I just need to be honest. So yeah, you need to trust that I’m doing it for your best interest, not just to keep you a friend.

**Dr. Josh:** And it’s great that you say that because trust is such a huge part of how we describe this hugely. There’s one for book, Speed of Trust, [unclear 00:43:24] copy and healthcares at low interest industry, and unfortunately, patients don’t trust their doctors as much as they should because of the influence of insurance. We hear it all the time when we work in the E.R., my doctor does but does not do something because he does where he does not get paid. It doesn’t have to be logical and it’s an assumption.

So when they flow it, they’ve been shorted on their care, they’re quick to assume the doctor did something not aligned. So that’s one reason we encourage docs to offer unlimited visits or no co-pays or free procedure. I’m not doing the procedure because I make money off of it. I’m doing it or—and versus I’m not doing it. I’m not avoiding it because I don’t get to charge you. It’s just, what do you need? Upping the cost of cholesterol medicine to perpetuate some myth that they’re from the pharmaceutical companies because I think you need it. And so, I’m going to give it to you at my price so you know that this is a very maximally trustful relationship.

**Dr. Doug:** Well, in this day and age, it’s difficult enough as a physician even to stay up to date with recommendations because different societies or organizations will have contradictory recommendations. But there hasn’t been this much snake oil in society since the late 1800’s. I mean, you look at Dr. Oz just recently promoting things that have very little, if any, scientific datas to support them but there are things out there that people think are good for them. Vaccines are bad for various reasons. Well, they’re really not, and scientifically, we know that.

So, being able to trust your physician and have a relationship with somebody that you know is working in your best interest, not their own, for financial or other reasons, is absolutely paramount to bringing the profession back to what it used to be. And it somewhat still is but I think we have a ways to go to get back to our patients truly trusting what we’re doing for them.

**Taylor:** I’ve already jotted down a couple of books you all mentioned: The Starbucks Experience, Speed of Trust, How to Win Friends and Influence People which is one of my favorites. Are there any other books you recommend or researches you recommend?

**Dr. Josh:** 9 ½ Things You Would Do Different If Disney Ran Your Hospital. Excellent book. Blue Ocean Strategy.
**Dr. Doug:** Getting to Why.

**Dr. Josh:** Getting to Yes.

**Dr. Doug:** Or Getting to Yes. I’m sorry.

**Dr. Josh:** Or Start With Why, that’s a fantastic one. We have a shared audible account so we can listen to business books. So we have a bunch of those but yeah, and I would encourage docs to do that a lot but The Checklist Manifesto, David and Goliath, Start with Why, Leaders Eat Last.

**Taylor:** We’ll put a link to all these on the interview when they go live. Walk us through the story of the physician who gave you a car a couple of years ago, what the situation was, and what happened.

**Dr. Josh:** Yeah, Dr. Jon and Harry Izbicki out of Erie, Pennsylvania had a great story. I think a real standard example of a physician struggling in an insurance model and then their success story converting to Direct Primary Care. But he said, look, we’re having a very difficult time financially and we think insurance will run us out of business within a year and this was a year ago this June. He said, I feel like I’m filling as a physician, a husband, and a father. And I said, man, that’s everything. That’s why physicians have the highest level of depression and suicide.

So we got him to convert and they did a three-month conversion. They did a fantastic job, had a huge response. 400 plus enrollees Day One into their practice and they’ve grown since. So and now they’re at the point that they were able take vacations, a year or nine months into it. They’re probably one of our best success stories. So for physicians to be able to see an example of yeah, that kind of fits my story. I’m struggling financially. I’m not happy in this practice. I don’t feel like medicine’s going to be a long term job for me because the stress is so high, can see how well it can work when it comes over.

They didn’t do anything special. They didn’t have venture capitalist money. They’re your regular guys doing a regular clinic and for regular people. And they were able to make it be successful very easily. And so they can do it and they’ve told other doctors how to do it and just every Direct Primary Care physician in the space is I think so happy to find success and a professional satisfaction that they’re willing to share that with other providers who are going through the same thing.

**Taylor:** I’ll let you [unclear 00:48:22] while I’ll flip the mic back on here but we were talking about one of the criticisms this model gets is what’s going to happen with the physician shortage?

**Dr. Josh:** So depending on the study, they say that we’re going to have a physician shortage of 50 to 100,000 providers in the next several years. And everyone understandably is concerned that Direct Primary Care will worsen the physician shortage because yes, each doctor’s seeing fewer patients.

Our response is, no current model led to a physician shortage. I mean, driving doctors out of practice and making them inefficient is what is causing this problem. But in reality, we don’t have a physician shortage. We have inefficiency issue.

There is a study published last year that said 22 percent of a physician’s time is spent doing insurance paperwork. And if you’re just spending 22 percent of the time, you’re doing pretty good. But, they said,
22 percent of that time multiplied across a physician workforce will be like adding 165,000 physicians back into the workforce. Upwards have tripled what the shortage is projected to be.

And so, it really is an idea that Direct Primary Care is going to make us significantly more efficient but also it’s one to restore the passion to medicine again. It’s going to keep older doctors from retiring which means we can get 10, 15, 20 more years of care from those experienced physicians. It’ll get other doctors back into either full-time medicine or away from specialists because that’s not their only option or hospital or ER [unclear 00:49:59] for it. They can be satisfied in a state of practice like this. And it just encouraged family students, medical students and residents to focus on primary care. So we want to see direct primary care as the only solution. The current ship is sinking. That we know. And it will just keep sinking. Direct Primary Care is probably the only ship coming along that can do something other than sink.

**Taylor:** I think what probably gets me excited about this is it’s a paradigm shift both from the business perspective and the care perspective and that as you’re looking at root causes, so the—from the care perspective, if someone comes in and they’re overweight and they have high cholesterol and high blood pressure, with traditional model, what happens? You give him a blood pressure med. You put him on a Statin and you say good luck because you’ve got six minutes. Whereas we’re talking about if you have DEXA machine, you can walk people in to do a DEXA scan attracting their [unclear 00:50:54] adding muscle-producing fat and so she’s not going to need a cholesterol medicine. She’s not going to need blood pressure because the root cause is going to be addressed.

**Dr. Josh:** Well, it’s flat pricing. So if she needs an hour, she gets an hour. And because you have a lot of issues, let’s take the time to talk about it in one sitting efficiently rather than seven minutes at a time and letting you get lost in the system.

**Taylor:** But the same is true from the business perspective. If you’re looking at it from the perspective of a resident or even a college student, right? You’re going to go—you’re going to spend all this time in education and you’re going to be a [unclear 00:51:32]. I actually have a friend who’s in his third year of medical school right now and he’s between family medicine and cardiology. And one of the big arguments he has against family medicine is just economically, it’s going to be really tough, right? It’s like he’s got all of his student loan to pay and he’s going to come out and how is he going to pay this doing family medicine in the traditional model? And all of a sudden, DPC is like, this is how you’re going to pay that.

**Dr. Josh:** We have also more people. We know we have an economic expense in this minus maximize my economic possibilities and go to a special—I’m going to work hard no matter what I do and I might as well get paid as well as I can from working that hard.

And [unclear 00:52:11] physician, family physician, primary care, is kind of the unappreciated stepchild of the medical system because mostly we just keep seeing 40, 50, 60 people a day. Our reimbursement is the lowest per patient. We see the most patients. And so, this is a solution that really does fix it. Now, you’re not being paid for quantity. You’re being paid for quality while in a very unique way, making it cheaper for the patient. And so, this is a win-win for patients, physicians, employers and even insurance companies and ultimately the government.
Taylor: Yeah, I want to kind of shift gears a little bit here and talk about technology and where you see technology going the role it’s going to play in primary care specifically and kind of medicine in general and then also talk a little about your software and what you’re all working under that.

Dr. Josh: Yeah, we’re supposed to speak in about this before we got started and it’s definitely a passion point for us. Very exciting now that we’ve removed the healthcare model away from the payment model of the insurance. So there’s not a delay in getting new features, new services into a doctor’s mix. So, MIT is doing research on scanning, social media for science of suicidal thoughts or depression. Awesome. I don’t care what the insurance reimbursement is on that. I want that code. I want to pay for that code. I want to insert it into my EMR because we already have our patients’ Facebook and Twitter accounts linked in to there.

So now, my EMR is looking for signs of depression in patients. And maybe even suicidal thoughts without me having to do it. Looking for that quiet call for help or now there’s a plethora of blood pressure cost and pedometers and what are the scales and [unclear 00:53:55] that sync with your phone. I want all of that new digital data to integrate with our chart. That’s me helping you provide better care. That’s exciting.

If your employer want a corporate wellness program, wants everyone to walk 5,000 steps per day, we can facilitate that. You added some game theory. I would be more than happy to give our patients a discounted rate per month if they checked their blood pressure once a day and they walk 5,000 steps and they took their med. Yeah, absolutely. If I’m getting the healthier patients, that’s easy to work for me, that’s better results. I’m more than happy and able to take less income from them.

So there’s just a whole new horizon out there that were just incoming upon as that technology gets better, and Apple’s health book and Google has a similar product. I don’t want to say snubbing the nose at HIPAA, but identifying HIPAA for what it is good at and not good at. It’s [unclear 00:55:01] not a benefit. People are more comfortable sharing their data now than ever. They want that. They’re demanding that. And as such, we should, as a market, comply with that.

So young, healthy people were checking their blood pressure and watching their attentive level and getting their labs. They want to share that data just like they would share financial data. We can have 1,000 congestive heart failure patients going on a 1,000 scales everyday and only seeing the 20 who are going to have an exacerbation and going to the hospital in three days. That’s the third most expensive hospitalization so at 30,000 a pop, if we prevent even a few of those, we’re doing amazing things. So, that side, we’ve built our own EMR to help doctors who are doing insurance [unclear 00:55:48] and does all these things. That’s why it’s so exciting.

Taylor: And this is—these are thought experiment I’ve run before and there’s not a right answer to it. But what is the day-to-day life of a physician going to be like in five or 10 years where you got all these tools?
Dr. Josh: I think it will be still a lot of work. I mean, I wanted to be so rosy color and say, it won’t be work any successful job has worked. But it will be efficient work. It will be meaningful work. So they say anywhere from 22 to 45 percent of a physician’s time is spent on non-clinical paperwork, insurance forms, et cetera. That’s what sucks the life out of doctors.

But if I can have my futuristic Google glass on here or my tablet, showing me picture data, the blood pressure’s high. Medication compliance is down. I can text message a patient that you need to increase your—you need a dose of this medicine or congratulations, you and your kid have walked 10,000 steps each day for the last few days and look at your way, it’s come down.

So it’ll be a very integrated experience but now, a much more fulfilling experience because everything that the physician is doing is focused on care and less about insurance and paperwork forms and ICD-9 and coding. I haven’t coded anything in three and a half years. And I love it. That’s not a benefit to our patients in the grand scheme. So even though some will receive 600 patients and some will receive seven or eight or 900, there’ll be shifts in fluctuations and variations on the model. The key points of a simple payment system that smooths out those complexities in this ever growing but ever sophisticated integration of technology and data.

I joke that doctors are or should be data [unclear 00:57:47] hoarse. I can’t do anything if I don’t know what your blood pressures are. But the research shows if I’d manage the blood pressure well for 10 years, that decreases stroke risk by 80 percent. So we may never have strokes again if I can just get patients to check their blood pressure once a day on a regular basis. Now, the technology has never been so health focused and so advanced and now the business model is adapting to that. So we’ll quite literally be able to move at the speed of the technology, if not, being slightly faster.

Taylor: From a patient perspective, that’s what’s exciting to do about me. It’s easier and easier for me to track all these data about myself and I even open this app on my iPhone. It allows just tracking how many steps I’m walking. I didn’t even know the app did that [unclear 00:58:33] ago. I walked 6,000 steps. I did great.

As a patient or someone who doesn’t have either the knowledge base or the experience, I have all these data about myself. I’ve got blood work I’ve done every six months for the past three years. I have no idea what to do about it. I know where I want I go. I’ve got all this data about where I am now. I need someone to help me get there.

Dr. Josh: I think most doctors aren’t good with their finances or legal stuff or accounting things. So those are great examples to again, put ourselves into a patient’s experience of being the uninformed person in the room. And so yeah, I put everything into Mint, the financial app for my investments. I knew I had investments. I didn’t know what they were doing, where they were at, and I knew I had a lot of debt but I didn’t get it. But now I can pull that up anytime I want and see where am I at, what’s growing, what’s shrinking, what are my student loans? And I can take that to my financial adviser and say, are we on track now? I’ve got the data and I can work with the people who have the experience to treat the data. I mean, that is the great equalizer in healthcare.

Taylor: And tell us a little bit, you’re working on some software here that you’re building out to run your practice.
Dr. Josh: Yes.

Taylor: Tell us a little bit about that, how it works. Educate us.

Dr. Josh: When we started, we had nine different software platforms open for the business of running the business. QuickBooks for billing, Practice Fusion for free, medical charts, Outlook for scheduling, Outlook for emails, my phone for text messages, Twitter, Stamps.com for postage, a shared file on the server for faxes. Another online source, [unclear 01:00:15] Scripts for the pharmaceutical inventory, Dymo for the custom label printing. It was just a very complicated, inefficient system and it was sinking the ship. It was going to affect the overall rate that we can grow or even if we can be sustainable.

So, it was six months in that, Doug and I looked at each other and said, if we run into another physician, we would have to show them eight or nine different places to get data or six or seven different passwords. None of it was mobile, none of it integrated. We need extra staff for the inefficiencies.

So we started building our own, just again, out of necessity and featured [unclear 01:01:05] has probably been the buzzword for all of this. Can I get a calendar? [unclear 01:01:08] Now, can we click to drag? If we can schedule them, can we text message them about the appointment? If we can text message them, can we email them and oh, can we do other things within that model and oh, if I can—anything that I see is digital data. Can I integrate that in? So I want to go track that email so that I don’t have to double chart the email conversations and I want that to be effortless. I want it to be mobile and I want to run across the smartphones, tablets, and desktops. I want it to be web-based so it’s always live and I can never lose them and then we just keep adding more features, whether it’s security features or lab integration or inventory or billing.

So now, again, for us to be able to run a three-physician practice with one and a half staff, we’re more efficient with 1600 patients than we were at 300 patients because it is just all right there. The invoice has automatically happened instead of my wife spending 40 hours of prep work before the end of the month to make invoices happen.

The labs, when they’re ordered, that price just drops into their invoice. If they’re part of an employer group, that Math just gets divided up to the way that employers ask for it to be done. So, anything that’s repetitive, we can kind of program a smooth process for it. So that’s been a lot of fun because now, it just opens up the doors to whatever we need or whatever other physicians need. So, our EMR, Atlas MD EMR is built, I think, uniquely for physicians doing [unclear 01:02:43] model. So yeah, a lot of fun.

Taylor: I see. Well, where can people get in touch with you if they had more questions [unclear 01:02:50]. What’s the best way?

Dr. Josh: Oh, call, text, email, Twitter, Facebook. I think we’re the most successful physicians I know because we would just respond to any doctor and patient response because—or inquiry because we’re so passionate about the model. Our EMR is Atlas.md for—no dot com. That’s the cell site but our clinic site is Atlas.md/wichita. Then you can email us at hello@atlas.md. Twitter Atlasmd, Facebook.com/Atlasmd and then you can even call my cell, 316-734-8096 because we will just—any physician who’s even thinking about exploring this, we know they just want to keep [unclear 01:03:37]. They’ll never get to
steps two and three and four. They don’t get past step one. So I think step one is, learn about it from someone doing it. Get past the misconceptions and learn how it really could work for themselves and their patients.

Taylor: And we’ll link up to all that stuff on [unclear 01:03:55] so you all can find it easily and I would definitely recommend Dr. Josh as [unclear 01:04:01]. Hey, I’m going to be in Wichita. Can I catch you [unclear 01:04:04]?

Dr. Josh: Sure, come on.

Taylor: So, super welcome and super friendly. So, thanks for joining us and I appreciate your time.

Dr. Josh: Thank you. It’s a pleasure.

[Hey guys, this is your host, Taylor Pearson. To give you a little background on the show, after seeing my dad and sister, both physicians, struggle to find a good resource for how to transition from their traditional practices, I launched Concierge Medicine Radio to create a resource to help physicians and healthcare professionals launch, run, and grow patient-centered direct pay or Concierge practices. If you enjoyed the show and want to help us spread the word to other physicians and healthcare professionals, it really helps us out if you’ll leave a review on iTunes. I know the iTunes interface is a little clunky, to say the least, so we put together a quick guide on how you can leave us a review at conciergemedicineradio.com/review or you can go to conciergemedicineradio.com and click ‘Spread the Word’.]

[Thanks for joining us today at Concierge Medicine Radio. If you found today’s show valuable, we’d love it if you spread the word by leaving us a review on iTunes or sharing it with your friends. To see notes on today’s show, please visit us at conciergemedicineradio.com. While you’re there, leave us your email to hear about all upcoming episodes.]