Podcast Introduction and Guest Background

Welcome to the Doctors Making a Difference podcast, where we help physicians to be empowered with the tools they need to successful in medicine, in finance, and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. I'm very pleased to welcome our guest today, Dr.

Josh Umber. Joshua has the interesting story of not only being a board certified family doctor and going through the training and working in his home state of Kansas, but he decided to take a little bit different path than most of us.

I am a family Doctor, Josh and I were talking before we hit record, I see the complexities of medicine from that side, kind of get a full spectrum perspective of all the things that people deal with.

But Josh decided to do something very interesting called Direct Primary Care. We'll talk about it in the episode. I know probably a lot of listeners have heard of it, may not know the specific details, but I'm very excited to dive into this with Josh and talk a little bit more about why primary care makes sense to direct primary as a primary-care doctor and how this can influence the system in United States and it can also influence our individual patients one by one as we come across their stories.

Josh, would you mind introducing yourself to our audience? Yeah, thank you for having me on. Like you said, my name is Josh Umber, a family doc, born and raised in Alma, Kansas, then moved to Manhattan, KS for undergrad.

So go Wildcats. We're a house divided though, because I then went to med school at the University of Kansas. so we can cheer for K-State for football and KU for basketball.

But then, went into Wichita and trained in family medicine, finished my residency there and stayed and started our direct care practice right out of residency.

Well, tell me about that part, because it's quite a thing in, when you started this, I would say the majority of doctors finishing residency of all types, maybe especially family medicine, were going into employed model sort of a practice.

And somewhere along the way, you had enough intelligence or bravery, or maybe your wife was brave enough to start her own business, and not only that, but started in a different model than the most people do it.

So I'm kind of curious about how that story unfolded. Yeah, you know, it's an interesting arc. Growing up, my joke is my dad was a trash man and he was, but now he's a lawyer.

So we still tell people he is a trash man because it is less embarrassing. And he has gone full circle. He is our lawyer now. It was honestly a blast.

We loved it. and we worked on that truck for forever growing up. Um, and it was great business model. In hindsight, You paid once a month. You picked up once week.

so I'd seen 20 years of a great, business being run. And then in about 2000, as an undergrad, started working for a surgeon who was fresh out of fellowship and had no idea how to bill insurance, right?

Brilliant cutter, absolutely amazing.

Why Josh Chose Direct Primary Care

And nowhere in all that training did anyone ever say, here's how you bill the insurance to get paid, not even well, just correctly, I saw him just leave enormous amounts of money on the table because for him, billing insurance was a frustration, and not a requirement.

It kind of broke that. idea you have growing up that if you work hard, the appropriate payment follows. And so I could see that you could be an amazing skill person.

If you just didn't know how to play the game, you're going to lose. we kind of in-person closed, I could point that out and say, this isn't how a good business is run.

And that started a career long journey of looking for doctors who did insurance free practices when that was concierge in 2000, 25,000 per person per year, which the dirty little secret there was 98% of those practices failed.

25000 isn' even the one percenters, it's the 0.00 percenter. So that was really hard for docs to find success in. Others just doing an insurance free model, maybe more fee for service than membership.

And we watched that for the next 10 years, undergrad, med school, residency, and I just knew I wanted to run my own business. I didn't want to do insurance.

Probably, as the Emperor's new close parable goes, the child who points it out is a wise fool. I didn't know how hard it would be. We have a banner in our office that says, we do this not because it's easy, but because we thought it'd be easy.

Just getting to residency and everything is hard and no one teaches you how to start a business. And so we did all that, but it left all the room to make all of the mistakes and figure it out.

Once you carved out that okay, we're not doing insurance, it was freeing in a sense of great, you can do anything you want. That worked out great. We knew this was what we wanted for forever because it just made sense.

Kind of going back to my personal statement for getting into med school. I had this fantastic, eccentric neighbor, Trottel, a German immigrant, and I watched her go through a broken healthcare system and the eccentric, crazy, fun, interesting, unique person that I knew, the system made her into a bad patient.

She didn't show up on time. she asked too many questions. The system didn t give her any reason to trust it either, and they treated her like a number.

I wanted to be in medicine, but not that kind of medicine. And I think that carried us through a lot of this kind, you know, figure it out. Like you said, You wanted treat your patients like an individual, not like a number.

and you wanted be able to say, I want to offer the care that they need, Not the insurance or somebody else dictating that to me, But rather giving it to the person in the way that the need it.

Maybe I had to back up one step and just have you define, again, most people on this are going to hear direct primary care and they're going have an inkling of what that means.

And you mentioned concierge medicine. I think a lot of people kind of have this idea of, hey, we're gonna pay $25,000 a year to have direct access to some primary-care doctor or somebody to come to my home.

But would you mind kind walking through the model? What is direct-primary care? Help define that briefly for folks who may not really be intimately familiar with it.

Yeah, on some level, primary care is what I think is going to fix the healthcare system because it gets back to kind of first principles, a smarter way of providing the service.

We're using insurance wrong. A wrench makes a decent hammer, and a hammer makes horrible wrench. So we need a better model for primary In this sense, it is an insurance-free model that charges patients a monthly membership, like a gym or like Netflix or Amazon Prime, for a broad range of access and is based on age only.

So for our patients, that's $10 a month for children, 50, 75, or $100 a months for adults, just based their age ranges. And those are the prices we started out with 2010. And we've been able to hold on to those, right?

What insurance company has been, you know, been ever to go a year without raising their prices. But we knew in exchange for that, we wanted to offer as much value as we could.

So the membership provides unlimited home visits, work visits office visits phone calls, text messages, emails, video chat. but also we been to eliminate copays.

Copays are a speed bump. that the insurance requires so that patients have to spend a little bit of their own money before they spend the lot of the insurer's company's money.

We don't need it as a business model, right? And no more than a gym needs a copay to try to keep people from coming into the door.

How the Direct Primary Care Model Works

And so we love that aspect of it because it hits those quadruple aims, more care, faster, easier, etc. But then continue to add that value. Any procedure we can do in the office is free.

Stitches, biopsies, joint injections, ultrasound, although we're not as good at it as we Could be. I see the residents coming out of training. They are so much more used to that than how we trained.

We have a DEXA for bone density screening, body composition, et cetera, full term monitor. And because, you know, those procedures are all essentially extremely low cost and EKG costs me 40 cents.

The coffee in the waiting room costs 80 cents a cup. So if I don't bill your insurance for one, why am I doing it for the other? I just don t need to anymore.

And I'd rather not have the frustration than the revenue. But it keeps going. I feel like that's the beauty of the direct care model is it tries to touch more than people expect primary care to do.

We can do wholesale meds and wholesale labs. Or about 80% cheaper than Amazon, 70% than GoodRx, and about 40% cheap than Mark Cuban. There's not a billionaire alive who can get med's cheaper then a direct-care doctor.

And if you go direct with the labs, CBC is two bucks, TSH 250, A1C 3, Lipid 350, right? The goal of direct care is to make most healthcare too cheap to ensure.

And be able to get all that for 50 bucks a month is a huge step in the right direction for putting patients first in order to fix healthcare. Yeah. So I want to clarify that a little bit because it sounds kind of astonishing in some ways, because I think like you said, $10 for a child per month.

That means they're going to pay $120 per year. And I know when we bill just a well child visit one time, the insurance pays probably over $200 for that.

Well, Chad, but that has to also pay for the insurance that I have to, you know, for malpractice insurance has, to pay the receptionist and a nurse and the biller, not to mention the brick and mortar space that we're seeing the patient.

And then we have, also, pay an expensive electronic medical record system. All those costs kind of get fed in and

then also the doctor is supposed to get paid.

And so I think people listening to this are going to say, how could I possibly stay in business if I'm charging $120 a year for unlimited access? Or if an adult patient on this more expensive end of spectrum, $70, you're still paying less than $1,000 a continuous access to your doctor.

And goodness, I just think about how much the list price is for the services we offer for patients. But we also have this big complicated system that has to be built around what the insurance will pay, not necessarily what this service actually costs to provide.

So walk us through that. How do you stay in business? Yeah, it's funny, I had a patient use our online scheduling option recently and he came in, we did our appointment and at the end he's like, can I just ask like is this working?

I'm like yeah, why do you ask? We've been here 15 years. He's, like there are so many open spots on the calendar for self scheduling. I just didn't know if you didn' have any patience.

And so we had a good chat, you know, and then last like, no, this is how it's designed, right? Most of what we do doesn't have to be done in the office.

It sure can be, but meeting people where they're at, calling, texting, emailing, video chats, pink eye, may get them right away. First thing where the guy want to.

No, just shoot me a picture of your eye. now and every hour until we're kind of comfortable with how this is progressing, because that's so much better care.

It drops into EMR, it takes a short amount of time to evaluate, etc. But when you're limited to that you only get paid when they come through the door, that changes everything.

We have one staff member for two physicians, basically. At least that's what we recommend. We're busy with a lot of irons in the fire, so sometimes we staff up.

But that is the general math for the business. So you're talking about one nurse for every one to two doctors and 1,200 patients. It shouldn't work. They should sound too good to be true.

You should call the BS flag. We were participating with a documentary recently and the theme of the documentary was, why are health care prices so high?

I said, oh, they're not. The cost of healthcare is quite low. EKGs, meds, labs, I can buy a thousand amlodipine for eight bucks. It is literally under a penny a pill.

And that's not because we're good, that just the wholesale cost, right? That's for a regular family doctor. We keep making healthcare expenses and then trying to use insurance to cover everything.

There's an economics book, Predictably Irrational. We would never buy car insurance if it was sold to us like health insurance. Why do we keep buying health insurances in this broken way?

We're working with an employer group tomorrow. Their health-insurance premiums are going up 27%. unsustainable. And they're saying this wiped out their last three years of raises.

There has to be a better way. So yeah, the cost of a well child check or any visit in an insurance model looks inflated, but it is because you have so many more hands in that pot.

But when, I joke, there's no profit in direct care practices. Functionally, you has overhead, nurses, rent, EMR, malpractice, et cetera, and then whatever's left over goes to the doc.

So it's an extremely lean, but extremely efficient and kind of just intelligent business model. So I like to reference these two stories. One is Christopher Columbus's egg.

And the short version is they say, well, you're not that smart for discovering the new world. We all thought it was round. He takes an egg, he challenges all the king's horses and all of the King's men to make the egg stand up.

Of course, an egg won't stand up. And so they say it's impossible. So you all agree, it is impossible, takes the egg, smashes it, egg stands up, right?

The idea is he made what everybody agreed was impossible i.e. fixing healthcare with a simple trick, made it so benignly simple anyone could do it. Right?

That's what direct care is. Or Napoleon's aluminum. When he wanted to impress dignitaries, generals ate it off silver, Napoleon ate off gold, and dignitaries ate of aluminum, Fast forward, you introduce a new technology and now we have aluminum foil we throw away.

Good business, capitalism brings the comfort of kings to commoners. Doctors have this fear of being involved in business. To me, family medicine and business is a love story.

I love being a family doctor. I love using business to help complement being family doctors. that it's not personal, it is just business. There's nothing more personal than this business, you are feeding my family in exchange, I'm caring for the health and well-being of your family.

It's extremely personal. So not having insurance involved, not have a red tape and bureaucracy, finding solutions to meds and labs to make all of this affordable I tell my med students all the time, if we take our own seriously and do no harm, that has to mean, do you know financial harm?

It begs us to strengthen our business skill so that we can continue to solve the problem of healthcare affordability. Then, yeah, there's no reason these things have to cost that much.

They're just, they do because we have a broken, bloated system that were not trying to fix the right way. Thank you for answering. Another question I have is, so I told you before we hit record, I work in a rural area.

And I think half the town probably has my cell phone anyway, and they come at all hours, day and night, in text, nights, weekends, holidays. It's the life I've chosen in rural setting.

But I thing a lot of doctors are saying, hey, kind of like having to be able to turn off the phone and I like to not have to called in all the hours of the day.

And when they hear direct primary care, they say, but that would mean I would have to be on the call 24-7-365. And so, you know, kind of walk us through that.

How does that work with your life? I definitely feel like the work-life balance is better in direct-primary care than it was even in residency. When we were starting our internship here, the graduating residents were heading out to the workforce.

Three years later, by the time I'm graduating, half of those residents are leaving medicine because of burnout. We talk about burnout in all these funny ways, but I don't think we actually address it.

You're burnt out because you're playing an unwinnable game. There is no way to win in an insurance model. They're always going to leverage bureaucracy against you.

It's a cold war, you know, to the point that we don't even include the review of systems meant something. Now it's so meaningless, it is not required in insurance, Billy, or so my medicine is telling me.

because we've just abused that fact. We keep playing this game of who can chart more, who to bill more who, can beat the insurance games. They'll win all the times.

The frustration comes from playing that and then the game is the paperwork, not the patient. When we were med students, we're all Bernie, right? We're wet behind the ears and newbies, but we loved patients, We loved songs, loved all of that.

And that gets beaten out of us through a complex system. When you get to sit with a patient for an hour and get know them and know their family and like you do, I think one that brings a lot of that spark and love of medicine again.

The American Academy of Family Practice has a report out, says 92% of direct care doctors are happy with their career choice and 54% insurance-based doctors.

So we're doing something right. I say, yeah, I'm available 24 seven. I may not reply 24 7. You have patients who text late at night for refills or early in the morning, you know, about pink eye.

They don't really expect you. they know you sleep. And I think even that's fun because I was out of town Friday, Saturday, Sunday with my wife and we went to learn how to fly fish.

Right? Everything relates to direct care in my world. I had no idea what fly fishing really was. And the needles are insanely small. Ridiculously small because they don't want to hurt the fish.

Sure. Less is more. Designed by subtraction. So I have this whole article I want right in the head of even in fly-fishing. The rule is do no harm. You focus on this one process and you get in flow state.

Doctors can't get into flowstate because they're being interrupted every seven minutes. We want to be with patients, not with paperwork. Building a model that allows you to do that, you know, 600 patients is what we consult with doctors and recommend.

That seems to the right size. So on any given day, I'll probably see three or four patients in the office for 30 to 60 minute appointments. extremely manageable.

And then a handful of call, texts, email, things that come through. So when someone does need you at night, we're on the weekend. I had a patient send to the ER, I have your doctor's history, so I want to say I'm special.

But being available is the special part. She started off with what looked like Venus lakes in her lips, but she doesn't have those. Between 9.30 and 10 o'clock, more bruises show up.

It's got to be a sulfur allergy. It's that, you know, this isn't going to be good. Ended up being ITP, but she needed to go and nobody wants to in the ER, it's, 10 o'clock at night.

No, This is real. You gotta go. To the point that it, I'm not special. It just that we have time. I post funded a group yesterday on Twitter because they published a study that Stoffer, more time with Medicare patients improves outcomes.

We had to study this. Like we went so far. It's like, well, seven minutes. Can we do six? Can do five? Why? It seems like outcomes get worse. What if we just gave them more time?

Like, I don't know. Seems like what if use toilet paper? Uh, it's such an obvious thing. And then we studied it and we're proud to publish this, we reinvented more tolerance patients.

We've come full circle through the uncertainty. And I know that's a long answer to a short question, but no, this is a

very sustainable work-life balance.

I like working, so some people might be 500, I can flex up to 700 patients easy, along with running the other stuff. So the beauty of having continuity with patients and flexibility, you're working for the patient, and you are not fighting insurance.

The care itself is drastically easier, let alone the others pieces. And Josh, it does sound too good to be true. A patient panel of, again, primary care doctor often has 2000, 3000 patients in their panel and you're seeing 20 to 25 patients a day.

You're saying a patient of 500 to 600, three to four visits per day, you are available, but it's not like the numbers are so overwhelming. And you probably know most of those people because you sat down with them for 30 to 60 minutes a couple of times a year and they don't get penalized for coming in more than once if they need to.

And so, again, it almost sounds too good to be true. And I guess that's one of the things on direct primary care. I wondered how has the insurance industry responded to direct-primary care?

As you've rolled this out and patients have adopted this in various locations around the United States, what's been the response to that when patients do that and they don't have necessarily traditional insurance paying for their primary-care?

I mean, it is interesting. Big insurance never paid too much attention to it. I think, understandably, they were too busy doing their own thing. So with smaller groups, we always worked with Allied National out of Kansas City.

And you could go in and say, look, the pitch was spend $50 with direct care to save $500 under insurance. And the smaller insurance companies were fine with that because they just wanted, they had to fight for the business and be creative like that.

But it also gave them an edge when they could offer insurance that was 30 to 60% cheaper than a standard plan that wasn't trying to innovate. I think the big insurance could go the way of Kodak is not because their bad at it per se, The game they're playing is unwinnable too, because the government structure rules around how insurance companies have to spend the money, essentially have a perverse disincentive for them to make anything cheaper.

Technically, they'd get punished if they saved too much money. The Affordable Care Act is currently written. So discouraged innovation in such a large way in an insurance model.

That being said, now that it's to the point of breaking, Even the insurance isn't happy. They know this isn' working. A 27% premium increase, they're going to have people just not take that insurance.

Agents are getting less commission. It's harder to get and keep business. So you're seeing that squeeze kind of come at it from all directions and make everyone more pliable to find solutions.

Doctors are frustrated, but they're very risky. 15 years ago, they didn't think this would work at all. Now, we had our largest national conference ever this summer with the AAFP, and it got oversold twice.

And then some residents just crashed it. Who crashes a CME event? It wasn't standing remotely, it was sitting remotely. The doctor was so ready. He said, okay, I've seen this work in my town.

I hear it more and more. My frustration with the insurance model is higher every year and my comfort with a direct care model being functional improves every years.

So that delta makes it easy to change. I think this will be the only way to practice primary care, really any outpatient care five, 10 years, because we can't afford to insure it anymore.

It was never logical to affordable things, but we kept doing it. So you don't beat the system, you let it kind of punch

itself out. And now you're seeing a lot more insurance innovation, especially post the big, beautiful bill passing to clarify direct care and HSAs are legal.

In my opinion, have always been legal that allows employer groups. A lot of flexibility now that they were kind of standing on the sidelines for. So yeah, I think DPC will grow faster now than it ever has.

Work-Life Balance and Burnout Relief

Yeah. I want to clarify that for those who didn't know that direct primary care previously was excluded. If I've got this right, Josh, excluded for paying for direct, primary-care fees.

But with these clarifications this last year, they are included. So folks can use their, can they use flexible spending count of dollars to pay for it?

So my little bugaboo about it was it never illegal. The IRS was just quiet on it. And by all definitions of IRS document 213D and 502C, the legal definition of a medical service was any legal payment to a physician, surgeon, dentist, chiropractor, et cetera, right?

It's a document written in 2003. It doesn't even mention nurse practitioners or physician assistants anywhere as a qualified medical expense. But it's a living document.

It's meant to be implied that any specialty, any trainee, physical therapy, speech therapy et cetera is a legal medical expense. So we always did it. We operated with thousands of doctors for the last 15 years doing HSA.

But for bigger employers, they were more afraid of the IRS than they are of their potential savings. Now that it's confirmed legal, it makes the larger employer groups much more comfortable.

So it was always being done. It's just now we know it. We got that checkmarked. Well, and so for folks who are listening, who may have been nervous about doing this before, or if like I'm thinking about some of my family members that take advantage of having a drug primary care doctor as their doctor, there's always this question, can we use flexible spending account money?

Can I use my health savings account associated with the high deductible insurance? That's been legitimized 100% now. And I guess another question related to that is, You know, of course it's a good idea to have insurance cover those big catastrophic items.

And I agree with you, why are we insuring something that's affordable? Like that makes total sense. Why do we have to insurance to pay for something? That shouldn't cost that much.

In context of that, how, what percentage of your patients over these last 15 years, would you say do carry some sort of high deductible or catastrophic type insurance?

So if they are hospitalized or experienced cancer or something like that. We actually have a pretty high uninsured rate and it's kind of gone up over the years.

Most direct care docs will tell you, you know, 75% have insurance. So that's 25 to 30% who don't. Whether that just can't afford it at all, employer doesn't offer it, they don' meet subsidies, They feel healthy enough to keep their premiums because they need it for something else.

And putting the car before the horse, I think we've always done that wrong that you need insurers to get care, right? You need to pay $1,500 a month premium to Get Metformin that costs two cents a pill.

Right? I mean, not even I can buy a thousand metformins for $13. Like, what are we doing here? Right. Your A1C is 250. Let's just. Which is funny because then I asked doctors, I think we're well trained on the pathology of sight, not the application of it.

And the applications of good psychology is getting patients to understand that if their meds and their lab tests are more affordable, then it's easier to invest in their long-term preventative health.

If it is not transparent, if it s difficult, it it expensive, they're going to push those things back later into the future and that will create problems.

The business model, combining with the psychology of how to change patient behavior. The lower the price, the more compliant they are, and the better the outcomes we get.

Yeah. Well, those are some big principles could be applied to the whole system. Like you say, why pay a really expensive premium to insure something which, you know, 95% of your care really probably could done at your primary care doctor's office.

If you don't have to ensure that because it's not so expensive, you know, maybe we don't have to have insurance be this thing that's supposed to catch everything.

And then you don' t maybe leave quite so many people out on the back end. Because I wish everybody had access to some sort of catastrophic insurance. Yeah.

You get a car wreck, you get cancer, or you some horrible diagnosis. If you're going to be in the hospital, it's going cost more money. But like you say, why do you have spend so much money just for access, to take care of your basic metabolic syndrome diseases?

A lot of the medications, especially the ones that have been around for a while, they aren't very expensive. And the tests get marked up a lot in the labs, but truly don't cost that much for a lab to actually run the test.

I think often we get sort of typecast or pigeonholed as anti-insurance because we don t take insurance here. But we're really just more pro-efficiency.

Like having life insurance, car insurance homeowners insurance. They're affordable enough and I almost never use them. If I do, my premiums go up. We can get to a point where.

You make 80 to 90% of care, 80-90% cheaper. Now, the question of ensuring everybody gets so much easier because I don't really care who pays on some level.

Could the government pay?

Insurance, HSAs, and Employer Adoption

Yeah, absolutely. Charity pay, sure. Should they pay $100 for a CBC when we can get for two? Absolutely not. So it makes the purchasing power of the money we put into healthcare 10x better, but it also means we can cover more people less often.

And I kind of had this bug about how doctors are trained to solve problems. We tend to do it in a very sort of multiple choice way. rule followers and rote thinkers and stuff like that.

Because we're not trained to, of course, not going to be good at this, but taking a problem and saying, well, why do we keep trying to insure everything?

Somebody asked, how do you fix health care? Give everybody insurance. No, you can't just keep spending money indefinitely on it. That's not the answer.

The answer is often behind us. If we studied how other things get discovered or innovated, it's usually going in a completely different direction than the rest of the group is.

And so the problem to solve is that we want people to use lesson shifts. The general way we thought for forever is more insurance is better. If I could just get that poor person insured, then I can get them everything they need.

That's true on some level, but then higher taxes, that's harder on small businesses. Then people have to stay in jobs. We have the dog that doesn't bark type things where we don't appreciate that there's a significant financial harm to patients and their families and lives if we keep trying to just use this tool of insurance for everything.

Where, and yet sounds a little too good to be true, we want our cake and eat it too. We want more care, more often, cheaper, better, faster, easier. But I mean, I've got a supercomputer on my wrist that has more computing power than went to the moon when it's because of good innovation, right?

So we shouldn't be so afraid to say that can't-be-done. we should say, how could it be done? And explore that. And now if you can get the women for them, then you don't care who pays.

The church could pay, the government could, pay their family could. But it's 98% less than if we insure. We keep problem solving like that and I think we just got to be better about that because Insurance isn't the best way families can spend their money, right?

If they're in debt, they could get out of debt. They could start a business. they can invest in their future. There's a lot that can happen if we lower the cost of health insurance premiums.

We're not really trained to think in that way. It seems counterintuitive, but like buying the fake diamond for your engagement feels wrong to say you have less insurance.

we want you to have the right size of insurance, Liberty car insurance pay for what you need. You see these kind of ideas everywhere else, but not healthcare.

If we decrease the cost of healthcare by 80%, we can insure everybody for a fraction of the price that we're doing now. And then we could do all kinds of good with the money left over.

On a $4 trillion system, the math works out pretty well, and I know it's shocking, But we should probably say $2 trillion out of health care system. Economist Sean Flynn in a book, The Cure That Works, written about this.

Another MIT economist, MacArthur Genius Grant award-winning economist has a books, Risky Business, How Insurance Companies Fail. They see how much waste there is in the system.

Everybody agrees the healthcare is broken. When you say, but I can get that medicine 99% less. Seizure Medicine at Walgreens, $108 cash price out the door.

Our cash is $1.32 to the patient. make it make sense, right? And then people say we can't fix healthcare. It's just, yeah, the numbers are too big. I'm often told if you just lowered the price 30%, more people would believe you and more would probably try to buy it.

And ironic, but probably true. No, thank you for your reflections. I mean, I think these kinds of conversations need to happen nationwide at the grassroots level.

And then our lawmakers need look at it as well, because there's so many third-party people with their fingers in the pie, so to speak. The insurance companies have a lot of incentives, and the pharmaceutical industry does, the hospital associations, everybody that has anything to do with our current model, has a reason where the inertia says don't change it because we're profiting from this or it's working.

If it ain't broke, don' t fix it, that kind of thing. But I think you're arguing, hey, it is broken. It does need to be fixed so that this is sustainable for our kids, for the next generation.

We talked about on this podcast quite a bit, leaving medicine better than we found it. And what you' re talking

about, Josh, is a way that that could possibly happen, where we say we make primary care really the home for, the majority of your health care, 80 to 90% of you needs are going to happen there.

And you can go, like you said, more often to longer visits, whatever you need without this big disincentive to go get care. I think it could make a huge difference if this was implemented at a larger scale for other people.

The sad part is kind of our self-limiting lack of imagination that we can fix this. We have a private space race across multiple billionaires. We now have reusable rockets.

We have more satellites, self-driving cars before we got affordable healthcare. It's so wild, but that's what they chose to fix.

Scaling Direct Care and Closing Thoughts

Because healthcare is weird and broken, they believe we can get to Mars. What kind of healthcare are they going to get on Mars? Are they gonna find the Blue Cross network?

No, they're going to have a paid doctor communicating with them, et cetera. And what do rich people do? What do athletes do, you think they wait in line for insurance?

No. They just pay a lot for it. Satellite phones used to be expensive too. Now my watch has a phone. These things get much cheaper. We just have to the imagination to think that it can be done.

Yet we can leave healthcare better than we found it, and I think we could empower family medicine. unlimited visits, telemedicine, procedures, medicines, labs, terrible medical equipment, cash price radiology, normally 80% less.

We do doctor-to-doctor telespecialty consults. So I can call up a dermatologist, talk doctor to doctor. 35 bucks, I get a Dermatology opinion in one to two days, right?

It costs me more in staff time to have my nurses fucks with the local dermatologists who won't see them for six months. Right? So skip it. Play a different game.

Invent a solution. We have the bet. Yeah, there's a great book. Everybody's probably familiar with Simon Sinek, Start with Why. I tell my med students, we have best why in the world.

We have patient care. Anything we do drastically improves their lives. And anything that we can recreate, we share with other clinics, other direct care practices, direct special care, and pass along best practices.

We are truly only limited by our imagination. In our system, We Have nearly 2,000 doctors. we offer them a free radiologist, cardiologist pharmacist and lawyer, right?

Because the cost of fractional ownership of a cardiologist to read x-rays across 2000 doctors is minimal. And now any one of those doctors, if they're not sure about EKG, they don't have to put their patients out to the system and wait and get billed a lot more.

They just call up the cardiologists that they have on speed dial and getting an opinion on an EKGs. It seems so silly that that's all it costs to fix this.

hire a doc to help docs, we couldn't have done that 15, 20 years ago. We are limited by our imagination, not by the government or what insurance, if we play that a different game.

If you're trying to get insurance to pay for it, whoever pays the piper picks the two. So it's just vital that we show, especially our med students, how to use that skill, flex that muscle, look for solutions.

Man, Josh, thanks for sharing. It's pretty exciting. What you're doing is amazing. And it's not just an idea. You've

done it for 15 years. I want to give you a chance to just kind of plug some of the stuff you've been doing as far as promoting this.

Yeah, our main website, atlas.md is for our software for direct care practice and EMR. And then you can reach everybody there live chat. Hello at atlast. MD.

Our clinic is of course, Atlas MD family practice. I feel like I'm like George, he named all his boys George. I name all my businesses Atlas and so we also have atlas.direct that's the website for an insurance company designed specifically around direct care patients which of course is a whole other topic and seems counterintuitive but if insurance big insurance was going to fix it we thought we would ourselves so when you combine directcare and insurance you know it's like chocolate and peanut butter.

Now a family of four under 45 years can be $450 or less a month for $100,000 in coverage each. We can take big bites out of a broken healthcare system.

But all of our consulting is free to anyone interested in direct primary care. So you can reach us on the website and it's our favorite topic. we love helping and whether you're a patient, a doctor, a company interested in trying to fix healthcare, we're happy to be your easy button.

Man, Josh, thank you, I appreciate you taking the time to do this. I find it fascinating, and I'm confident others listening to this will be like, oh my goodness, i have got to talk to Josh.

So be aware, there'll probably be some people emailing you and contacting you because this is fascinating. It has a chance to really make a difference across so many different areas of medicine.

And if you're feeling burned out as a doctor and you say I've got a change to something to cut out the middle man. Josh Umber has got your solution here.

Thank you again, josh. Appreciate you for taking time. My pleasure. Anytime. Thanks for tuning in to the Doctors Making a Difference podcast. And thank you for what you do to help your patients and your community.

Your work truly helps so many people. We produce this content to have the tools you need to stay in medicine and to highlight the amazing work being done by physicians around the world.

Please note that while I am a physician and many of the guests on this program are also physicians or other professionals, the discussions on the podcast do not represent my employer or any professional organizations to which I belong.

This podcast is for your information and entertainment only, and should not be taken as professional advice. You should seek appropriate professional advise pertaining to your own situation.

Please check out more of our content on our website, doctorsmakingadifference.com. Also, please follow, like, or subscribe on your podcast player or YouTube channel, and give us a five-star rating.

It really helps to spread the message. Finally, if you'd like to be a guest on the podcast, Or if we'd to nominate someone else to a be guest, Please visit the website or email admin at doctors making a difference dot com.

See you next time.