[Music by C. Ezra Lange]

David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health’s podcast series for healthcare revolutionaries. Outcomes matter, customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, October 5th. Our fall decorations are out and there's a bag of freshly picked Macintosh. Apples on the counter in the kitchen. What could be better? They say an apple a day keeps the doctor away, but what about physician assistants or nurse practitioners or does that require the American Medical Association? And that's what we're going to talk about on today's show, new research that shows that more PAs and NPS are providing primary care to patients to tell us what this trend means for the healthcare market and for healthcare consumers are Dave Johnson, founder and CEO of 4sight Health, and Julie Muchinson, partner at Transformation Capital. Hi Dave. Hi Julie. How are you guys doing this morning?

Dave, you're talking about fall decorations, but I just can't believe how hot it's been. They canceled the Twin Cities in Milwaukee marathons last week due to excessive heat. I still haven't put away my shorts for the winter and that this rate of climate change, who really needs Florida,

David Burda:

Right? Yeah. It was in the mid eighties this week. Pretty crazy for October. Julie, how are you?

Julie Murchinson:

I had the same experience. I was in San Francisco for the week, and it was 85 yesterday and I was not prepared. So coming back to Seattle, I put my puffy on to get off the plane thinking, Ooh, it's going to be cold here. And it was hot in Seattle. Weird.

David Burda:

I will say that shorts in Chicago are not a barometer of temperature. I'll just say there's very little correlation. They aren't

David W. Johnson:

For you.

David Burda:

They aren't. Aren't for me. Yeah, exactly. Now, before we talk about this new report and all the scope of practice disputes taking place across the country, let's talk about your experiences with physician assistants and nurse practitioners. Dave, have you ever been treated by a PA or np, and if so, what was your experience?

David W. Johnson:

I fell while running a couple years ago when I got up, my left pinky was at a 90 degree angle. I tried to pop it back into, yeah, I tried to pop it back into place, but it was still crooked. A nurse practitioner at a nearby urgent care clinic fixed the problem for me. He took an x-ray, saw there were fractures, and realigned the finger joint basically by pulling it and putting it back in place. I did chuckle when the bill

described this activity as surgery, insurance covered every penny. Can you imagine what this would've cost if I'd gone to either an orthopedic specialist or an emergency room?

David Burda:

Sounds like it all worked out. And there's a pull your finger joke in there somewhere that we could talk about offline. Julie, how about you? Has a PA or MP ever taken your blood pressure or checked your heartbeat?

Julie Murchinson:

An NP fired me from my OBGYN office after I had kids, and I've been seeing her for a couple years, and she sat me down one day and said, you don't really need to keep coming here anymore. It's nice to see you, but you can just go back to your PCP. And I thought, oh my gosh, you just fired me. She was great. So yes.

David Burda:

No, I don't think I ever heard that one before.

Julie Murchinson:

I'd been fired.

David Burda:

Okay. Too bad. I saw a nurse practitioner instead of my cardiologist for my annual heart checkup after he canceled at the last minute, and she was terrific. And I've seen a physician assistant in urgent care when I have bout of bronchitis, I need an inhaler and some steroids and I'm good to go. Even I know that, but you can't get them without a prescription.

Okay, let's talk about this new study in the British Medical Journal that everyone else is talking about. Researchers from the Harvard Medical School looked at 276 million visits by Medicare patients in outpatient clinics and skilled nursing facilities from 2013 through 2019. The percentage of evaluation and management visits, which basically our primary care visits delivered by PAs and NPS rose from 14% in 2013 to almost 26% in 2019. For physician assistants, it's rose from 5.1% to 8.4%, and for nurse practitioners, it rose from 8.9% to 17.3% over the same period. The percentage of visits done by primary care physicians dropped from 42.4% to 33%, and the percentage done by medical specialists dropped from 43.7% to 41.3%. It all adds up to a hundred percent each year. I checked.

Dave, at the end of last week's show, you challenged the notion that the only way to cut anesthesia costs was to cut down on anesthesia. You suggested that certified nurse anesthetist could do it better and cheaper. I know you've got a thing about this scope of practice issue. What do you think about the study findings? Is this trend a good thing or bad thing for the healthcare market, and is it a good thing or bad thing for healthcare consumers?

David W. Johnson:

Good thing. This is a great thing for the healthcare marketplace and for healthcare consumers. Dave, if I could wave a magic wand and do one thing in US healthcare, I'd eliminate the indirect billing provision that requires all medical bills to be submitted under the direction of a supervising physician, such a

waste of time, energy, and money. No wonder physicians believe and act like they're captains of the ship service provision and billing should align around outcomes best result at the lowest cost not process. For example, why do I need a licensed dermatologist to conduct my annual body scan for troublesome growth? A nurse or even a machine could be just as effective or even more effective at doing this really basic task. The only reason it happens this way is they can bill more money for it. You're right that this scope of practice issue is the one right now that's making my head explode.

Not that I've moved on from revenue cycle management. This latest one started in August when I spent a couple hours in the simulation lab, sawing bones, threading catheters, and doing internal suturing with a DaVinci machine at the Mayo Clinic. And as I moved from station to station, I was just struck at how routine and mechanical all these procedures were. And every time I got to a new station, I asked the doctor supervising it. Why do we need doctors to do this? Looks pretty straightforward, and I always got the same answer. We're here in case something goes wrong.

All surgeons in the United States, regardless of the type of surgery they do, usually require 13 years of training, four years of college, four years of medical school, three years of residency, and two fellowship years. This is the equivalent of training bicycle mechanics with the same intensity that we train mechanics for airplanes or nuclear power stations. It's just a crazy system. Why not align training with the particular surgery, particularly for routine procedures like angioplasty?

As I sat there and thought about it afterward, why don't we have the equivalent in medicine of surgical mechanics?

What I'm about to say is absolutely sacrilege in medicine, but I'm not even sure these surgical mechanics would need to attend college drone operators don't need to know how to fly airplanes near, as I can tell. All they have to do is be good at video games. The current system takes very talented people, sends them to medical school, gives them an excruciatingly long training period, loads them up with debt so they can become drum roll. Please, surgical mechanics other than to limit supply and inflate compensation. Does this system make any sense? Thank God we don't send plumbers and electricians through a similar training and credentialing process. They'd cost even more than they already do. So surgical mechanics, let's look at all these regulations and credentialing processes and let's have 'em make sense.

These contradictions or this misalignment between surgical task training and credentialing are only going to get greater as the machines become a bigger and bigger part of our lives.

David Burda

So you asked doctors at the Mayo Clinic why we need doctors and they let you go.

David W. Johnson

You

David Burda

Got gut, Steve, I'll give you that.

David W. Johnson

I was having this conversation with Molly Coy the other day, and she told me I needed to hire full-time protection as I start walking around the country. She might be right.

Julie Murchinson

Be actually.

David Burda

Exactly. Julie, any questions for Dave?

Julie Murchinson

Well, Dave, I saw an interesting article about an uprising among veterinarians. So we'd love to ask you, what do you think veterinarians and doctors have in common?

David W. Johnson

Well, the most obvious thing is they're both increasingly owned by private equity. That's probably why they're having the uprising.

For over 30 years, we've taken our cats to Blum Animal Hospital, which is right here in our neighborhood in Lakeview. And Blum has been just a terrific place. It's where Oprah used to take her pets, the Chicago standard for high quality, whatever Oprah does, the rest of us should do too. So when I was writing my first book, Market versus Medicine, I actually had a segment in the book that made the statement that our two cats at the time, Baxter and Bailey got better primary and specialty care than Terry and I did. They had a medical home, which was Blum Animal Hospital. Dr. Dan, our vet coordinated all the care. Baxter had hypertrophic cardiomyopathy, so he had his own cardiologist,

And he actually probably extended Baxter's life by at least 10 years. I mean, actually pretty remarkable. But the care was always coordinated. They shared medical records. There was transparent pricing. Everything went through Dr. Dan. I wrote this passage and I gave Dr. Dan a copy of the book and highlighted the page, and he had it on display in his office right up until the time he retired about three or four years ago. But boy has the world changed since 2015, 2016, private equity bought Blum. We now have pet insurance. We're constantly on the lookout for overtreatment. Prices have skyrocketed, and we are now in the same kind of battles with the insurance company over what they'll pay and not pay for. And so in that regard, Julie, to your question, it feels like pet care, which used to be superior to human care, has become more in line with human care, and that is not a good thing.

David Burda:

So Dave, do you think vets fighting against non vets, doing some of the things you described kind of parallels what's happening with medical doctors and NPs and physician assistants?

David W. Johnson:

I'm not expert on the area, Dave, so I'll just go completely into the realm of speculation, which I'm very comfortable with doing. But I think lots of the professions are trying to hold on to whatever credibility and responsibility they can have for procedures that can be done in better, faster, cheaper ways. So it wouldn't surprise me at all if vets are sort of rallying against these new and improved ways of doing things in the same way that doctors and nurses are.

Thanks Dave. Julie, it's your turn. What's your reaction to the study findings and what innovations or technologies are you seeing in your part of the world that would push these percentages higher or even replace most clinicians for primary care?

Julie Murchinson:

I was working with community health centers 20 years ago and they had team-based care down and they had to, because with their reimbursement structure, they had to provide access at the lowest cost possible, begging, borrowing, and stealing. So everyone they have was practicing at the top of the license. So they had this down and now today, fast forward. It is interesting. You're seeing it in a lot of commercial models. I will say some of the models that are doctor created tend to become very doctor centric, whereas some of the models that some are doctor created, but some are entrepreneur, non-physician created are really using NPS and PAs a lot more. Opry Health, one of our companies practices advanced primary care and uses an incredible mix of MDs and MPS and by the way, integrates behavioral health and uses coaches. I mean, they're managing the whole person. That's what Dave's cats expect.

I was just talking to Blue Shield, blue Cross Blue Shield of Arizona yesterday, and they launched their Sano model, which is their advanced primary care model using a lot of mixed clinicians in their model. Village MD calls their NPS and PAs their advanced practice providers and claims that they are champions for their patients. I mean, there's a lot of buildup going on of some of the venture models to really make this class of clinicians feel like they are one of the most important partners for their patients. So this is a big wave beyond just a small trend.

Another tip that I found, which I thought was really interesting is, which is a company we're related to from one of the companies that it bought, and they talk about how physician assistants have the ideal skillset to lead EHR and informatics projects because they're more facilitators in the practice and they're really excellent translators between nurses, physicians, patients, and other caregivers, and it makes them kind of more uniquely equipped to translate what's needed in the ER and what's needed in workflow to actually support more than just the doctor patient interaction. So Carrie was talking about how PAs could really develop their careers into more of the E H R and other digital health implementation and design, frankly, which I think is actually pretty interesting when you think about the need for that in the industry. And my last example is eConsults, Dave, you've heard of eConsults, of course, right?

Yep. Arista, MD Rubicon, MD Picasso, MD. I mean, these models are kind of game changers for primary care because they connect, whether you're a primary care provider or physician or a nurse or an MPEP A, they connect all those categories of clinicians to specialists. Even if you're a specialist and you need a specialty consult, they're providing real time clinical decision support. A lot of them are providing referrals and scheduling support and care coordination as well, and they're helping create the right path for patients who are seeing someone in the primary care realm. So this means that with these kinds of technologies, I mean, you don't necessarily need the physician. You could have a nurse with that patient in a rural setting. So honestly, the future is going to be defined by a number of things. But a few key vectors certainly is all the technology I just talked about plus ai.

I mean, just going to self-care, going to virtual self-care bot oriented care as your first line is definitely the first vector of change. The second I think, which is much more human, is when you start to see chief medical officers at these ambulatory care practices in acute care settings who are NPs, PAs or DOs and not MDs, you're going to see a lot more change because there's still a control function at that level. Just like the control function I talked about with physician created innovative models that are still pretty doctor centric, that's going to open up a whole new world of how the humans think about who the humans need to be.

David Burda:

I love the irony of moving away from MDs ultimately is better for patients. That's something most people think about. Thanks, Julie. That was excellent. Dave, any questions for Julie?

David W. Johnson:

I'm not sure it's ironic, Dave.

David Burda:

Yeah. All right. Right. It's true. Right, right.

David W. Johnson:

Well, Julie, that was fantastic. And I just stepped back and sort of look at everything you just said and project forward a little bit with AI and expanded capabilities among non-physician primary care practitioners. Does this country really confront a massive physician shortage as is so widely reported?

Julie Murchinson:

I have been saying this for, I'm going to say six or seven years now, and I used to say it pretty boldly, and then I got a lot of side eyes, and then I started to sort of whisper a little bit more. I dunno why I got so meek, but we are not looking at the facts of where ai, I'm not going to say ai, just technology and just proper connections and a better use of our capacity in this country on just a position level is one set of changes and all the other clinical levels can help support. I mean, I don't think that we have a physician shortage in the way that people talk about. We may have a lot of capacity misalignment. There is no doubt about that. We don't have the right types of physicians or the right types of caregivers in the right geographies or always in the right care settings. But at the end of the day, if we did a better job of utilizing all those folks through some of the technologies I just talked about, we I think would have a much smaller concern about our problem. But I think frankly, the only people who are probably still concerned are the ama. But

David Burda:

Yeah, no, no, that's interesting. Here's my million dollar idea, and it kind of dovetails with what you just said. I'm going to invent an online symptom tractor that after you answer all the questions, and no matter how you answer the questions, it says there's nothing wrong with you. Go to bed. Right? That's it.

David W. Johnson:

First do no harm.

David Burda:

Yes. Right? And then because every symptom tracker I've ever used says it could be a sign of something serious, go see your doctor just in case. That's how they all end. And if you can get an appointment like you said, Julie, so great discussion. Fantastic. Now let's briefly talk about other news that happened this week. It wasn't all bad, was it Julie, anything else worth noting today?

Julie Murchinson:

I have a really fun little tidbit, and it's really interesting when you think about it. I read this week the company Toast, which is the restaurant management app. If you've ever ordered something online for pickup or delivery, you may have used the Toast app. And some Wall Street analysts looked at toast. And this is a bigger macro like healthcare's impact on FinTech. Wall Street analysts looked at some longer term impacts on their stock, and they actually revised numbers down because they're expecting the appetite suppressant from, again, the GLP one. Drugs like Gospic and with Govi will have impacts on the volumes that restaurants as fewer customers order via toast. So toast will make less money. Isn't that interesting?

David Burda:

Wow. Talk about a ripple effect in the market.

David W. Johnson:

Juicy.

David Burda:

Yeah, that's a good one. Dave, what else was in the news that caught your eye?

David W. Johnson:

So Julie's headline is Toast.

Julie Murchinson:

Good, Dave, I like it. Is there a song in there somewhere?

David W. Johnson:

Could be. Could be.

David Burda:

Oh, don't start. No, no, no. Please.

David W. Johnson:

Dave.

David Burda:

Dave, what else was in the news?

David W. Johnson:

Well, I've been getting into some good trouble with former congressman John Lewis used to say in Minnesota, governor Waltz there has created a very high profile task force that launches this week to study the University of Minnesota's Professional Healthcare Training and education program. And this is all tied up with the U'S multi-billion dollar funding request from the state to revitalize its academic clinical enterprise, which I think is among the most ludicrous things in the world, that somehow this is going to lead to better health in the state. So I'm really watching this task force to see whether they come down on the side of health, more health or more healthcare. And by the way, this is not the first

time we're going to confront this issue of public funding to prop up financially struggling clinical and academic enterprises

David Burda

Shiny new patient towers. That's great, Dave. Thank you. And thank you, Julie. That is all the time we have for today

If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.

[Music by C. Ezra Lange]