Primary Care Cures

Episode #31 - Cristin Dickerson

Ron Barshop: Most problems in healthcare are fixed already. Primary care has already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and it's totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with us, Ron Barshop, CEO of Beacon Clinics. That's me.

Ron Barshop: Well, I was pretty hit this week. I had a poky seafood dinner with the former Muni Bond trader friends and last night they gave me hope for American healthcare. About 10 years ago they had to disclose their 3% commissions to their customers that they'd been dealing with with for decades. And decades long customers were outraged they were getting 3% on multimillion dollar bond trades. They demanded a 90% fee cut and virtually all the traders walked out that day. It's been mostly an automated exchange now and so there's flatter, fewer middles in the bond world, for better or for worse. Hospitals soon have to disclose their pricing. Big pharma was supposed to announce pricing on TV this summer, but a big pharma friendly judge blocked it. PBMs are being pressured by employers, like Caterpillar and others, for transparency as are brokers through a movement launched by Health Rosetta.

Ron Barshop: A former guest on our show, Dave Chase, expect flattening, it's coming. There's more like direct primary care is squeezing out all the middlemen like Atlas MD, publishing all their primary care fees, flattening out those who are charging too much, Surgery Centers of Oklahoma, another former guest, all imaginable surgeries are on their website. Sono Surgery, the same thing. Medibid, it's a long list of people that are flattening the curves with the middles. So there will be fewer middles like muni bond brokers, potentially like PBMs. It's impossible to stop transparency movements. So how soon before prices drop and we see this actually happening in the market? Well, nobody really knows, but this is an era of disappearing middles. Whether they drop out quickly, months, years, it's coming undeniably, undeniably for sure. In fact, Jeff Bezos, when he speaks

publicly now talks about the impending death of the middles in all sectors of the economy.

Ron Barshop: So this is a pivot point in history. Thank you millennials. This transparency movement started with your outrage and the lawsuit of benefits [inaudible 00:02:47]. And today's guest is another person who you can eliminate the middles with her service. Cristin Dickerson practiced 13 years at the Diagnostic Clinic of Houston as a radiologist where she served as a two term president of a 50 physician clinic, not shabby. She currently practices radiology as a partner in a very large group called Radiology Group of Houston. And her interests include oncology, MRI, CT and breast imaging and cardiac screening. She founded Green Imaging to provide affordable high quality medical imaging for the uninsured, for the high deductible patients in Houston and rapidly expanded the company to provide services in Texas. So welcome to the show Cristin.

Cristin D: Thank you. Nice to be here.

Ron Barshop: Well, so tell us how the Green Imaging journey started.

Cristin D: Okay. We had a 21% uninsured population in Houston in about 2012, and I think that's a conservative estimate because we have a lot of cash pay imaging that's coming in from immigrants that never gets documented. But there really were no options for affordable cash pay imaging in Houston. In fact, everything was based around the international visitors who came and who were paying 10 times, 20, 30 times Medicare for exams. And they were Medicare age, but because they were coming in from other countries, the hospital systems were really upcharging the exam. And so everybody was feeding on that for so many years in Houston and that tourism that nobody really had good cash pay pricing. And additionally, the biggest chain of outpatient imaging centers had been purchased by a hospital and went to hospital pricing. And so there were very few in network options for people who had good health insurance.

Cristin D: They were subject to the hospital pricing, the $5,000 MRI when they went down the hall to have their MRI. And I as the rating practicing radiologist was reading for a lot of these centers. A lot of the centers were billing out of network, meaning they were credentialed with say United Health Care, but they weren't going to accept the in network rates. And so it was seen as a surprise bill. It was seen as this $10,000 bill. And a lot of these, because employers were not savvy, they were not limiting the out of network benefits once a person and hit their deductible. So they were maybe scanning 10 patients and hitting it big on two patients, and that's the way they made their living. And that's not a good way to practice healthcare. It's not good for the patients, it's not good for the employers.

Cristin D: So I decided to open my own imaging center and I did it pro form and it was going to be about three to 4 million to do it the way I wanted to do it. And I looked around and the facilities were all at 50% capacity. So I had the idea to do a Travelocity like model and actually do a lease arrangements with the facilities and buy their extra time on their scanners at a discount. I was head of a group of radiologists. We would push the images to our PACS system and we would interpret the exam assuring quality of the images and the reports across the board. Everything would be read by a board certified fellowship trained radiologists, and we would be watching the images to make sure that the quality was where we needed it to be.

Cristin D: We've had a number of physicians in Houston. We're very well integrated into the medical center here. We had a number of physicians who had patients with high deductibles who began referring patients our way. Patients started finding us organically. The ones who are searching around who knew that they had a $6,000 deductible and knew that they could afford the down the hall pricing at the hospital. And we really started needing to go be throughout Texas. We had MD Anderson doctors whose patients would go home to Amarillo and wanted to have their scan there before they came in for their appointments. So we did buy... About 15 months ago, we were in 110 locations throughout Texas and really had most of the geographic areas covered.

Cristin D: But as I began speaking on cost containment and speaking about healthcare reform, I had employers coming to me and saying, this is great. We want to do this, but we have employees all over the country. We really need a wider network. And that model was difficult to scale. So it took me a while to figure out that we have a scalable model now. We try to contract with radiologists owned centers nationally, get the private equity, the middlemen out of there. There are a few exceptions to that. There's some very well run chains of imaging centers that we work with, but our goal is to target independent and radiologist owned centers. And we now have a national network of about a thousand centers.

Ron Barshop: Fantastic. Well, so you need to update your website because it still says Texas.

Cristin D: Does it? Well, our heat maps of the nation. But, yeah.

Ron Barshop: Your bio.

Cristin D: Oh, my bio, probably yes. This is really literally been... last August is when we started this mission. So, yeah.

Ron Barshop: This is exciting news, very exciting news. So what the average customer, patient doesn't understand is that you can go to an imaging center owned by one of your clients that you've leased time from, and the payment is literally one half to one fourth what it would be if it was a hospital owned facility, even if it's across the street from a hospital, it doesn't matter. You may not even know it's a hospital affiliated. Is that correct?

Cristin D: That's correct. My down the hall video is, where's the most expensive place to go for an MRI? And it's when your doctor writes a prescription and points you down the hall to schedule it. Because 70% of physicians in this country are employed by or subsidized by hospital systems. And whether we like it or not, and whether it's legal or not, have quotas to fill on their referrals.

Ron Barshop: Nobody would go to a movie theater to go pick up a six pack of Cokes and nobody would even probably go to the corner store to do the same if they can just stop by the grocery store. It's kind of almost that type of a markup. Nobody would go to the airport to get a scotch if they can buy their bottle themselves down the street. And it's exactly the same model. Most people don't... There's a little obtuseness and maybe a little masking going on with who owns the center that you're going to get that x-ray or that CT scan at. There's not truth in advertising in America right now, is there?

Cristin D: There's not. And even the independent outpatient centers, those out of network facilities that we frequently are they reading radiologists for, the little known fact is, and physicians do have to disclose if they have an ownership. The independent doctors actually have to disclose that there basically self-referring. But many of those, if not most of them, have physician investors.

Ron Barshop: Well, and the patient is signing away forms, they're signing consent forms like candy at a Halloween party. They don't really know what they're signing. They don't know that they're signing on with a very expensive location. They have no idea.

Cristin D: I was at Texas Children's Hospital with my son last week seeing an orthopedist and literally there were 25 pages of paperwork to sign.

Ron Barshop: Yes. That's incredible.

Cristin D: For an outpatient business.

Ron Barshop: There's no way they're... it's a user agreement that they're clicking yes on their website. It's no different. It's just they've got a pen in their hand. Okay, so let's talk for a second about the future of imaging. Is this where we're all headed now? Not just uninsured, insured, but this is where

employers that are self funding are going, because I can't imagine they're going to want to pay higher prices and they need to.

Cristin D: No. And when we started building the Texas network, having been a self funded employer, diagnostic clinic, I understood incentivizing employees to use lower cost, high quality facilities. Any care that our employees received within our 50 doctor group, and our imaging and our lab was all at no cost to them and we held that away from our Blue Cross Blue Shield plan. It was so cost effective we didn't care if it hit stop loss or not. I have employers all over the country now who are incentivizing their employees with a low copay or zero out of pocket, or sometimes even shared savings, to use us as a preferred network. And it's amazing. I just had a woman who gave us a five star rating and said she drove 210 miles to save 50% on her exam.

Ron Barshop: Incredible. Well, so what do you think about this transparency movement? We talked about it at the top of the show. Do you think this is a good healthy thing that the flattening of the middle is a good thing?

Cristin D: I do. I worry a little bit about... There are two things that I worry about. I worry about, we have 70% of doctors employed by hospital systems, and a lot of those who are very good doctors. I worry about their being able to adopt in their own offices, even as the hospital may be making some concessions. It's going to be tough. Most of them don't understand what a third party administrator is. They don't really understand who's paying for healthcare. I am working with the Association of Independent Doctors to put together a group that helps to educate doctors on what changes are coming in the next few years and how to be part of it. Because if the doctors are not on board, if they're just manhandled by the hospital systems or told what to do, I think there's going to be a lot of resistance.

Cristin D: I think if doctors realize that they're going to get paid better, which most reference based pricing is better than they're being paid by the networks, especially for independents. Independents spend 30% of their revenue to collect 70% of what they're contracted to receive from the traditional insurance company. And so once they realize that 120, 130, hundred and... I see some plans at 160, 170% of Medicare. Once they realize that's gold and much less bureaucracy, I think we're going to have a phenomenal movement. But if the doctors don't understand and there's not a willing base for receiving reference based pricing and other payment models, I think that's where we're going to struggle with the cost containment movement.

Ron Barshop: Now explain to us referenced based pricing for those who've never heard that term or don't understand that.

Cristin D: Okay. It's a fancy word for a percentage of Medicare, because I know of no other system that anybody is comparing it to, no other reference that anybody's using. So basically it is a percentage of Medicare. So typically in the independent world, Blue Cross Blue Shield is paying anywhere between 85 and 120% of Medicare for outpatient services in the Houston area. They pay tons more than that for hospital care, about three times that, but that's the reference. So what a Medicare patient would pay, and it's pretty paltry these days for an MRI, of the extremity, $237 for a non-contrast MRI of the extremity. If it were referenced based pricing at Medicare it would be the 237. If it were 120% of Medicare it would be closer to $275, but it is a percentage of Medicare.

Ron Barshop: So essentially what we're doing now is the onboarding of doctors is going to happen because they're getting a better deal. The onboarding of patients, uninsured and high deductibles is happening because they're getting a better deal. Employers who have a need to keep their self funding costs down are getting a better deal. Direct primary care, I'm assuming is a market for you. They're all looking for a better deal for their patients. It seems like the hospital MRI is going to be going the way of the dinosaur eventually. I know it's a huge percentage of the MRIs done out there, but don't you think that's a declining market over time?

Cristin D: It is. There are certain things that will never go away that can't. I feel like 90% of care can be performed at the primary care and independent doctor level, and there's about 10% of care that has to be handled in a hospital system. That's a far cry from the the 30% being handled in primary care and independent docs right now, and 70% in the hospital system. There's a huge differential switch that's going to happen. I believe we should have flagship hospitals. I believe the cost of care there is much higher. The administrative burden is much higher. The bureaucracy is much higher. I believe those 10% should be paid better than independent doctors. Their overhead is much higher. But we've got to make that shift. There are going to be hospitals, I think, that are shutting right and left, and we're already being that in the rural market, unfortunately. And that's the place where we most need them.

Ron Barshop: Yeah. They're closing about one every week right now. And they're hanging on by their fingernails, the ones that are surviving. Pretty hard to get a doctor to want to move out to nowheresville Houston, outside of Houston when they can work in Houston for a lot more, a lot better quality lifestyle and a lot or income. So that's the problem. They can't attract the doctors.

Cristin D: Right. And I do know a benefits advisor who's trying to work with these rural hospitals and actually create plans for their own employees and opportunities for the employers in the area. Right now what we're having

to do, the smaller hospitals won't negotiate. So we're having to get a good deal such as the employees drive an hour and a half to go get an affordable MRI. We can keep them local if they'll work with us. But the problem is they don't understand what's wrong with the system. I think very few people in this country really understand what's broken about the healthcare system.

Ron Barshop: Well, I mean if I was to go get an MRI and I knew I had some time before I was going in for my procedure, there's no way I would let the hospital do that. I would get it done somewhere else every day of the week. But that's an educated consumer. I don't know how many folks out there are educated to even think that way.

Cristin D: They're not, nor their employers and nor are most doctors, and that that's real... And I think we're just... I think that, I think when you want to talk about transparency, I think the veil is being lifted off. I just looked at claims from 100,000 life school district. And traditional third party administers... So it was administered by one of the major insurance companies. And we found about 600, and this is just for a group of 10,000 lives, we found about 600 MRIs and CTS that we're billed at astronomical prices and they got through whatever their claims processing scrubber is because they were billed with hospital codes only. They weren't built by CPT codes as they're supposed to be. Either that or Cigna lifted the CPT codes.

Cristin D: We're not sure which, but the hospital system was a gap. We had looked at their claims data with CPT codes only, which is how we identify specific studies and we identified $2 million in savings by using it. Once we found these additional 600 codes, and these are MRIs and CTS in the 26, $29,000 range. That is a catastrophic event for a family of a bus driver or a school teacher, a catastrophic event for a school district. The these teachers raises were completely eaten up by the increased premiums in their health care for the next year, and they were having to go from a 30% coinsurance to a 70% coinsurance. It's just crazy.

Ron Barshop: One of the best thing I saw that was Commonwealth Fund did a study of the last five years, and 78% of the raises or 70% of Americans raises were absorbed completely by health care premiums, deductibles and copays.

Cristin D: Right.

Ron Barshop: Three out of four. All right, so let's talk about the future of MRIs. What a bleak industry that has been the last 10 years. The reimbursements used to be maybe five times, so you were in a high margin, low volume business. Every physician got into it and at the cocktail parties were all bragging that they owned a piece of this one or that one and they were popping up

like McDonald's on every street corner. And then suddenly reimbursements did a funny thing. They got slammed and to one fifth maybe one seventh of where they were 10 years ago even. So what was a high margin, low volume business turned on its head. It became the low margin, high volume business. You talk about 50% utilization, that is enough to go broke. Right? I mean, that's not a profitable center.

Cristin D: Absolutely. And there there's more and more pressure to buy equipment that's more and more expensive that doesn't necessarily add diagnostic accuracy. Like in the case of the 3T MRI, it certainly can be used to increase throughput. Most of the imaging centers that have them don't use them to increase exam. The dirty secret is most of them do not improve exam quality. They use it to increase throughput, which can be a very good thing. I mean, you can have decreased motion on the exam, which will add image quality, but mostly it's to get those patients in and off the table the fastest.

Cristin D: There are couple of exceptions, a breast MRI, there are some studies that show that it may be a little more diagnostic accuracy and prostate and staging prostate cancer. But other than that, there aren't studies out there to support that it's better. So that's one of those things for shoppers. That's one of those things for the educated consumer. A 1.5 Tesla magnet is in general, it's going to give you equal diagnostic accuracy to a 3T, so you don't necessarily need to go to a more expensive site to get the 3T.

Ron Barshop: So I'm going to say a couple of things you may or may not agree with, but the first thing I'm going to say is I believe that radiologists, like every other specialty, really are strong in an area and weaker and other areas. And that the QA, quality assurance, that goes on is minuscule and nothing is put in writing when there's a quality issue and there's no feedback to the radiologist who did the misread. Now, I'm getting that from a previous guest who has got a company now that has determined that about 30 to 40% of all radiologist misread, not because of sloppiness, but because people aren't sticking to their specialty. You're an oncologist, a radiologist, and so you understand when you're looking at those scans.

Ron Barshop: So, number one is I think if our wish radiologists could stick to their knitting, and I think that's going to be mandatory in the future as this artificial intelligence branches out in pics where the people are good and where they're not. And the second thing I want to get your feedback on is the over testing. The over-testing is just... I think every 13 seconds, a test is unnecessarily ordered in America. So you want to deal with the first one first and the second one second?

Cristin D: Sure. I think there are training differentials in radiologists. There are chiropractic radiologist who have not only a difference in number of years

trained, but also their training on basically this spine and extremities, and yet they're reading body imaging and they're reading other modalities other than MRI and X-ray. And I think that's that that is a very difficult problem. I do understand that chiropractors who refer may want a chiropractic radiologist to read the spine MRI because they speak the same language, and that's good and great. But what happens when they miss the renal tumor that's sitting there that they haven't been trained to read? And that's the other thing about super specialty is that yes, you may have somebody who's great at the joint, but they're going to miss the atherosclerotic disease that's going to kill the patient next week.

Cristin D: There's a happy medium and I'm not sure. I worked closely with some of the AI companies developing AI, and in fact we're doing and AI image bank. But I do worry that sub specialization also... and I'm a general radiologist by trade. I will say that, but I do know that I get brought a lot of things, studies, that's the MSK radiologists or the neuroradiologist read, and there are actually other findings there. So I think that's one of the things that's a balance and we have to do better and I hope AI will actually help us in a way that computer aided detection was unable to.

Ron Barshop: So Kristen, one of the things I love about your website and your values is that you will tell a patient if they're over testing, they're asking for tests they don't need because they read something on Web MD or they saw a television show that was interesting. I love that you guys made sure that the patients are clear what they need and don't need.

Cristin D: We do, and I've got a caveat there as well because the economics of a $250 MRI, which is what they cost at the center I own in Houston, compared to a $5,000 MRI are very different. So in general, yes. I think if you have good primary care, I look at my DPC docs and we have about a 10th of the imaging because they actually examine and talk to the patient, compared to the patient who calls the nurse for an appointment with their doctor and the doctor says, go get an MRI first and then I'll see you. That's an entirely different animal. The other thing though is there a lot of applications for MRI and other imaging modalities that are very useful that that we're not traditionally covered. Say you've got a runner who's got shin splints. Do I just have marrow... Can I run this marathon next week? Do I just have marrow edema or do I have an actual stress fracture?

Cristin D: Things like that that can really make a difference to people. And then the same thing for an elderly person who has maybe sacral insufficiency fractures, maybe just this little sacroiliac arthritis. Should I keep walking my two miles everyday, should I not? That's a big health question. When you have an appropriately priced imaging exam, especially the ones that don't have ionizing radiation, they become a different tool. And I think that's what we have to look at. The economics of, especially MRI, are

going to change over time. And ultrasound, we know that for screening, where there's no risk and we get some benefits, especially the carotid artery screening, which we know is the simplest cheapest way to screen for a increased cardiovascular risk. Those things become, as the cost comes down, the economics of it changes.

Ron Barshop: So now talk about the over testing required of the patient because you don't want to send them and patient courtesy issues. But what about the over testing done by physicians who are doing the CYA? Do you ever feed back to the docs, hey, you don't really need that one or do you just comply because you got to?

Cristin D: We typically will. We will feed back and say, hey, I think if this CT, especially on a young person, we'll say, why don't we try an ultrasound on this one? I know the mother's worried, the patient's worried, but let's get an exam that has no risk at all and a lower price point. Yes, we have turned away... we certainly would turn away exams that are unneeded and unnecessary. That's never a question. People who want to do screenings, PET CT, for the whole body radiation does, that's not an appropriate use of that modality.

Ron Barshop: So where is all of this headed? Are we flattened now or we're about where we're going to be for pricing. Are there any more shocks in the MRI world coming at you that you're aware of or preparing for?

Cristin D: I think as hospital pricing comes down, I think that's going to be the big juggle. I think the pricing by traditional insurers right now is not sustainable. I mean, when you're talking about Blue Cross Blue Shield paying $240 for an MRI, you can't buy your new machine and sustain that. I think a lot of people are... And the thing is, in most countries we're working on older 1.5 Tesla magnets and there's been shown to be no diagnostic difference. But as the helium shortage escalates, which we feel strongly it will, and the independents have less buying power, I do think that the hospitals will find their way into this market, and it may be unsustainable at that point for the independence centers because they don't have the buying power. But that's going to be the big shift.

Ron Barshop: Think of all those little broken hearts. Think about those little broken hearts at birthdays aren't going to have helium balloons at that time. [crosstalk 00:27:09] pizza.

Cristin D: Yeah. We need to pump them into our MRI machine.

Ron Barshop: So Kristen, what is your vision for Green Imaging in the next five to 10 years? What do you guys look like a few years out?

Cristin D: I think about that a lot. I want to provide low costs imaging nationally. I don't want to lose the touch that we have where it's radiologist owned and we don't have private equity middleman. So I don't know what kind of growth we can sustain doing that. But my favorite thing is to go in and help an employer. They can save 10% on their total healthcare spend just immediately if we just do a quick educational process and incentivize their employees appropriately. I don't ever want to grow beyond being able to take care of patients appropriately. So we'll see. We'll see how we're able to scale that.

Ron Barshop: Well, I'm glad to see a warrior as smart as you in the transparency movement and in the flattening movement and we love having all the best and brightest we can attract, and you're certainly one of them and you're accomplishing. I applaud you. So two questions, where can people find you? And the second question would be if you can fly a banner over America with a simple message to all Americans, what would that message be?

Cristin D: Wow. That cost does not equal quality in health care. That's my simplest message. There are no studies that show the cost and quality correlate appropriately. And number two, you can reach us at www.greenimaging.net, N-E-T. If you do .com you will end up in Canada.

Ron Barshop: Okay. Nobody wants to end up in Canada from Texas. By the way, it's nice interviewing somebody I can actually understand with a Texas accent.

Cristin D: Born in Austin, born and raised here.

Ron Barshop: Love it. Yeah, I can spot that Austin in you. All right, well thank you for what you brought to the show today and we're looking forward to keeping up with you as you grow in the future. Thanks again.

Cristin D: And I look forward to hearing more from you. Take care.

Ron Barshop: Thank you for listening. You want to shake things up? There's two things you can do for us. One, got to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing, and leave us a review. It helps our megaphone more than you know. Until next episode...