Primary Care Cures

Episode #49: Dutch Rojas

Ron Barshop: You know, most problems in healthcare are fixed already. Primary care is 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 is totally inaccessible to most of the employees. The big squeeze is always on for docs, it's the acceleration of costs 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: Have you ever read a quote that changed your thinking about something important? Today's guest is one of those quotes, if not my favorite quote in all of healthcare, and I'll get to that in a minute, but first I've got to address a headline I saw this week. Last week you heard from a guest of ours, Rebecca Love, who is a nurse practitioner who is a thought leader in that space. And the headline I saw this week was a dentist was selected to head the National Institute of Nursing Research. So the NIH is the biggest pot of money for nursing research and they just hired a dentist to oversee everything. Well, the problem with that is nurses represent the largest category of caregivers in primary care. In fact, all of care with 250,000 graduates annually. But the fallout rate, wait for it, is half after only two years. Wow and wow.

Ron Barshop: Undervalued they say, and only 2% of articles written about healthcare talk about nursing, so they also feel invisible. I was with an HR exec for the largest hospital in Houston last night, and she said hiring and retaining nurses with five to seven years experience is the bane of her existence. It drives her nuts. In most States, nurse practitioners have restrictions as to the scope of their practice. Why? Well, docs say they lack the 10,000 hours of training that Malcolm Gladwell counts towards becoming a Beetle, if you're a band member or Steve Jobs, if you're a geek. You need 10,000 hours to get to genius. And residencies for doctors are about 12 to 15,000 hours, so there you go. Even if a nurse were to do 10,000 hours and have it under their belt, there is still no pathway for them to practice widely and deeply as a physician, even though they're called doctors of nurse practitioners.

Ron Barshop: So I heard today from a nationally respected family practice doctor, when I asked him about this why. And what he said was the 10,000 hours, he

often finds are poor hours. He said they're given by a bad teacher. And I'm saying to myself, "That is not logical because the same could be said of good and bad teaching hospitals." The same could be said of bad and good chief residents of good and bad hairdressing teachers for God's sake. "So what if the 10,000 hours came from a good instructor for the nurse," I countered and he didn't have an answer. So why can't nurse practitioners provide a wider scope after 10,000 hours of genius time and practice? They are after all doctors," as I said, well, it's likely economic. I always follow the money when I'm trying to figure out what's going on. Long as doctors can bill these providers out higher than they cost it's too profitable to let them fly solo, so keep them down.

Ron Barshop: I learned last week the chief of nursing officers, our lovely title with very little budget authority and the true path to make a difference almost always involves an MBA, not a DNP alone. So a VP of nursing with an budget trumps a pretty title like Chief Nursing Officer. And it's not the case for MD's, they don't need an MBA to advance. So there's the rub. Here's some the nursing beef that I disagree with and we'll get to this summary here. They think that training should be federally subsidized like the doctors, but the problem with slots for MD residencies is that there's 60,000 paid to these docs over a three to four year period, yet they're billed out at 2.4 million each. That's a nice profit center that the federal government probably should not be subsidizing, I would rather see them lay off some of the debt of the medical graduates that are getting out of primary care.

Ron Barshop: So here's the takeaway from all of this. Choosing a dentist to lead a giant budget from the NIH dedicated to nurses is a very sad poke in the eye. And large systems that want to give a flip about nurses should give them VP roles and budgets to actually do the training, the hiring, the recruiting, the retention necessary to play the game properly and get rid of their nightmare. So, let's get to that quote that I read that changed everything I think about healthcare. My favorite quote before this one was from a former guest, Keith Smiths of the Surgery Centers of Oklahoma, and he said, "Why should we trust the guy driving the getaway car to solve the heist?" When I asked him if Washington can solve healthcare problems? So I thought that was pretty funny and pretty accurate. But this one's a little bit better and this comes from our guest today, Dutch Rojas.

Ron Barshop: "If a family does not have $1,000 in savings and a deductible of 4,500, does it matter if they even have healthcare coverage?" Dutch Rojas is a healthcare entrepreneur dedicated to making medical treatments affordable and accessible to all. Currently, he's the CEO of Sano Surgery, a bundled price network as well as the founder of Every One Health, a consumer marketplace to purchase medical treatments. Dutch emigrated to the U S from the Netherlands and has served in the U.S. Marine Corps from 95 to 2002 and Dutch, welcome to the show.

Dutch Rojas: Thank you for having me.

Ron Barshop: Yeah.

Dutch Rojas: I loved the rant. I really love that rant.

Ron Barshop: Well, look, these ladies, when you feel invisible and worthless, no wonder half of 250,00 are disappearing. That's a million nurses and we're losing half a million nurses.

Dutch Rojas: I can't even believe... I got to read about that number. That's... I just went like, I don't get shocked very often, but that's the first time I've ever heard that.

Ron Barshop: Yeah. So we don't really have a shortage of providers, we have a shortage of retention strategies.

Dutch Rojas: Yes. And you know, I've met with the Nurse Practitioner Association, they're not the most welcoming folks, especially if you're not a clinician. They...

Ron Barshop: Why do you think that is?

Dutch Rojas: Look, I think academia, right? Which is in parallel to what you just talked about, doesn't listen to non other academics. In other words they'll say, "Well, if you're not a clinician, how do you know what clinicians do?" Right? But they never really took the time to ask me or my firm what we did.

Dutch Rojas: They just dismissed it by way of saying, "Well, you don't know what we do." It doesn't matter that we built surgical centers and surgical hospitals and that we've dealt with large practices for 20 years, that didn't matter to them. So, I want to, at Sano Surgery, I wanted to integrate and asked the board members of the Nurse Practitioner Association for several years, "How do we integrate you into direct contracts?" And they literally just wouldn't even make the time to have a conversation. So, I don't spend many hours cold calling, so I just gave up on it. I said, "Listen, this is a conversation I want to have out of curiosity because I've served with a lot of great nurse practitioners." In the Marine Corps, you don't even get a nurse practitioner, you get a doc who's not a doctor and they fill bullet holes and they help people with amputated limbs.

Dutch Rojas: And so to me, I was like, "Hey, I think nurse practitioners serve a wonderful role in our world." Some like to be called mid-levels, some like to be called clinicians, some like to be called providers. I don't want to get into all that. But nonetheless, they serve a wonderful role in our healthcare

system. I think like you, they feel underappreciated and how do we fold them into direct contracting? And they didn't want to have that conversation so we never had it.

Ron Barshop: Well you've mentioned the word twice to some of our listeners may not be familiar with, direct contracting means exactly what?

Dutch Rojas: It means a contract between the rendering provider, whether it's a clinician, a mid level or a physician and the true payer, whether that's the patient as a consumer or the employer as a payer or whoever the payer might be.

Ron Barshop: All right. Can that also mean an MRI center or some other diagnostic center?

Dutch Rojas: Sure. It can mean labs, it can mean imaging, it can mean physician consults, it can be nurse practitioner, it can mean anything. Just the agreement between buyer and seller.

Ron Barshop: Okay. So if I have a large imaging group or if I have a large surgery group and I want to contract with employers directly, I'm going to go through Sano Surgery as an intermediary to make sure that I get the best match. Is that sort of what you guys are doing?

Dutch Rojas: Sure. I mean that's probably the... The largest part of what we do is we help physicians, clinicians that you just mentioned who are owners of either a radiology center or laboratory, where did your laboratory testing or a surgery center, surgical hospital. There's still physician owned surgical hospitals. We represent them and do a direct contract between them and the employer.

Dutch Rojas: We are not per se an intermediary. Right? You don't have to go through us, we just supply the agreement expertise and the understanding of what a fair price might be. And so we help them negotiate the contracts.

Ron Barshop: Well, so fair price is a very tricky word because fair price means to me, you're not talking to hospitals systems or big systems that have facility fees. So you're working primarily with independents?

Dutch Rojas: Well, surgical hospitals and surgery centers, ambulatory surgery centers have facility fees. Hospitals are more difficult to negotiate, but as we've been doing direct contracting for just under 16 years and so now they're finally figuring out that the country and employers and consumers are demanding them. And so more people are open to it. I mean, we have contracts with a good amount of health systems around the country.

Ron Barshop: Okay. And they're willing to price it at the same as the independents without the added charges is what you're saying?

Dutch Rojas: Oh, absolutely. Yeah, they're willing to give us a fixed or bundled price. There is a difference for the services they render. That's absolutely true.

Ron Barshop: Okay. And I want to unbundle the language of words like bundled packages. When I think of bundled pricing, I think of if I'm getting an arthroscopic knee surgery and there's a complication or there's rehab or there's anesthesia, it's all part of the price no matter what. There's no surprises, it's all wrapped in a nice, neat bow. Is that a bundled price?

Dutch Rojas: More or less. If I could be more articulate, as we work on bundles, you mentioned Keith Smith earlier, great friend and mentor to me, bundles on a contractual basis mean facility fee, physician's fee, anesthesia fee and an implant if you're talking about a knee replacement. It does not mean rehab. The reason it doesn't is because so many of our patients travel. Now I know there's probably some of your guests will say that all healthcare is local, but they don't really know what they're talking about. So, for non emergency surgeries and procedures that are intense, right? We'll call them surgeries for the sake of this conversation. We don't add things that people who travel can't participate in.

Ron Barshop: Okay. So you're, if I'm in Arizona where you live, I may or may not elect to get my surgery done in Phoenix or Tucson. I may have to go to Vegas or to LA or somewhere nearby. And so that's what you mean by travel. Okay.

Dutch Rojas: Absolutely. Yeah, we think there are seven to 10 at most locations where all total joint procedures will be done. So, if we look out three to five years from now, there isn't... total hips and knees will not be done at every single hospital in the country. The experts will be found and that's who everybody will go to, bar none and that'll be seven to 10 regions of the country, specifically cities and that's where all these procedures will be done. We will certainly see where outcome quality data, appropriateness data is magnified and an actual marketplace will exist.

Ron Barshop: It's almost as simple as how many surgeries that clinic does. In other words, if that system, if that surgery center is doing 6,000 a year, 3000 a year, they're going to be a lot smarter place to do your surgery than 300 a year.

Dutch Rojas: That's right. I mean like it's basic economics and industry principles that everybody believes in every other industry except in ours. And so, we were hired by a major league baseball team last fall and they said, "Listen, here's our data. We want to know who the top surgeons are for these 65

procedures that we do on a regular basis and we are only going to go to them." Right? And so we went out in mass found those surgeons, did all the testing that we could, found what we think are the best outcomes and the best price and then off they went for a bundled procedure.

Ron Barshop: I don't think I'd want to be that pitcher that has 65 procedures done on his body, would you?

Dutch Rojas: No, but we did have a really good client the other day. He's had two Tommy John's and he's still making it back to the major leagues. The guy throws a 102.

Ron Barshop: Wow.

Dutch Rojas: Pretty fantastic.

Ron Barshop: That's amazing. That's some heat. All right, well let's talk to them about the... Where do you think all of this is headed for you? Are you going to have contracts with essentially all of the surgery centers and you're just sort of the marketplace that everybody's going to think to go to?

Dutch Rojas: We hope so. We think that more... What we'll do more of is what we did a little bit of, like I mentioned for a major league baseball team. We think what we'll see is more independent truly direct networks where large companies, let's say over 10,000 employee lives, will hire companies like Sano to go out, look at their claims data, evaluate their claims data over let's say a period of five years and then say, where are the best physicians and facilities in the country, and then where do we go to do those things? And they'll own that, that will be a proprietary network to them. No one else will also be a part of it, no one else will own it. The good news is that rewards the physicians who consider themselves good physicians, right? Because now everybody has to be transparent. Everybody has to say, "Well, here's my outcomes, here's my pricing, here's my everything. Here I am, choose me." Just the way, same way you shop for a car.

Dutch Rojas: I know a lot of people will say we don't like that, but it is the same. It's all a commodity, it's just what's the value of that commodity and what do we base that value on.

Ron Barshop: So Dutch, you've been doing this for over a decade. Do you feel like that future you just described is getting closer because it just seems so far away? Probably when you got started.

Dutch Rojas: I think you know... Everybody that knows me says that I turned from the pessimist into an optimist the last two years. I've seen more adoption of these free enterprise ideas in the last two years than I've ever seen.

Ron Barshop: Do you feel like it has to do with the employers? Are they pushing it? Is the employee the pusher? Okay, so employers are demanding this now, that's what you're saying?

Dutch Rojas: I'm saying they call themselves healthcare activists today. And they are pounding on their desk and saying this is the way it's going to be and look, the only people who are going to get left in the dust are the carriers. They're making record profits today, but in five years it will not be that way and they know it and we know it and they've been put on notice. I mean large companies, big global brands have said to the carriers, "Look, you're with us another two, three years maybe and we're not ever going to do business with you again. You have not done right by us."

Ron Barshop: That's interesting. So whether they want to or not, Dave Chase says, "Every employer that is self insured is a health insurance company." Do you agree with that?

Dutch Rojas: Absolutely, I agree with that. Look, nobody wants to be a health insurance company, but everybody is, right? I mean I disagree with very little when it comes to Chase.

Ron Barshop: Well that makes two of us.

Dutch Rojas: We do have really good conversations, but we disagree on very little. Like he really does believe healthcare is local and I believe that for the vast majority of treatments, they can be local. But once it jumps from a procedure to a surgery, so instead of... Think of a procedure as an injection done by a dermatologist, an interventional pain specialist, right? An injection in your spine. Once it jumps to cutting, it's a totally different ballgame and everything will be... None of those things will be local anymore. They will also be so inexpensive because people like Keith Smith led the way.

Ron Barshop: Couple shows ago, I had a, I'm going to call him the Denton Cooley of India, on this show, a doc named Devi Shetty. He's the most preeminent cardiologist if not doctor out of India.

Dutch Rojas: Everybody knows who he is and if someone doesn't know who he is, they should look them up right away.

Ron Barshop: Well, Devi has a Cayman Island Cardio Facility that Robbie Pearl, who's one of my heroes, said is superior to American care. And Devi on the show explained why he thinks it might be superior. It's number one of ours, number one, that they've done surgeries, number of surgeries they've done. The price of the surgery is maybe 10,000 versus 150,000. But most importantly, the caregiver becomes, let's say the wife after the heart

surgery and she's taught how to dress a wound, she's taught how to cook the proper foods. She's taught how to make sure that patient gets rest, that her husband gets rest. She's taught how to do the rehab, physical rehab, so she's turned into sort of a minor nurse with videos, with training with ongoing support, constant calls, constant contact. We're not doing that in America. Is that something that we can learn from Devi Shetty and Indian model?

Dutch Rojas: I would disagree that we're not doing it because not means a finite period. There are physicians who do those things. Dr. Ella Gala, who runs Sonospine, one of my very favorite physicians in the world, he absolutely does those things for all his spine patients. He's a fighter against spines fusions. He's developed his own techniques, people fly from all over the world to him. I just met a professional golfer who was in his treatment room the other day. I mean, and he does the exact things you're talking about. Keith Smith's doctors do the same thing, so it's not that it's not done, it's just not pervasive. Right? Because in the reimbursement world, we're concerned about maximizing profits and not concerned about maximizing value and we're looking short-term like Wall Street wants us to and we're not looking long-term, which is how we ought to look.

Ron Barshop: Okay. Do you believe that we are overdoing spinal surgeries and back surgeries or do you think we're doing exactly the right amount? Or do you have any opinion on that?

Dutch Rojas: I have a nonclinical opinion about it, which is that the data shows that we're doing entirely too much. But you will get a lot of pushback from spine surgeons who say, "You're not a surgeon and that's not true." What we've found is when we work with data, we find that 30, 40% of these spinal fusions are no good. They produced no good outcomes. In other words, the patient was in pain out of six and they were able to do, they had limited function and they exited the surgery and four months later they still have the pain level of six and they still can't function any differently. So that data is very different from a spine surgeon who's got a world of experience, went to all the best schools, says everything it says, "My colleagues and I would never do a fake surgery."

Ron Barshop: If your brother-in-law or your best friend... Okay, so that's very instructive. If your brother-in-law or your best friend were to come to you and say, "Hey Dutch, I'm thinking about getting surgery X." Outside of the spinal surgery, which you just said is 40% ineffective, what surgery would you say, "Well, wait a minute, take a step back and there's something else that you should do before jumping into surgery."

Dutch Rojas: All of them.

Ron Barshop: Okay, really?

Dutch Rojas: Look, every single person in the United States of America who's considering having surgery on a non-emergency basis, right? If it's an emergency, that's totally different. By the way, that's only 4% of procedures total, so just kick that to the window. But everybody else better have a second opinion. If you are going to spend money, why would you trust one person? I mean, if you buy a house, how many people do you ask? "Hey, do you like this house? What do you think?" You ask your mom, your dad, your sisters, your brothers, your cousins, your friends, you show them pictures. When you buy a car, you do the same thing. Why would you do something different for surgery? I don't understand that.

Ron Barshop: Let me give you a theory. I don't know if this is accurate or not, but I think people put surgeons on a pedestal. I'm not sure how many professions people put on a pedestal in America. It used to be maybe the po-po and the firemen, maybe not so much anymore. I think people still put maybe a nurse on the pedestal, but surgeons are on a pedestal, people are almost intimidated to talk to a surgeon and waste their precious, valuable time. So to disrespect them by questioning their brilliance and going to a second surgeon seems impolite at best.

Dutch Rojas: Well, I think that's a viewpoint that people over 50 carry, that's not a viewpoint that people under 50 carry. The difference is that it's not meant as disrespect by asking a question, right? And that's how our society has become is like, "Oh, you asked a question, therefore you must be disrespecting me." Well, no, it's not disrespecting you. You want to open my chest like dear God, ask all the questions you want.

Dutch Rojas: I mean, I know a hundred surgeons that love getting questions from patients. They don't say, "Well, you're dumb for looking it up on Google." Now I have encountered those physicians and I have to have a serious conversation with them. I'm like, "Don't ever talk to a patient that way." But people, you're working on them, you're a doctor, you're supposed to take care of them. So that means you have to baby them at times and that's okay.

Ron Barshop: Well, you mentioned another issue that I think is a big one, Dutch is that I am... It's not in my top 20 concerns, but I'm deeply concerned when patients start telling doctors what medications they want, what surgeries they want to order, what procedures they want done.

Dutch Rojas: That's just silliness.

Ron Barshop: [crosstalk 00:22:52] testing because they come into this doctor's clinic and their WebMD smart and they're not getting good information and I'm not

saying WebMD is bad information, but they're coming with something they've Googled, they've got a bad source and they're requesting a test that has zero value that has no diagnostic interest to a doctor.

Dutch Rojas: If you're a doctor, why would you do that? Tell him to get out of your office. "Hey, no, go away." You're the physician, you're the responsible person. Tell him no. I know why doctors give in like I know a lot about interventional pain in orthopedics and when you have people in a tremendous amount of pain on a regular basis that they live with, they can ask you a hundred times and a lot of times the physicians will just give in. "Okay fine, you can have this medication." But at the end of the day it's not the responsible move because it's their license on the line. You give somebody the wrong medicine, you get to pay the fine or go to jail, not anybody else.

Dutch Rojas: So look, we shouldn't order unnecessary tests. Patients shouldn't be asking for whatever drug they want. The physician should be administering the drug they think is best for the patient.

Ron Barshop: So, one of my favorite things to do on this show is talk to smart people like you that have plain speaking abilities. You've got both of those apparently on you're a Marine, so thank you for your service. But, here's my question is there are so many interesting problems going on in healthcare today, like burnout and I mentioned the nursing issue, like physician shortages. What do you see as, there's no such thing as a one size fits all solution, but what do you see as the solution to physician burnout? I don't want to go into a surgery and have my doctor 50% chance he's had a bad morning.

Dutch Rojas: I mean that would take us all day and probably all next year to discuss. Physician burnout is a result of many factors. Some are personal things. Look physicians... And I'm telling the whole truth, right? Don't be mad. Physicians every day come out of med school, residency, internship, fellowship, and then as a 35 year old first year at a private practice physician, will go out and buy a super fancy car and the biggest house on the block and then they'll say, "Dutch, why am I stressed out all the time?"

Dutch Rojas: So, physician burnout isn't just loans, it isn't just what patients do. It's a lot of times the result of, "I deserve this after I've achieved this." And so physician burnout it has a lot to do, mostly I think it has to do with the financial bind that people put themselves into. And you don't have to be a physician to be in that bind, 90% of America is in burnout mode. So yeah, I mean really tough to get around, plus you have the limits on how many physicians, how many specialties, right? That's a function of Congress working with the American Medical Association. Then you have physicians who want to own part of a surgical hospital or be a part of a

hospital and they're kicked out because that's now illegal. So there's a whole bunch of factors for physician burnout.

Ron Barshop: Well, I have a solution we'll have to share over a tequila when I come to Arizona in a few weeks.

Dutch Rojas: That'd be great.

Ron Barshop: I don't want to waste our listeners time with my idea. So we're here to talk to you.

Dutch Rojas: I know you have lots of good ideas.

Ron Barshop: Well, so let's talk a little bit about the next steps. What else does San's doing to further the aims of the company and to make the transparent free market economy simpler and easier for employers and employees and doctors?

Dutch Rojas: Well first I think we have to define who's actually important in the equation. We believe the triple win is important. I say it all the time, it's about the physician and the sustainability of their practice. It's about more private practice physicians, not the acquisition of health systems. It's about patients and it's about the true payers, IE the employers. And so if we can solve the problem for the three of them and create an equitable system, then we'll win. And in order to do that, I mean you have people like me and you have hundreds like me who say, "Well, we have to get away from the carriers."

Dutch Rojas: Well what does that mean, getting away from the carriers? Well that means more direct contracting, more actual disintermediation of the carrier business. And I think we'll continue to see that over the next few years. There's a larger move to that than I've ever seen before, at least in my 18 years of service.

Ron Barshop: Great. Okay, so Dutch, I have a trick question I ask everybody and nobody's yet passed this test. If we could find a banner over American, you could give Americans one message on that banner, what would it say?

Dutch Rojas: Don't give away your freedom, it came at a big price.

Ron Barshop: You know, you're the first guy to do that on a banner instead of on a constitutional document. Thank you for that short answer.

Dutch Rojas: I mean it's the best I can do.

Ron Barshop: Yes. Very nicely done. How do people find Sano Surgery if they're looking for you?

Dutch Rojas: Sanosurgery.com, S-A-N-O. Sano means healer in Latin. So-

Ron Barshop: In Latin? Okay.

Dutch Rojas: Yeah.

Ron Barshop: How do you say it in Dutch?

Dutch Rojas: Salno.

Ron Barshop: Salno, very similar. Okay. Because you do speak Dutch and we did try to test each other out and failed at that.

Dutch Rojas: That's right. I'm glad we failed at that, we don't want to succeed at that.

Ron Barshop: No, Dutch. So, I really mean that about the tequila you're buying and because I'm traveling to get there, so that's going to happen.

Dutch Rojas: Wonderful. It's been a joy to talk to you. Thank you so much for having me on. I hope I provided your listeners with a little bit of good content and a nugget to walk away with.

Ron Barshop: Absolutely. Thanks again, Dutch.

Dutch Rojas: Thank you.

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