Primary Care Cures
Episode 101: Tim Raderstorf

Ron Barshop:
You know most problems in health care are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance 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 cost, deceleration of reimbursements. I want you to meet those in this show that are making a difference. With us, Ron Barshop, CEO of Beacon Clinics, that's me.

Ron Barshop:

There are four issues with nursing that we're going to be talking about which directly impact primary care. The first one is that chief nursing officers are popping up everywhere, but most have no budget to recruit or to retain, and no true access to the C-suite leadership without a budget. It's a fluff title with no spend in many cases. It's somebody to talk to when you've worked your 12th 12-hour shift with no pee break, no food break.

Ron Barshop:

MDs and DOs have almost a $600 million federal budget. Those funds pay for the $60,000 a year residencies and fellowship salaries that give them their 10,000 hours of expertise, which is kind of a joke because they're billed out at 20 to 30 times the 60,000. They cover their pay in weeks, not months, yet one is still subsidized and nursing is not. Thank you, hospital lobby. Hat tip to the American Hospital Association, but I digress.

Ron Barshop:

Back to nurses, they have no such federally subsidized apprenticeship, so no parity in learning on the job. To the rescue, state legislatures. Cali just approved nurse practitioners that will have now parity with MDs after three years of supervision under an MD, so their scope of practice is that basically of an MD or DO, with a few minor exceptions.

Ron Barshop:

That's now 28 states that have MD equivalency with nurse practitioners. It was 21 when we interviewed Rebecca Love this time last year and talked about nursing then. This is a sea change, and there's winners and losers that get very mad at this thing that's happening with nursing equivalency.

Ron Barshop:

Number one, docs are very PO'd right now. Hey, they sacrificed five to seven years to learn medicine. These nurses didn't take any MCAT. They didn't take no stinking boards. They didn't pass all these equivalency exams. They've been saying this for decades, and the nursing community looks at this as basically pushing them down to economically benefit from these formerly mid-levels, and now they're basically not mid-levels anymore.

Ron Barshop:

The second is students. Suddenly your path into medicine requires a lot less school debt. That's a very interesting thing we'll be talking about today. The third thing is the patient. Will you get the same equivalent care with a nurse as you will with a doctor? One could argue you'll get better care. In some instances, one could argue you will get worse care. We're going to talk about that again today.

Ron Barshop:

The last issue is the winners and losers list that I like to bring up in public policy. Is this good for public policy? Boom shaka-laka. It solves the doc shortage programs that we have. Who wins? It's complicated. If the patient loses ... and I'm not saying they do ... that's not a good thing, but there are lousy residents who become lousy docs, so expect a lousy apprenticeship with nurses too.

Ron Barshop:

Today, we get a nursing point of view on all of these big questions that have direct equivalency to primary care. I'm going to introduce you today to Dr. Tim Raderstorf. He's the Chief Innovation Officer at The Ohio State University College of Nursing and the Head of Academic Entrepreneurship at the Erdos Institute, and the Chief Operating Officer for NursesEverywhere. He's given TED Talks, he's written textbooks, and Tim uses every platform he can find to empower those on the front lines to change healthcare. He was the very first nurse to hold the Chief Innovation Officer title in academia. Tim, welcome to the show.

Tim Raderstorf:

Thanks so much for having me.

Ron Barshop:

All right. Well, do you have any comment on what I said? I try to be even here, but boy, did the doctors get pissed when you guys won another victory in the state.

Tim Raderstorf:

Yeah. I mean, it's hard to listen to your rant there without having my blood pressure raise a little bit, because it's not about doctors and it's not about nurses, it's about patients, and that's where we need to be coming at this with the focus level. I'm most particularly interested in the components you talked about last there about patient outcomes, and this doesn't need to be an either/or scenario. This can be a both/and.

Tim Raderstorf:

I think it's time for healthcare leaders and clinicians across the world to swallow our pride and really start developing patient-centric care versus patient market share. That's where we need to land here, is where can we figure out how to deliver a high-quality healthcare system that, frankly, we're not doing right now. We have the best and brightest talents in the world, so we need to come together and develop a solution that puts our patients first and improves our clinical outcomes.

Ron Barshop:

Let me describe to you what I think patient care is going to look like from a nursing perspective in the next 10 years. I think the care team of the future is going to be probably led by nurses. The care plan may be put in place by a doctor, but the nurse will have a lot more direct contact with the patient on the day-to-day, for a lot of different reasons that we can talk about.

Ron Barshop:

I think that the patient, I've lost 45 pounds in the last two years by walking a whole lot more, getting a lot more vitamin D, which turns out to be a winner for COVID. I'm eating differently because my body's changing, and I'm hydrating better and I'm sleeping better. That can all be managed by a nurse. I don't need to go in and see a doctor, and run a copay and run a deductible to get better health. I just need to have a care plan that actually I know that I'm doing the right, next best thing. Does that sound like a future where everybody wins?

Tim Raderstorf:

It does, absolutely. I mean, we have to move from sick-based care to health-based care, and health and wellness particularly. I know that this is something that people are talking about frequently now, but the next crisis that we face is going to be a mental health crisis. We're in the beginning stages of it right now. That's not something that we know that you fix with a script. That's something that you fix with CBT or other metrics, things you fix with what you said about eating right, exercising right, getting enough sleep.

Tim Raderstorf:

These are all things that are going to require a personal touch. That doesn't mean that it has to be a nurse. It can be a physician, it can be a PA, it can be a community health worker. Again, it's all about leveraging the assets that we have. The greatest asset that we have in the U.S. health system is the nursing population, 4 million strong, making up somewhere between 50 to 60% of healthcare professionals in our country. We need to better leverage that, and we need to give them better autonomy to be able to do so.

Ron Barshop:

I want to talk about the autonomy for sure, but let's talk about the burnout. I learned from Rebecca last year that of the hundreds of thousands of nurses that are trained every couple of years, half of them burn out in two years. We can be adding. It's almost like we're going backwards. We're not even moving forward because of this burnout factor.

Ron Barshop:

These prized nurses that have five to seven years experience, oh, my gosh, everybody wants a piece of them, but they can't get them because there's not enough nurses to go around. What is being addressed at your university and at your medical center to deal with this issue, so that they feel like they have a voice and feel like they have some kind of leadership looking out for them?

Tim Raderstorf:

We're very fortunate to work at The Ohio State University, where the Dean of our College of Nursing, Dr. Bernadette Melnyk, is also the Chief Wellness Officer for our university. As we're recording this, literally last week at this time, she was hosting the second biannual Clinician Well-Being Summit, which focuses on providing clinicians not with resiliency, but with the tools that they need to be able to navigate health systems, while also advocating to the health systems that things need to change.

Tim Raderstorf:

Being resilient is not the answer for this. That puts the blame on the clinician and the provider. Boy, with all the burden that's already being placed on clinicians right now, whether they be nurses or physicians or whomever, there's no need to shift even more burden onto them and say that this is their fault or they need to develop more skills to be able to navigate this. The system is what's broken.

Ron Barshop:

Yeah. I'm with you brother, and I'm not even a Christian, but I praise you, what you say, because resiliency is not the answer. It's like telling the coal miner to be resilient when you don't give him the tools. You're going to put a nurse in a front line. You're going to give her gowns that she has to recycle every three days and a mask that she has to recycle every three days, and tell her or him that, "Hey, dude, get it together. It's not our fault, it's your fault."

Ron Barshop:

Resiliency just, I think, is so overused. It's a ridiculous term. You can't expect people put in harm's way to be resilient. You've got to expect them to be protected and taken care of. I don't know how this is going to bounce back in some of the hospitals. I know your hospital is probably better at this than most, but some of these hospitals that are still teaching resiliency after they've done what they've done to their front-line staff is something that's going to come back and bite them.

Tim Raderstorf:

I agree. It's going to be in the ways that you talked about, with clinicians leaving the profession. Again bringing this back to the patient, that's where it hurts us the most. I'm an innovation guy. One of the main reasons that I love innovation is because it improves patient outcomes. Let me explain that to you, though. It's not by people developing new technologies and widgets and gadgets. Those are intended, but very inconsequential often, because most people don't get to that phase of launching their ideas.

Tim Raderstorf:

When people engage in interprofessional collaboration and innovation practices, that improves clinician job satisfaction. When we improve clinician job satisfaction, we decrease clinician burnout. When we decrease clinician burnout, we improve patient outcomes. Getting our clinicians involved and engaged and empowering them to be innovative in their practice and to solve the problems. Instead of saying, "Hey, be more resilient," it's, "Hey, come to us with your problems. What are you facing? What do you want us to solve for you?"

Tim Raderstorf:

A lot of times, saying back to them, "We'll probably be better off if you solve this yourself. What resources can I give you to solve this problem for our organization?" Instead of taking that burden on as a leader who doesn't understand the problem, giving it to the front lines and allowing them to self-select and self-solve the crisis at hand. The organizations that do that, I think, are the organizations that are going to succeed.

Ron Barshop:

I think there's models out there that have already accomplished what you just said, Tim. I see, for example, direct primary care funded by employers as a quintuple-lane win, meaning the patient wins ... let's talk about them first. The doctor wins, they're happier. Those are the happiest conventions in America, DPC conventions. Then you have the employers are obviously big winners, participating 20 to 60%. Then you have the population health is improving, because people are reversing and eliminating the need to go to the ER. Their need for medications, their need for length of hospital stays shrinks, and the fifth theme is cost. The costs go down overall for the system. Doctors, patients, employers, population health, money wins. Everybody's happy.

Ron Barshop:

The other model that seems to be working is we've interviewed ChenMed and others that are full-risk, value-based care. When you go full-risk, the incentives are in place again for everybody to win, as opposed to for one or two or three parties to win. This idea of a business model that can change healthcare I think is what's going to be taking hold in the next decade. That's only good for nurses, and it's only good for nursing.

Tim Raderstorf:

I agree. Some of the things that you've left out when you talk about the future of nurses and nursing, I see nurses becoming much more engaged in their community. I think in those 28 states that you talked about, you're talking about independent scope of practice and equivalency for physicians for nurse practitioners. I think we're going to continue to see nurses rise to the top of our scope of practice. You're going to be able to see retail clinics that are run by nurses. There are going to be things that are regulated to allow for nurses to be the front lines of care. We're going to start seeing RNs, not APRNs, take on a more active role in the health and well-being of our communities.

Ron Barshop:

You just raised the blood pressure of every physician listening by saying that. How would you address that, Tim, when they are saying, "Okay, go get your MCAT and then I'll listen to you"? They're very upset about this equivalency because, A, we're not creating enough doctors, so we have to do it with nurses and with PAs. What are nurses doing to get that confidence, instead of referring out to another doctor a problem that they can't deal with, where they can actually deal with it right hands-on themselves? What types of 10,000 hours of training are they getting, in your overview of what's going on?

Tim Raderstorf:

One, I think, without taking this too personally, I think it's disrespectful to say that nurses aren't qualified already to do that. We are highly educated individuals and healthcare clinicians. I think that that point is moot.

Tim Raderstorf:

Two, without pointing fingers, I'd say to all of our clinicians, the system we have right now is not working. That's clear. If you look at the data of nurse practitioners versus physicians ... and I hate the word versus there, because this isn't a versus. Again, this is about patients.

Tim Raderstorf:

If you look at patient outcomes for who they're being cared for, until we get to the tertiary care, nurses and nurse practitioners, the data shows that we're providing equal or greater-than care than our physician counterparts. I don't mean that disparagingly. I think our physicians are great. I think our system is set up for failure. I think that it's doing a wonderful job at pitting us against each other, instead of figuring out how we can be complimentary services to everyone.

Ron Barshop:

We had Devi Shetty on the show, and he's a world-famous cardiac surgeon ... and every American can now go to see him in the Caymans, COVID permitting ... but he gave a very interesting take on why nurses and nursing has actually got to be pushed into the home. What they do in India, they simply don't have enough caregivers, so they have to teach the wife or the husband of the person who went through the surgery how to caregive as if they were an RN. They teach them wound setting. They teach them hygiene. They teach them nutrition and exercise and rehab, and they basically push into the home just a highly-specific rehab plan for that cardiac recovery to the spouse, to the loved one. What are your thoughts about that? Is that something that America might see someday?

Tim Raderstorf:

I think involving the family in the care is essential. I think a lot would have to change. I don't think that it's necessarily fair to call a one-week or one-day or whatever training that a caregiver, a home caregiver, someone who's taking care of a family member, equivalent to RN care. I'm not saying that we need to be territorial about that. Again this becomes a both/and situation. Where can we move our nurses to the top of their practice? Where can we move other individuals who are caring for patients to the top of their practice, and where can we rely on our communities to help with care?

Tim Raderstorf:

I don't think there's a nurse in the world who would argue that having loved ones taking care of their loved ones is a bad thing. I think what we need to make sure of is that, again, it comes down to the outcomes, that we're leveraging our resources appropriately and we are maintaining a clinician workforce, whether that comes from nurses all the way to physicians, that is not getting burned out and getting eaten up internally by the process, worrying about if they're going to lose their market share instead of worrying about how we're going to care for patients.

Ron Barshop:

Doctors in surveys, the last Gallup poll of doctors, 75% would not recommend their children go into medicine because of their terrible experience, their coal miner experience. What would you say to your children if they said that, "Dad, should I get into nursing?"

Tim Raderstorf:

I'd say, "Absolutely go for it," but let me be honest with you. I was going to be a physician first, and I had that conversation not with my parents ... my parents were not physicians ... but my godfather was a physician. He was a world-renowned neurosurgeon, and I didn't even heed his advice. I kept pushing through it, without identifying all the red flags and barriers in front of me that being a physician was not the right path for me.

Tim Raderstorf:

He said to me, in the prime of his career, "If I had to do this all over again, I would be a high school chemistry teacher." I was young and naive at the time. I was 21 and didn't really take that to heart. The older I get, and having children now, I realize what a gift that was he was giving me. I wish I could have adhered to that a little bit faster in my life. Eventually I did heed his advice, but it took me some more scars and lumps before I made that decision.

Tim Raderstorf:

When it comes to my children wanting to be a nurse, it has been an incredibly rewarding experience for me. It's taken me to areas that I had never dreamed of. I did a direct entry program to come into nursing. My first nursing degree is a master's degree in nursing. Even in finishing that, I had no idea that a role as a Chief Innovation Officer would ever be a possibility for me, much like when I was 16 or 17 and excelling in the math and sciences and STEM in high school.

Tim Raderstorf:

Did I ever think nursing would be a possibility to me, because I went to college prep school and everyone said to me, "Oh, you're great at those things, you should be a physician"? That's one of the things I'm also very passionate about, is getting young men and women who are traditionally getting pushed into professions that have been regarded and heralded in the past that may not be as great for people anymore, opening up doors to other ways to care for patients, to care for people in their communities.

Ron Barshop:

We had as a guest Catherine Tesler. She won the Lady Bird Award. I think that's like the People's Choice Award for nursing. The people actually elect the nurse that treated them the best in this award. She's interested in a management career. What would you advise someone like Catherine ... she's in her early twenties or mid twenties ... to do to advance her career as you have in nursing, to the heights that you've achieved?

Tim Raderstorf:

Well, the first is to do some self-assessment and determine what do you really want to do. Because when I started this, I thought it would be wonderful for me to run a health system. You mentioned CNOs. The more that I worked within health systems, I found that being a CNO is not the right fit for me. If you're looking to get into management, you have to dangle your feet in the

river of opportunity. You need to say yes a lot and you need to say no very selectively, but then, the way that our system is set up in the country, you also need to find a way into higher education.

Tim Raderstorf:

Now, I am incredibly biased, but I think we have one of the best programs to prepare healthcare leaders in the world. It's our Master's of Healthcare Innovation program at Ohio State. This is all focused on innovation leadership and changing systems, because the leaders of tomorrow are not the leaders that we trained 10 years ago. The leaders who are going to get us through this crisis are the leaders that we are training right now.

Tim Raderstorf:

They're going to be the people who are at the front lines, who are going to take their lumps. They're going to take notes, and they're going to realize what worked well and what didn't. If you can find a way to couple that with the right credentials, then I think those are the people who very quickly will rise to the top of leadership in the next five to ten years.

Tim Raderstorf:

Because the other beautiful thing that's happening right now too is that we are entering a phase where we had so many pioneers in healthcare IT that have led their organizations to new heights, and are now moving on to either retirement or other frontiers. There's a ton of Chief Information Officers and Chief Innovation Officers and directors of technology at organizations that are transitioning out, and a new generation is coming into those roles. I'm incredibly excited to see what this young talent pool is going to do for healthcare moving forward.

Ron Barshop:

You chose, when you wrote a textbook that was number one when it came out, to talk about innovation leadership, and you also chose in your TED Talks to address innovation leadership. Can you talk about what is innovation leadership in a commonsense language so we would understand it, not too academic, please?

Tim Raderstorf:

Absolutely. The easiest way I think to think of innovation is as the process of implementing new value. If you can create something for your organization or your system that defines or brings in a new value that was previously unrealized, then that's where innovation occurs. There's a novelness, a novelity to this, of what people think. "Okay, if it's been done before, then it can't be innovation." Personally, I disagree with that, because I think almost everything in the world has been done before. What you have to do is, within your system, be not a change agent. You don't move from A to B. You move from A to B with value, and that's innovation.

Ron Barshop:

Or move from A to Z and skip B and the middlemen, and just go right to the end result you want?

Tim Raderstorf:

You know, this may sound weird coming from a Chief Innovation Officer, but that is incredibly hard. What you're talking about is disruptive innovation, and moving from one component to the next. It's very hard to do in general, but in healthcare, which is a behavior-based environment, disruptive innovation is incredibly, incredibly challenging.

Tim Raderstorf:

I wouldn't say impossible, because we're seeing a bunch of things, now that COVID has hit, that I would say were disruptive and impossible or nearly impossible in the past occurring quickly, but things that other people are saying are amazing right now like telehealth, which has been around, Ron, for what, 10 years?

Tim Raderstorf:

We're finally opening up the doors to things that were very incremental. They're very obvious. That's what healthcare tends to do as we innovate or bring in new systems. We just follow the incremental innovation pathway. That's not necessarily a bad thing, but because there's so much behavioral change that needs to occur, healthcare is really challenging to do disruptive innovation within.

Ron Barshop:

Well, I invite you to subscribe to my show, because you'll meet all the people that are doing exactly that on my show. That's who we find as guests. I probably have 25 shows out of the last hundred that we've done that feature people exactly like that, that are just sidestepping the system and doing something completely abnormal, enervating, scary. It works because people are so sped up.

Ron Barshop:

Well, Tim, this has been great. I've got to tell you, at least once a year I've got to have somebody of your or Rebecca's caliber because ... and it's too bad we're not video, because y'all are so good-looking and I'm so not. That's why we choose not to. It would be such a good move for us to talk once a year about nursing at least, and all the innovation and change, because again, 21 states a year ago, 28 states. I suspect if I talked to you or Rebecca a year from now, we're going to be talking about a lot more states. Don't you think?

Tim Raderstorf:

I agree. I mean, there have been regulations put in place during COVID that are allowing even more states to do it. There's been pushback from the American Medical Association, trying to make sure that those are dispelled once the pandemic leaves, but the argument here is if it's good for our patients now, it's going to be good for our patients always.

Tim Raderstorf:

Let's continue focusing on what's great for our patients, not worry so much about what's great for our egos, and make sure that the United States continues to move upward in patient outcomes instead of continuing to fall backwards, which we've done relatively consistently for the last number of years.

Ron Barshop:

Great way to close the show. Tell us, Tim, how to reach you if we're trying to find Tim Raderstorf.

Tim Raderstorf:

Yeah. I'm a big user of LinkedIn. Find me on LinkedIn at Tim Raderstorf. There's only one out there, the blessings of a strong, misspelled German last name.

Ron Barshop:

If you could fly a banner over America with any message, what would that be?

Tim Raderstorf:

Be kind.

Ron Barshop:

You know, that is such a good message. It actually fits the banner, and it's not talked about enough. We have been so unkind to each other in the last ... I don't know if it's the last year or if it's just a long-term trend, but a great message. Thank you. Tim, we'll bring you back and get an update. Thanks for your time.

Tim Raderstorf:

Thank you, Ron. I appreciate it.

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.