Primary Care Cures

Episode 134: Niran Al-Agba

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

What is the best way to upset nurse practitioners and physician assistants? Just call them extenders or mid-levels, watch the food fly. And, how do you upset MDs and DOs? Call them providers. Words matter because today in 36 states they've approved NPs in full or near full authority for their scope of practice as physicians. There's three states that are doing the same for PAs. Private equity and big systems and nurses themselves are behind this push for good and unholy reasons. The good is that nurses with appropriate experience are still employed by docs, in the old days, to profit, so they can see more patients and build the nurses out at doctor NPI rates. So, they're paid 30% less, so they became a profit center and they didn't like it. So now in 36 states, they profit off their own labor if they choose to go into practice for themselves.

Ron Barshop:

And, the unholy reason is that they are 30% less cost to hospitals and private equity groups, but they tend to order and are pressured to order more useless tests and procedures that make volume centric models like most hospitals very happy, and they add nothing to the outcomes, all these procedures and worthless tests. In fact, there's a worthless test ordered every 15 seconds in America, and they're simply about profits and bonus achievement. So, the nurses I know well hate this role they must play and they would flee in a second if they had a better opportunity. So they're sadly margin feeders, according to several studies touted by today's guest. Now 60 years ago, physicians established NPs and PAs to offer better primary care. So, this was really all about a supervised assistant, if you will, who can do a lot of the roles with a doctor, see more patients.

Ron Barshop:

And, today those numbers have kind of flipped on the primary care world and that 50 to 75% of NPs are still in primary care, the rest are not, and 33% of the PAs are in primary care, the rest are not. Why? Well, it's kind of obvious. The specialist can pay more and they make more and big systems and private equity backed groups vacuum up these folks, so they can provide other types of care and pay them more and earn more EBITDA. So, remember the scope of practice is ever-

widening so they can, for example, cut beneath the skin in some states or prescribe them medication class one, class two with no supervision of a doc in some states. You therefore may see, literally, nurse GI specialists or nurse brain surgeons, neurosurgeons with no testing, training or supervision, and have zero reason to be in that operating theater.

Ron Barshop:

But this may be rare, but it's a very real and fearsome possibility. So, today's guest is going to teach us about direct entry and that is where you can say, let's have a bachelor's in economics or journalism or liberal arts, and that now gives you an entry point into nursing school, any bachelor's, not pre-med, not biology, but journalism for goodness sake. So, there are several NP programs with 100% acceptance rates, no fails. What do we call those? Diploma mills, and yet what is the best trusted profession in every Gallup poll for decades in America? Nurses and doctors are always fighting it out for annually number one spot. So, this is a problem. People don't know about this yet. They trust these folks, and are these diploma mills getting reported or are they self policed? I don't know, but today's guest does. Let's talk, MD and DO hours of practicum before they're allowed to actual practice.

Ron Barshop:

So, we know from reading all these great books that 10,000 hours is how the Beatles got to be the Beatles, and that's how Bill Gates got to be Bill Gates and Steve Jobs got to be Steve Jobs and it takes a doctor not 10,000, but really when you throw in the two years of medical school, about 15 to 16,000 hours before they're allowed to get out in the real world and practice without supervision. So, that's two years of medical school, three years of residency, and then many have a fellowship of two to three years as well. So, what does the nurse have to go through for the same practicum to get out in the real world and practice for themselves? 500 hours to 2,000 hours, and it's even less than for PAs. So 36 states, remember, have scope equivalency. So the big question, is this safe for patients to be treated if a nurse or a PA is not supervised until they have thousands of hours practical experience?

Ron Barshop:

That's really the question for us today and let's be fair, on the nurses' side, they have no federal funded residency. The feds pay teaching hospitals nearly $600 million annually to subsidize residents, not a dime for nurses or PAs. So, what are they supposed to do? Make it up? They're asking a fair question here. So, that's the rock and the hard place we have to work between today. There are two nursing teaching programs that have lost accreditation in the past year. One of them in the Bronx called Lehman College, and one of them called the Medical Prep Institute of Tampa bay, and there's others under investing, the so-called diploma mills. So, hundreds of nursing students were scammed. They didn't get their credited hours, they're not getting a refund. What about the nurses who practice today as graduates of these sham schools and their patients? Another big question.

Ron Barshop:

This is an interesting set of problems we've got here. So, appropriate training and supervision is the crux of this whole issue. Now some states also, I want to talk to today's guest about, have a one to six supervision ratio like Texas, some like Florida have a one to 10 ratio. I don't know

what the rate is for hers in Washington, but it's all different across the country, and sometimes the doctor has to be on site where the nurses and the PAs are, sometimes they don't. Most of the case they don't and I'd argue that's not supervision, that's profiteering. That's good lobbying. So, there's a lot going on here and to sort all this out and we're going to welcome Niran Al-Agba. She's a pediatrician in private practice the past 20 years. Following the footsteps of her dad and her grandad, treating the third generation of her dad's patients now, pretty cool. She recently co-authored Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare. You've seen her articles in Fortune MedPage Today and the Seattle Times. Welcome, Niran.

Niran Al-Agba:

Thank you for having me and what a great intro. There's so much to cover.

Ron Barshop:

It's a lot of meat, isn't it? None of this is small stuff.

Niran Al-Agba:

It isn't, and the only thing I would disagree with is it's not all that rare. So, today you're probably about as likely to see a doctor as you are to see a doctor nurse, and they may not tell you they're a doctor nurse. They may just say they're a doctor too. So, I would argue that now if you go into any ER, or urgent care, frankly, you're more likely to see a nurse practitioner or PA as your primary care person in that setting.

Ron Barshop:

Niran, my read of your book is you're not anti-nurse, you're not anti-PA, you're anti-private equity and big system is really turning this into a profiteering system.

Niran Al-Agba:

Absolutely, thank you for getting that and leading with that, because to be honest with you, that is really what got me. I am the antithesis of the large corporation. I've had a small business, it's been in existence 50 years and it's continuing to remain as an independent facility in independent practice. And so, everything I stand for is for patient safety, for the patient, and really against these private equity and corporate takeovers of a business that really shouldn't be a business. Healthcare is an art and it's a calling and it's a profession.

Ron Barshop:

So, it's kind of like the mouse that roared. They're sitting on BlackRock billions, and you're sitting on a small megaphone. What do you hope to accomplish with this book? I know it speaks the truth, but what is your fondest expectation?

Niran Al-Agba:

Well, my fondest expectation, which you're going to think I'm a little crazy is that first of all, I've given up on politicians, I've given up on corporations, you're right, they have millions to throw at us. So, I really wanted to reach patients with this book. And, if I reach doctors and I reach other

healthcare professionals, that's great, but I really want to arm patients. I often say I have the smartest patients in the world and they keep me on my toes and they help me take good care of them. And so as part of it, I want to take better care of them and arm them with information, so they can empower themselves when they're in a setting when I'm not treating them. So they can ask, who are you? What is your education? Are you a physician? Are you a nurse with a doctorate? Are you a PA with a doctorate in medical science? What is behind the title doctor?

Ron Barshop:

Let's dig into some of these issues. Are there any medical schools that have lost their accreditation like these nursing schools have? I just looked at 2020, that was in one year we lost two and it looks like there's another one or two that might be on the platform to plunge over the edge as well.

Niran Al-Agba:

Not that I know of, and again, I didn't exactly look at that to prepare for this, but I have not heard of any specific medical schools in the US that are having their accreditation called into question. But again, we've had the Flexner Report for nearly... Well, actually 100 years, and we've really standardized our education, and that's a part of this book that the nurse practitioners who've read it really say, "Wow, this is a problem in our profession." And, I am absolutely not anti-nurse, anti-PA, anti-anything. I'm pro-patient and I think most nurse practitioners that I've talked to, and there are many I've talked to who have said, "We need to clean our own house. We need to make sure we are training great clinicians." And it can be done, it just needs to be done carefully and safely.

Ron Barshop:

Well, I'm going to make an argument that the most powerful lobby in America based on getting the martial funds is the hospital lobby. American Hospital Association got 175 billion, no strings attached, didn't need the money, won't ever use it for anything other than acquiring independent practices more than likely, and here you are essentially telling the American Hospital Association that you need to now consider funding a residency for nurses, which they're never going to do, the feds are never going to do, to give them the equivalency of the apprenticeship that you got.

Niran Al-Agba:

Well, you know me, I'm not telling the American Hospital Association anything. I think hospitals are a disaster. I think as much as we can stay out of hospitals would actually be better for patients, and I think that essentially, we're going to have to do it despite the American Hospital Association and whether or not that is other nurses training other nurses, whether it's academic centers putting on these residency programs, essentially we need to think about the professionals we're churning out to take care of patients. So, we've got to do something.

Ron Barshop:

There's six states that have now done something very interesting with foreign medical grad, just it's kind of exciting, and this might work for nurses too, and in fact I think it's already in place, but six states have said, "You know what, if you already went through the gauntlet in India,

Mexico, any of these countries where you're considered a doctor and now you come here, you can skip residency if you come to our state because we're definitely in need, particularly in the rural areas of you doctors that are already trained." So, they're skipping the residency, but for three years, you do have to work under the supervision of an American doctor, so that you can learn our system. Do you think something like that would work across the country for nurses?

Niran Al-Agba:

Well, there's kind of two answers to that. First of all, I think it's a brilliant idea for physicians. My father was an FMG. He was educated in Iraq and then came to England, got his pediatric training in England, came here and had to do one year of internship and then a year of a chief position in New York before going on to do his endocrinology fellowship. So, I'm a big fan of FMGs because I think often they're trained extremely well in many of the countries that they come from. So, I think that is brilliant. I think the same idea, this transition to practice idea for nurses is not a bad idea, but I would love to kind of talk about where the profession came from because to me this is the way it should have worked.

Niran Al-Agba:

Our problem is primary care, and a lot of these programs are training what they purport to be non-physicians in primary care, which I don't think is a bad idea, and the original study was done in Canada actually, in Ontario and the Burlington trial and two family docs went to McMaster's University said, "Hey, we need help, we're full. We have these two wonderful RNs who have excellent skills. Can we put them in a training program and then have them see some of our uncomplicated follow-ups and some of the more basic protocol-driven conditions that really kind of take our time and isn't really practicing to the top of our scope?" So, they did that and essentially it was a resounding success. These two nurses came back, they started seeing some of the more straightforward follow-up conditions and they actually could see about to 45% of the patients on their own.

Niran Al-Agba:

They needed some help or intervention on a few of the others, but it allowed the practice to increase their ability to take patients by 22%. So, if you could expand on that idea and have really well-trained nurses with graduate or master's degree level education starting to work in primary care with... And, I didn't say for because I don't really want to own or become a profiteer physician either. So, working with someone who has really good skills and then maybe working, maybe it's three years, five years.

Niran Al-Agba:

I would have to go through and kind of figure that out, but essentially starting out seeing the followups and then bridging and branching out more and getting more and more experience. I know this is a long-winded answer, but I do think something like that could work, but again, we're not sending out primary care trained nurses into ERs to work alone. We're not sending PAs out into urgent care centers to work alone. That is an entirely different conversation, and that's where the private equity firms have really taken over, and they'll put anyone in these urgent cares and ERs, and then patients don't know. So, I do like your idea of the transition to practice and I think it could work very well.

Ron Barshop:

There are some exceptions. I don't know that I want a nurse and an anesthesiologist to be putting my child to sleep when they're getting some work done, unless they're trained in that specialty, but there are nurses that do specialize in and do a fellowship, if you will, in areas like that, aren't there?

Niran Al-Agba:

There are, and specifically my answer was really geared towards primary care because this argument about putting... A lot of the organizations are right. I'm in a small, underserved medical area and we really don't have enough doctors out here. I'm a pediatrician who sees adults, and I don't really say I love to see adults, but a lot of adults can't find a doctor, even temporarily to help with asthma, to help with colds and coughs, pretty basic things. There's just no one else, and so that is a real problem, especially as we get more and more rural. So, I do think there is this gap we need to fill and I think that's what we've talked about is training non-physicians maybe to do that. That's very different than going into a hospital and operating on a child or a anesthetizing a child, or specializing in GI or neurosurgery or you name it.

Ron Barshop:

So, what is the happy medium here for primary care? If the primary care is going to survive, it's going to need to throw more bodies at it. What is your answer for that? I think for medical graduates is the answer because we have 15,000 PDs that are trained and they're just waiting to go through slotting and they can't get enough slots. There's only 5,000 slots. So, there's a backlog in internal medicine PD, and FMGs are the beautiful solution in that they can go to rural areas, they'll tend to work with gerontology more than American doctors. They'll work with the aged population, Medicare population. I don't know that the answer is going to be so-called mid-levels to fill in the gap that we're having with this silver tsunami.

Niran Al-Agba:

I agree with you. I think the foreign medical graduates is frankly my number one request or idea to help with rural care. I think the second option would be to uncap or fund more residency slots. We have so many unmatched graduates. I think there's about 10,000 floating around right now that have finished medical school. So, in medical school you had said two years, it's four years actually. It's two years of academics, and then two years of all clinical work before we then go on to residency for another three years.

Ron Barshop:

I meant the practicum, the actual time when they're seeing patients, touching [crosstalk 00:16:28]-

Niran Al-Agba:

Exactly, so again, we have 10,000 US graduates in medical schools that cannot find a residency position to then train and go out into the clinic and see patients. So again, we have a double backlog, I think FMGs is the first place we should go. The second place is to expand those residency slots and to fund those positions, and then if at that point we've exhausted that opportunity, I think that nurse practitioners really can help support these rural areas and I think it

can be done right. There's so many wonderful nurses and nurse practitioners, as well as some PAs out there. I'm not as familiar working with PAs collaboratively, so that's something I'm not as hands-on about, but I work with a pediatric nurse practitioner myself. I did look for a doctor, I couldn't find one.

Niran Al-Agba:

She has been a pediatric nurse, she did not go to a diploma mill. She went to a brick and mortar school, and frankly, she is appropriately scared out here in a small setting, and we talk all the time. She goes home and reads. She talks about how much more she still has to learn, and she really works hard and loves patients. That's the kind of person you want to work with. And I want to be clear, she does not work for me. She works with me. She is growing her own practice and we are sharing overhead. And so again, I think there are great ways to do this and expand ability to care for patients, but we just need to be really careful and we need to put the patient first. Everyone needs to put the patient first, the doctors, the nurses, the hospitals, the lobbyists, and I know that's a pipe dream, but it's still what I think needs to happen.

Ron Barshop:

I have an elementary school chum who's now on the national board of the AAFP and he said he's never through learning. He's always interested in learning more, and it's a lifelong passion for him. He's 62 years old.

Niran Al-Agba:

It is, and my father, I remember when we had a hair tourniquet, which is just a hair can get wrapped around a child's appendage, and I was going to have to cut it in a certain way, and I looked at him and I said, "Is this how I have to do it?" And he said, "I think so, it's the best I can come up with." And I said, "Well, when are we done learning?" And, he was 81 when he died and I think we had this conversation about six months before he died, and he said, "I don't know, I'll let you know when I'm done learning."

Ron Barshop:

Wow, so Niran, what do you think adding slotting looks like? The feds aren't going to do it. They're not going to come up with that money. They, since 94, have been trying to add slots. I have a theory and I want to try it out on you and see what you think. So right now we're slotting, the slots are about 60, 65,000 per resident, and when a school stops teaching, like what happened this year, they auctioned it off for over a billion dollars, these slots. I don't know what it worked out per slot, but it was a big number. Why? Because the average resident is built out at about 1,000,008. So, if they're costing them 65,000 minus the 65,000 they get from the feds, so they're basically costing their [inaudible 00:19:24], that is a massive profit center for them. And, I don't think that we need to fund a single residency slot. I think if they're already profit-making machines, just encourage the schools to add slots that can add slots because if it's a profit machine, why do they have to have the 60,000?

Niran Al-Agba:

Well, it's a great point. I suppose we could somehow just add in slots and I don't know the details because to do that, I know the ACGME oversees it. I know they have rules and regulations they

have. You have to have a certain number of cases per resident. For example, if you're doing family practice and they do their nursery month, there has to be 45 babies, I think, that they see, and some of these smaller hospitals have trouble meeting those benchmarks sometimes. So, I think there would be some details to work out, but again, I think what's interesting is we're going to end up fixing this problem anyway because what's happening now, and what I'm sort of becoming involved in is a number of... In particular, in the cases that I'm reviewing, children are dying. They're just dying of simple cases, whether it's pneumonia, whether it's sepsis, whether it's influenza, children are dying all over the country when they go to these urgent cares and ERs, and they're not staffed by physicians.

Niran Al-Agba:

And so, those legal cases are kind of winding their way, they take about five years or so to get to completion, and they're winding their way through the legal system and then we're getting large settlements in the one to 2 million to $6 million range and lawyers, I love lawyers because I think they really are going to shine a light on what kind of problem we're having right now. Once these cases start winding their way through the courts, I think it's going to start costing hospitals more because when they're settling for 6 million, maybe let's say 10 million, whatever it is on a regular basis, and I am aware already hospitals realize that. They're starting to question credentials of non-physicians, looking at where did they go to school, looking at these diploma mills, things are happening.

Niran Al-Agba:

And so, I think what ultimately they're going to be forced to do is having non-physicians working independently without the proper training, so not in primary care is going to cost hospitals more than it's going to make them, and they're going to turn around and look at those $65,000 residents and say, "I think this is probably a better investment." So, I do think you are correct that hospitals will ultimately, because it is a cash cow, it does train more physicians, it would help with our shortage, I think they are going to eventually head in that direction. It's just it's going to take time for this tide to turn.

Ron Barshop:

I wonder if when they make a settlement if the malpractice pays or if they have to come out of their balance sheet to pay.

Niran Al-Agba:

It doesn't come out of their balance sheets, it's their insurance. However, remember to buy insurance once you've had a $6 million settlement... So I'll give you an example, the case in our book, which is the $6 million settlement I'm talking about, the Alexus Ochoa case. That hospital actually closed after... I'm not saying it's a direct cause. However, within about a year of that settlement, that hospital El Reno, it was a Mercy hospital in El Reno, that actually they said, "We're going to go bankrupt, so we're just going to close." And, they just shut down. So, you're right, it doesn't come directly off their balance sheet. There is no CEO that is saying, "Oh, here's half a million from my $5 million salary, but ultimately it becomes harder to insure the care being done at the hospital, and there are other problems associated with these multi-million dollar settlements.

Ron Barshop:

So, let's switch gears a bit and talk about a subject that's not in your book, but I wanted your opinion on. There is an independent practice resurgence that's occurring with direct contracting. Direct contracting is where large employers contract directly with primary care, not DPC onesy, twosy Kool-Aid stands, but it's getting organized now. There's three companies that have gone public or who are about to go public, two of them, including Everside, which used to be Paladina, including Babylon, which has 25 million patients worldwide and based in London and which includes One Medical. So, there are some subscription models that are no longer in the fee for service business, no longer in the value based service business, they're in the monthly collection business. And if docs migrate over there, by my estimation, somewhere around 25,000 independent docs now work for these organizations because there's 30 million patients. Do you think that's an out for the independent doctors as a solution?

Niran Al-Agba:

I do. I think if you're an independent doctor who wants to work for a large company and still wants to be technically employed, then I do think that that's an option. However, with all things when you try to scale up, and medicine's really interesting because we always talk about scaling. A lot of people look at how to scale it, and to be honest with you, it's really hard to scale up because, and again, maybe I'm narrow-minded on this, and my view of it is I'm on third and fourth generation patients. I have one for four generations who has seen a Dr. Al-Agba, to me that's a phenomenal thing. It doesn't exist in this country anymore, though it did used to exist 100 years ago. And, there's something special about that, there's something really unique about the care, not only for the patient, but think about me for a second.

Niran Al-Agba:

My job is actually easier because I took care of the mother as a child, I took care of the father as a child, and maybe I went to high school with the grandparents or whatever it is. It's really unique in that I can know everything about that patient in my head. And so, I do think when you scale up, while it is better because you are running a subscription model and you are focusing on a niche, you are directly contracting with the patient. So, it does help with costs. There's some amazing things about it, and again, I think it's way better than working for a hospital. I think I'm one of those people that's kind of fiercely independent. I often say I'd have to chew my own arm off probably before I'd really want to be employed by anyone else. So, there's always that kind of fierce independence running through-

Ron Barshop:

My uncle in Fort Worth is you. He worked for 62 years until he retired on four generations of Fort Worthians, if that's what you call them, and when I go to Fort Worth, there's 22,000 people who directly were benefiting from my uncle and I get treated like royalty down there.

Niran Al-Agba:

I had a new patient yesterday and she's 36 years old and it actually was her child to be fair, and she said, "Your father saved my life when I was four months of age." And I said, "Wow, that's quite a..." I don't even know how I'm going to hold a candle to the care he provided. And, she told the story she's heard since she was a little child, her mom saying, "I went to a couple

doctors. I came to Dr. Al-Agba," which is obviously my father, and he diagnosed meningitis and carried her in his arms across the street to the hospital to put her in the ER, do the spinal tap and do the evaluation, carried her himself across the street, and the thing is you can't get better than that.

Ron Barshop:

I don't know any hospitalists that can tell that story. I don't know many in corporate practice in medicine that can tell that story. So, this is a beautiful reason why you got in the business, why your dad got in the business, why your grandfather got in the business and why maybe even your children will follow your footsteps.

Niran Al-Agba:

My son for sure. I have three sons. The youngest one definitely wants to be a doctor. I'm still holding out too hope that my daughter heads in the same direction.

Ron Barshop:

Well, that's good. Good on you for accomplishing that. That's a rare thing today. So, if people want to find you, Niran, what's the best way?

Niran Al-Agba:

Well, let's see, I write for the Kitsap Sun Newspaper, a bi-monthly column, and we're doing a deep dive on medical choice in the Supreme Court this summer, which is kind of fun. I'm at niranalagba.com. It's my kind of personal site, and then Silverdale Pediatrics is my practice and sort of my livelihood and my life, and my email is real simple. It's niranalagba, with no hyphen, @gmail.com. So, I'd love to hear from listeners or readers or people who have questions or just want to talk.

Ron Barshop:

Outstanding, and if you could fly a banner over America with one message for everybody, what would that say?

Niran Al-Agba:

It would say patients first always.

Ron Barshop:

I love it. All right, well thank you for coming on board today. We learned a lot and it's a complicated subject. I think you unraveled it very nicely.

Niran Al-Agba:

Thank you, it was a pleasure being on. Thank you for having me.

Ron Barshop:
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