Primary Care Cures

Episode 146: Sean Kelley

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:

Okay. Place your bets mission or money in healthcare, what wins? Well, let me start with wow, because I just learned big pharma apparently owns the US Chamber of Commerce, who together are on the wrong side of 99% of chamber members, employers who are going to benefit for Trump and now Biden transparency mandates to publish med pricing. Transparency is a winning political stance on both sides it looks like, but the US Chamber is suing with the pharma lobby to stop all this ridiculous transparency emanating from now two presidents of opposing parties. What a rare but lovely concept. So the once great chamber joins the Chief Preservationist Campaign along with co-opted once great. Preserve secret pricing, and you preserve decades of gaming the rest of us. It's a tired position, it's a throwback and it's a guaranteed loser. How do we know this? Because big hospitals sued on similar grounds and loss to HHS.

Ron Barshop:

They argued in court that we consumers are simply too dumb to understand transparent pricing. The published prices only help competitors yet 85 to 90% of metros have monopolistic pricing among the one to two big hospitals there last study I saw. So what competition is fair to ask? Big arguments were hollow in court are empty today on the meds issue too. Most of the big systems who also must post pricing on 300 common procedures, aren't even complying only 10% last count and they've had nine months, but all of them must next year or they get to see risk slap fines of 104,500 a year, which works out to 300 bucks a day, their cost of band aids. So what are we looking at maybe 20% complying? What do you think? We see a proposal by HHS to grow these silly fines by 10 X, but let's wash the bigs crawl fish out of that led by their mighty lobby.

Ron Barshop:

They already got a six month extension because nine months plus three months, hasn't been long enough. And Medicare advantage plans are now freshly exempted from said hospital transparency. Well done lobbyists for Humana and United Health Group. Oh and AARP, a new sales division of United you never heard of, to double ARP you know about. The vast majority of insurance bigs growth came from federal plans. 88% of profits for the United unit the past 10

years came from federal plans. So the large and small employers are fleeing their paternalistic giant commercial plans with never ending rate increases. And most of most employers are now overwhelmingly going the root of self-funding. But that too is now losing some ground to the guests on my show who have opted out completely from big middles. About 30 million of us employees by my count. And that's just the CEOs who appeared on my show that are servicing about a third of the fortune 100 and most of Silicon Valley, Walmart and others who are now going the direct route with some or part of their health spend.

Ron Barshop:

So well over 18% of us, 160 million workers are now opting out. That's a lot. That's serious. That didn't exist even a few years ago. So we cash paying employers are skipping expensive bigs altogether as middlemen and direct contracting with the likes of today's guest, a transparent surgery center where you get your scopic knee surgery done in Austin by 11, eat Franklin's barbecue at noon and her tube and down the Comal river after lunch.

Ron Barshop:

Okay, he's shaking his head. So maybe that's aggressive, floating in your baby pool might be a little safer on that new knee, but pick up the ribs and the potatoes salad and the Corona light on the way home because you're in Texas. Healthcare is an expensive, big middles are monopolistic carriers and they're wholly own kickback addicted three card money playing PBMs are the ultimate big middles. They end other big monopolies invented low outcome care and it's expensive and it's uniquely American, but changing rapidly with this cash paid healthcare economy that's building, if we place 37th in the past Olympics, a few months ago, heads would roll, but that's our world rank in health outcomes. Croatia, 36 Costa Rica, 38 USA, 37.

Ron Barshop:

Together those two countries are the same GDP as Milwaukee, but I digress. Back to the once upon a time great US Chamber. When did the US Chamber ignore its 300,000 non-pharma members in favor of lobbying lockstep with 150 pharma employers? And not just lobby suing the president and HHS. When did the chamber pick money over mission? About the same time I'm guessing that AARP was lured by the big commission from selling United Health Medicare Advantage plans to its members. AARP has turned into really an insurance brokerage arm of United Healthcare than a force for silver-haired good, their Medicare Advantage sales dwarf member dues for over 30 million seniors. So AARP supported Obamacare when three fourths of the members didn't and opposed transparency when over three fourths of the members supported it. Gobs of steady revenue from big's Trump mission for these guys too, they too are ignoring members like the Chamber.

Ron Barshop:

And while we're talking mission, the AMA, American Medical Association lured by CPT code licensure fees now receives only 10% of its revenue from member dues. I'm from Houston, medical city USA, and only 12% of the docs there belong in medical city, USA. Over half of those are residents and medical students forced to join. They don't get a vote. Ironic that the once great AMA offers burnout courses for docs while licensure fee cash rolls in for 12,000 CPT codes causing the burnout. They too are seemingly ignoring their members and they're voting

with their feet. And the finest medical journals seem to have become really peer reviewed marketing journals for the bigs. Nobody has time to read them anyway, but they all know that the medical devices and big pharma pretty much vet what articles are not going to be published. If you're a reader and you're seeking the truth, you've been ignored money over mission again.

Ron Barshop:

And if you're not mad at me now, you'll never be. I'm poking fun at everybody today. So we published the missions of these mentioned in today's shows plus a few health charities for grins. It's all directly coming from their websites. And I promise you'll tisk tisk when you read some of their mission statements, because they're so far away from them, it's a joke. So we employers, we consumers, we taxpayers we're left as losers when betrayed by these institutions like the US Chamber who devolve into foot soldiers to canoodle with the bigs, their new true masters. They've all lost their way. These formerly great institutions seem to be living their mission statement from another era. The new mission statement should be cash is king baby. And is all this sinister? Well, if you've lost anybody to medical errors, arguably. If you've been permanently disabled by the medical industrial complex, yep. Or if you've been financially devastated. Yep.

Ron Barshop:

That is the plot line of plenty of sinister characters in movies and TV. But members who pay dues when abandoned by their associations are what not awake, not aware? I don't know. This is simply auctioned integrity earned by ancient victories these institutions seem to be coasting on from decades past and it's just bald faced all about the Benjamins and keeping cush jobs at the top and the complacent board of directors that run them are not asking enough hardball questions. They seem to be asleep. But happy days are ahead as we all win with the likes of our guests today because today's guest is all about transparency and outcomes and clarity for consumers and integrity in pricing and quality that is not for sale today.

Ron Barshop:

We welcome Dr. Sean Kelly of the Texas Free Market Surgery Center, it was established to offer bundled surgery pricing with centers in both Houston through Cypress, the suburb and Austin, Texas, all at reasonable and published rates on page one or two of their site. You can come into Austin, Texas as I said are Houston and leave on the same day and you'll save a bundle of money because you'll see the pricing is ridiculously low compared to the bigs. Now you met last year with Dr. Keith Smith who started this transparent pricing surgery movement in 94 in Oklahoma. Now we meet the second leader, but whose accent I can understand because he's a Texan. Welcome Sean Kelly.

Sean Kelley:

Thank you, Ron. Pleasure to be on your show today.

Ron Barshop:

Great. Do you have any comments of about what I said before we get started?

Sean Kelley:

Well, a quick comment. We changed our name a couple years ago. We've just now made it public, probably in the last six months. We're called Texas Medical Management now.

Ron Barshop:

Okay.

Sean Kelley:

And I can explain later on, we've expanded beyond surgery. And the other thing you're right. You're not going to be able to go Franklin's and float down the Comal or the Blanco or any one of the beautiful rivers here, same day of surgery. But you could go a couple days after.

Ron Barshop:

Okay.

Sean Kelley:

Or you can come another time. But yes, come to central Texas, come to Houston medical city. I love it. I grew up there. And so I know all about it. In fact, I was a great beneficiary of it. As a kid, I was sick. I had cancer. And so I'm a very big proponent of the Texas Medical Center in Houston and love it.

Ron Barshop:

Did you say you were sick with cancer as a kid?

Sean Kelley:

Yep. I had acute lymphocytic leukemia when I was 10. It was 1976 and three years and three months of chemo and the doctors at Texas Children's and I'm fortunately one of the lucky ones.

Ron Barshop:

I don't normally ask these background questions, but that influence your want to be a white coat?

Sean Kelley:

Yeah. So the other comment is I'm not a doctor. That's my brother and sister. I'm a business person. My brother's a cranial facial surgeon. Sister's a pediatrician sisters at Texas Children's my brother's at Dell Children's. It did influence... I'm the only one of the three that went to undergrad for pre-med. But unfortunately, or fortunately, however you see it, I found the fraternity house and the keg and things like that. And so my grades didn't do very well. So I took a detour, went the business route, finished school, got into business, went through several different careers, one in Louisiana, another overseas in Venezuela for a number of years, and then came back to the states and got back into medicine.

Sean Kelley:

And I've been working on the business side since 2005, trying to change things up a bit. First inside the system for a decade, the Ascension system here in Austin, it's a seat and hospital system working with my brother building surgical groups, but also at the same time learning all

of the stuff that was going on behind the scenes. And so when you talk about transparency, that's the last place in the world that there's anything transparent. And I learned all about that. And then I also learned where there were great opportunities to not only drive down cost, but also improve quality at the same time, which is an unusual will combination as you know, in business.

Ron Barshop:

Well, so you run with this transparent surgery model and you're now doing some other things I want to hear about, but I see on your website, the Herculean task of publishing all in bundled and guaranteed surgery prices. Did that require nine months plus some exemptions for you to get that published?

Sean Kelley:

No, no, no, no. Funny enough, so my brother's... Besides being a cranial facial surgeon, he's also trained in microsurgery and reconstructive plastic surgery. So he did a lot of co-cases with a lot of great surgeons here in central Texas from 2005 to around 2000, I guess, 14. So over a decade. And when we first started talking about this idea, we knew we could improve on the quality of surgery by selecting the quality surgeons, which is really not something that the networks, the carrier networks or insurance companies, or even your employer, anybody helps you with. And so what we knew we could do that, we knew the inside baseball. My brother had operated with doctors he would never operate with again and never send anyone to, but then he'd also operated with really great surgeons. So he had a list. And so when we first started on this idea, we were like, okay, we know we can produce better quality, great.

Sean Kelley:

We knew we can produce a better experience. Great. And then we also knew that we could really reduce cost. And we knew that another great benefit would be able to just simplify the whole thing. As anyone who's had an episode like surgery or... Most people when I talk to them, they get a little confused about, well, what's the benefit of a bundle? You just say birth. And when anybody has had a child, they understand it's bewildering, because you start getting this avalanche of bills coming in and you're like, well, I didn't even know that person was involved.

Sean Kelley:

And so I think that's really a great experience for people to see just how disjointed and siloed our healthcare industry is. And you as a patient are not protected from anything. Everybody sends you a bill, it's based on whatever they say is their price. Nothing's transparent. And really it's all filtered through whatever your health plan has agreed to, smart or not smart. And so the way we did it was we sat down and having built and run surgical groups for a decade I knew that the doctors were not getting the lion share of dollars. I didn't know this until later, but I found out later on that out of all the surgery dollars spent in the US in a year, 7% of those go to the surgeons.

Ron Barshop:

Oh, I had dinner with a Nigerian or a orthopod about a year ago. And I said, "What did you make on your surgery today?" And he goes "About $1,800." And I said, "Well, I'm looking up that particular surgery now at Surgery Centers of Texas, they have it's less than 20,000. You're telling

me you made 1,800 out of 20,000?" He goes, "Well, there's the joint that was replaced." He goes, "There's the devices that are put in them. In other words, there's the anesthesiologist, there's the facility fee. The hospital's making a take on top of the facility fee." He says, "Yeah, I get less than 10%. And I don't think it's 18,000. I think it's going to be more like 70 or 80,000." So yeah...

Sean Kelley:

Yeah. And so when we first started down this road, we knew the surgeons weren't making out and the surgeons are continuously beat down in terms of their reimbursement. And it's more and more expensive every year to bill and collect. In fact, the last year I was in the industry, the big organization that publishes this information, the MGMA said that surgical practices spent 30% of revenue on billing, collections and bad debt. So it's really complicated. It's frustrating. It's lots of bureaucracy. Each of our surgeons, well, the orthopedist employ five full-time people to do their billing and collections efforts. So it's a really bad system. And so what we did was we went to the surgeon, we said, "Okay, we're selecting you because you're really great." And they said, "Well, great, but I've got a lot of referrals that other doctors in the community know that I'm a good surgeon. So I'd appreciate sending me business, but I'm not lacking for it."

Sean Kelley:

And we're like, "Okay, well, let's see if we can make it worth your while." And so what we did was we started off by saying, "We'll pay you a lot more." And the way we did it was we just calculated a number based on time. And then we came up with a number and then, of course, everybody then compares it against what they're currently being reimbursed. It turns out we're paying anywhere from two to four times what the carriers are paying, the insurance companies. And then we also pay them within seven days. It's usually between zero and seven days. And when we do that, we pay them cash. We don't hold back part of it. We don't deny claims. We take care of all the pre authorizations, all the administrative stuff we take care of on our side.

Sean Kelley:

And so when it comes down to it... Oh, and then they don't collect any money from the patients because our clients, the self-funded health plans, employer health plans will share the savings with their employees and health plan members by making it completely free. And so you can imagine from the surgeon's perspective, it's like, "Oh, that sounds pretty good. Let me try that." And it's not difficult. They just do surgery, which is what they always do, right? I mean, that's their job. They see patients, we do ask them to try some other facilities that we're contracted with. Sometimes it's the facility that they do their surgery in it on a regular basis. Sometimes it's not. But the surgeon is the one who always makes that call whether or not he or she will be willing to operate in a facility that we contract with.

Sean Kelley:

Fortunately so far, we've been able to do that without missing a beat in Austin and in Houston. So back to your question about, did it take nine months to create bundles? We had these things, we called the Deep Eddie sessions and we'd bring in the surgeon and my brother and I would sit at this big granite table in this conference room, a friend of ours office in West Lake, Texas. And we had a whiteboard and we had a half gallon of Deep Eddie vodka and a 12 pack of Topo

Chico, and Austin's pizza. We didn't get Franklin's barbecue. It's a little expensive and it's long line, but we got Austin's pizza. And we sat there and we went through, what is their surgical protocol? What do you need, Michael Yen? He's an ENT that works with, what do you need Brandon Smoot?

Sean Kelley:

He's an orthopedist that works for us. What do you need to get the great outcomes for that problem? That bunion, for instance, for a foot and ankle surgeon or that tonsillectomy for the ENT what do you need? I need one pre-op, Sean. I need to be able to see the patient, put my eyes on the patient, touch the patient, talk to them get any imaging. Great. We'll handle that. And then the surgery, I need an hour. I need this facility. I need these implants. I need these sterile supplies. I need these people in the room, a surgical tech that's got subspecialization and my specialty, I need a surgical nurse. And then I need about an hour and a half in the post acute I need anesthesia and I need an overnight stay, or I don't need an overnight stay. And then I need a couple follow up visits. And we said, okay, we'll pay you for everything.

Sean Kelley:

How do these numbers look? And we would show them the numbers. And they'd say, let me talk to my office, come back and say, those numbers look great. Let's do it. That's how we built the bundles. And it was our job then to contract with everybody else in the bundles. So in the example I gave you, it would be the facility, anesthesia, and if there's any implant or sterile supply. And so we're able to negotiate quite a bit better than Blue Cross, just saying. I don't know why that is, but that's the way it is today. And when we negotiate, we always make sure that everybody that's operating or anybody that's involved in the bundle is it's an obligation to make a profit. You can't try to say, "Well, Sean, we'll lose a little bit of money on these so we could get some more."

Sean Kelley:

I said, no, no, no. It's, it's always got to be profitable for everyone. I don't want anybody not being rewarded for being involved in this because we want price stability. A lot of our prices, the majority of our prices are the same prices we've had since 2016. We don't change them very often. Occasionally we'll have a facility that needs an increase in cost. That's a lot of times due to labor cost, sometimes it's due to implant costs or sterile supply. The surgeons themselves have never asked for an increase. And the reason is, is because they're getting dinged downward every year by insurance companies and ours stays the same.

Ron Barshop:

Yeah, I was speaking with Keith Smith and their pricing has been the same or lower 94 on every item they have. They haven't raised their price on anything in 20, almost 20 years, 30 years. So a friend of mine I had dinner with last night is needing hip replacement. She's got bone on bone after running for decades on the uphill left hip, which that differential pounded over 10 millions of steps. It's nothing left. There's nothing left. So she unfortunately took a steroid. So she's got to wait 90 days and she's going right to hip surgery.

Ron Barshop:

And I said, I need you to talk to my guest I'll be on the phone with today on my show with. So let's start with the fact that she's the Chief People Officer of a decent size company. And she has a $3,000 deductible. She has 80, 20 coinsurance. She's not, I guess, paying cash out of her own pocket. How do you work with employers so that you get your cash rate of... For that hip surgery it looks like it's over 20,000 on y'alls website. How do you get your fee out of the insurance slash cash combination so you can work with employers that have traditional insurance?

Sean Kelley:

So employers that have traditional insurance are SOL, I'm sorry. The big traditional insurance companies will not deal with us. You can make up your own reason. And I've made up mine about why that is. We make them look bad, whatever, but they are very compliant when it comes to working with their own network partners.

Ron Barshop:

Well, I'm looking at what a hip replacement costs, according to the association of hip and knee surgeons, the cost of hip replacement in the US is 30,000 to 112,000. They survive on volume, not on savings. You would think that an insurance company like the blues, you mentioned, want to pay the lower end. And of course y'all are 30% below their lowest number. But they're not incentive at all. They win when they grow and they grow only by paying more, not less.

Sean Kelley:

You're absolutely correct. It's the 15% rule.

Ron Barshop:

Yeah.

Sean Kelley:

So you're right. And so when occasionally we'll get people who come to us and say, I'm really excited about your model. I heard about you. Some, some friends I've got Blue Cross and on a number of occasions, we've called up Blue Cross and said, would you work with us? Here's our deal. And in fact, your surgeon, our surgeon, sorry, is on your network. And they're shocked, because they think we're using a bunch of foreign medical grads. Maybe we're using some residents, stuff like that. And I'm like, no, no, no. Our surgeons are all on Blue Cross, United, Cigna, Aetna, and all the carrier networks. These are the top surgeons in our communities.

Ron Barshop:

Well, let's switch to a different scenario where it's a cash pay scenario. So let's say it's a self-funded employer. I don't know if they are or not. If they're self-funded now that as if they are paying cash, because now they're the insurance company. So you could do a self-funded employer.

Sean Kelley:

Well, we can, as long as they don't have a carrier ASL, an a administrative services organization that is where like say United has the network, has the TPA, has the stop loss has everything. In

that they've built up these walls of resistance and there's no way they'll deal with us. but you're right. If it's a self-funded company that does have an independent TPA, they can rent a network. If they're renting a network or they're in RBP reference based pricing, they absolutely will work with us.

Ron Barshop:

Okay.

Sean Kelley:

And so the carriers and them are very smart about making sure that companies and their members are trapped in these models so that they can't spend money outside of where they make money.

Ron Barshop:

Right. So how have you fared during the pandemic? Has this been a good, bad and neutral thing for y'all?

Sean Kelley:

It's been great. The first couple months because of the scares and the shutdown of the surgery centers and a lot of healthcare facilities back in March and April of last year through the first week of May, of course things were... We had nothing. Well, we did a couple cases based on fractures and things like that, but there were very few exceptions. And then after that, by the end of June, we were all caught up and ahead compared to the previous year. And so it's been great. In the last 12 months, we've grown at twice the rate we had been previously growing. So I think things are great. The self-funded market is independently from the pandemic has really started to pick up pace. We knew it would, but there were isolated employers out there before.

Sean Kelley:

Now you're starting to see a lot more employers take a direct contract methodology. And so when you go back to talking about how an employee or a member at a health plan could get to us, it helps tremendously when they have a direct contract with us. And that direct contract allows their members to have this choice. They can go within their network, whatever that network is, or they're alerted at the time that they have a medical need, let's say a surgery that they have this extra benefit and that extra benefit would be this, we call it free surgery.

Sean Kelley:

So we work with our clients and our clients say, we're going to save, like you mentioned, on the total joint, they'd save $10,000. We'd say, well, share that with your employee, your member. And they do. And so when it becomes free to the member, there's the right kinds of incentives then to redirect people towards us. Not everybody does that. Some people offer a thousand dollars off they're out of pocket. Some people offer none. But typically they offer it for free to the member. And then the plan obviously saves on it. Because as you mentioned, the range is from 30 to 120,000, we see typically in this marketing, we from 70 to 80,000.

Ron Barshop:

So the story is the medical tourism line of story, which is come to Texas instead of going to the big hospital and paying the lowest possible price at 30 instead you'll pay 20, 21 with us and the nine grand extra, you can put your employee on a nice vacation, stay at some posh four star hotels for a few days, eat with a per diem. And you're still ahead.

Sean Kelley:

That's correct.

Ron Barshop:

Yeah.

Sean Kelley:

And that's happening more and more. You're having more and more owners of companies and the public companies are not picking this up very well. And that's surprising because I think they have a great benefit in terms of picking up EBIDTA or net income.

Ron Barshop:

Well, I think they're worried about scale because there's so few of you free market surgery centers around the country. There's I think well you know better than I do. Of course you have Oklahoma and Texas, but don't you have a couple on the west coast and a couple on the east coast?

Sean Kelley:

There's about 60 around the country.

Ron Barshop:

Oh goodness. I didn't know that. Okay.

Sean Kelley:

At the end of the day, and I've said this before, when the history is written about this time period, when direct contracting between providers and health plans is just starting. When the history is written, people will say it was not a supply problem. It was a demand problem. If you get big employers to do direct contracts, now it's an option. So the member doesn't have to go. But if the member wants to go... And let me put it this way, I talked to somebody the other day that had about 15,000 lives in a group here in Texas. And they said, well, how are you going to be able to scale up? And I said, what do you mean scale up? They said, well, how many doctors do you need? I said, well, an orthopedist general orthopedist can take care of about six to 7,000 lives.

Sean Kelley:

A spine surgeon can take care of about 80 to a hundred thousand lives. A gynecological surgeon can take care of anywhere from 10 to 15,000 lives. So you can see, you don't need a whole lot of surgeons to take care of a whole lot of people. They're specialists. And so because of that, the scale issue is not that great. I mean, anywhere from eight to 10% of people on a plan in any one year, get a surgery that would fit within our model. So you have 15,000 lives. You're talking

what, 1500, 1200 to 1500 surgeries. That's a hundred, 120 per month. That's a couple per day. So when you get down to it, it's not that much to be able to take care of large populations.

Ron Barshop:

Let's talk about post-surgery. There are checklists that surgeons use that came from a brilliant surgeon out of Inter mountain that reduce not only the infection rate and the time in surgery and the success and outcomes of surgery, but also the rehab after surgery. You're bundled pricing... Well, first of all, do you use those kind of checklists to make sure you have the high quality control? And then second thing I want to talk about post-surgery what that looks like with y'all.

Sean Kelley:

Yeah. So the surgical checklist was popularized by Atul Gawande, but Dr. Marty McKay is the one who came up with a Hopkins. That is more about a perioperative checklist, which is kind of the pause right before surgery, where make sure that everybody's on the same page, we're operating on the correct appendage or leg or arm or whatever. And so what we do is we spend a lot of effort on the front end and selection of the surgeon. And then we do something called patient reported outcomes.

Sean Kelley:

We collect a survey from the patient on their condition, both in terms of pain, capability. And life stress. Prior to surgery, we share that with the surgeon so that they know what expectations are. And then we collect that same survey at 120 days and 365 days. So we spend a great deal of effort on the front end, selecting the best. And then we monitor with those patient reported outcomes. So out of those patient reported outcomes, come three measures, one, a quality on the outcome. Two, is the patient experience. And then three is really about the return to capability. And so the three things that we most care about are that the patient is better, has reduced pain, improved capability. And obviously the last, probably the easiest, in fact, in this model, so far as the money part, it's easy to save money.

Ron Barshop:

Is there a postoperative rehab built into your bundled pricing or is that extra?

Sean Kelley:

So we did that originally and Dr. Smith and I went back and forth on that. And he wasn't including it. We were including it for a little while. I think a lot of us now have broken it out into a separate and it really depends on the surgeon. The surgeon will say, I need rehab. And so with the pandemic, virtual rehab has taken off. It had taken off prior to the pandemic for sub-specialties like total joints. Most rehab, post-surgical rehab was doing virtual anyway. And so we have virtual rehab bundles available, but we also arrange for rehab bundles with local providers, if that's what people want. But it is extra. It is not included.

Ron Barshop:

Okay. But everything else is. And then the other thing is when you're looking at opioids. Opioids are obviously an enormous problem post-surgery. How do you ensure that your patients are not going to get addicted to opioid, but instead have lighter treatment and lighter uses of medication?

Sean Kelley:

I don't know of any of our surgeons right now they're using opioids. What we utilize are called pain blocks. And so it's an anesthesia placed catheter that goes up against a nerve. And what they do is right when the patient's leaving the facility, they'll bathe that nerve in a bunch of anesthetic. So it'll last anywhere from 36 to 48 hours, sometimes 72, depending on the nerve. And then there's pain pumps that they can take with them home. And that's included in the total hip and total knee bundles and that pain pump will then reside on their leg ,taped on there. And it continuously bathes that nerve for five to seven days. You're trying to get them through that really rough part of the acute pain that comes from an intervention, like a surgery. And once you get them through that, then generally they're okay.

Ron Barshop:

Okay.

Sean Kelley:

So again, I don't think there's anybody using opioids anymore.

Ron Barshop:

Okay, great. And again, I don't know the percentages, but it seems like the television shows are very dramatic when they have this full, open heart chest cavity open as opposed to orthoscopic, which is much lighter intervention. What percentage of your surgeries are light intervention orthoscopic versus the full, open cavity surgery?

Sean Kelley:

Well, so what we do as I mentioned earlier, we select the surgeon and then the surgeon is the one who makes that call. And our surgeons use arthroscopy. They use endoscopy, they use open, they use minimally invasive when it's the best thing for the patient. We have surgeons that love to use the robot for certain procedures, because of the minimally invasive part of it. Now it adds a huge cost. So we make sure that we're very good stewards with the patient of resources and that it actually is of value. And so we use minimally invasive procedures whenever the surgeon thinks it's the absolute best for the patient. So...

Ron Barshop:

Okay. So if people want to find you, what is the best way to look you guys up Texas Medical Management?

Sean Kelley:

.Com.

Ron Barshop:

Okay. Well there you go. And then if you could fly a banner over America with one simple message, Sean, what would that say?

Sean Kelley:

Surgery's complicated, but doesn't need to be, just give us a call. Even if we don't offer the surgery or you can't buy it from us, we can help you walk through the process.

Ron Barshop:

Yep. Great. Well thank you. And we'll keep up with you and I wish you luck in the future and keep on growing. We need this movement to grow. Yeah. Bye-bye now.

Sean Kelley:

Y'all have a great day. 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 podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.