Fixing Healthcare Episode 1 Transcript:

Interview with Dr. Zubin Damania (ZDoggMD)

Jeremy Corr: Hello and welcome to the inaugural episode of Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. I am one of your hosts, Jeremy Corr. I am also the host of New Books in Medicine. I have with me my co-host Doctor Robert Pearl. Robert is the former CEO of the Permanente Group, the largest physician group in the United States, responsible for caring for Kaiser Permanente members on both the East and West Coast. He is a Forbes contributor, a professor at both Stanford University School of Medicine and Business, and is the author of the best selling book "Mistreated: Why We Think We're Getting Good Healthcare--and Why We're Usually Wrong."

Robert Pearl: Hello everyone, and welcome to our monthly podcast aimed at addressing the failures of the current American healthcare system, and finding solutions to make it once again the best in the world. We are very excited to have you join us in this quest.

Jeremy Corr: For 40 years our nation's political and medical leaders have talked about fixing the American healthcare system. No one has succeeded, yet. We need a hero. Our guests are the top leaders and thinkers in healthcare.

Robert Pearl: The show's format is simple, a guest will have 10 minutes to present the roadmap for fixing American healthcare's biggest problems. From there, Jeremy and I will scrutinize the plan, posing questions that challenge our guests, and help our listeners separate real solutions from hype.

Robert Pearl: Unlike many other healthcare shows, we are not interested in hearing about a pilot project that worked in one location, or a new device that a company simply wants to promote. We're searching for truly disruptive change, not just a few minor tweaks.

Jeremy Corr: Our guest today is Dr. Zubin Damania, aka ZDoggMD. He is a UCSF and Stanford trained internal medicine physician, and founder of Turntable Health, an innovative primary care clinic and model for what he calls the re-personalized and transcendent Healthcare 3.0. The program was begun in Las Vegas, in partnership with Tony Shea, the founder of Zappos, and achieved national recognition for the excellence of medical care provided. But ultimately the offices were forced to close from the economic realities Turntable Health faced. Zubin learned much from both its success and its conclusion.

Jeremy Corr: During his decade-long career at Stanford, he started performing standup comedy for medical audiences worldwide. His videos have gone viral, with nearly half a billion views on Facebook and YouTube, educating patients and

providers, while mercilessly satirizing our dysfunctional healthcare system. He currently has over 1.7 million followers across Facebook and YouTube, and is recognized as an industry thought leader and disruptor. He's a frequent keynote speaker and rapper at some of the biggest conferences in healthcare. ZDogg, welcome to the show.

ZDoggMD: Wow, that's a funky introduction I love it, makes me seem more cooler, is that the right term? More cooler than I am. Thanks for having me guys, it's really an honor.

Robert Pearl: Doctor ZDogg, if I may call you that, please consider yourself an applicant for the job of leader of American healthcare.

ZDoggMD: Yes!

Robert Pearl: You're being hired, to your experience and reputation as a visionary leader and innovator. You're being hired because after decades of talking about the unaffordability of healthcare coverage, and nearly 20 years of lamenting lacking quality, and over hundreds of thousands of deaths nationally each year from preventable medical error, our country is ready to make a major change. As I told the audience, we're not interested in small, incremental fixes, or simply trade offs among cost, quality and service. But instead, we believe disruption is possible, and you are the right person to make it happen.

Robert Pearl: The deliverables are significant in size and scope. Unless we can achieve this level of improvement, we don't believe over the next five to ten years the American People will be willing to move forward. Doctor ZDogg, we'd like you to provide a plan to achieve the following: number one, increase life expectancy in the U.S., from last amongst the eleven most industrialized nations, at least to the middle of the pack. Two, increase quality outcomes as publicly reported organizations like National Committee for Quality Assurance, the NCQA, by 20 percent.

Robert Pearl: Decrease cost of care by 20 percent using federally reported data. Four, improve service and convenience by 20 percent on patient reported satisfaction surveys; and five, improve professional satisfaction for clinicians by 20 percent on physician satisfaction surveys. You'll have 10 minutes to do so. Outline the system of healthcare you believe is capable of accomplishing all five of these outcomes, and the steps you'll take to get there. Please start Dr. ZDogg, we can't wait to hear your thoughts.

ZDoggMD: Geeze Robby, no pressure. Alright, here we go. I think the first thing we have to distinguish if we're going to address this huge, huge, huge issue; and you're trying to actually lead change, is that there's this distinction between how to pay for healthcare, which is what we talk about all the time; and what you're actually paying for. First, we have to fix what you're actually paying for. So the first thing we're gonna do, is we're gonna invert our healthcare system from a

sick care, reactive system, that puts band aids on problems and sends them back into the street to a focus on actual healthcare prevention, education, etc., that actually keeps people out of trouble.

ZDoggMD: And, in order to do that, the first thing you have to do is start inverting the problem we have in this country, which is too many specialists and hospitals, and not enough primary care prevention: OBGYN, pediatrics, geriatrics, family medicine, internal medicine, etc. In order to encourage more of that, because we have good data in our experience with Turntable that actually focusing on relationship-driven, preventative, team-based care can actually lower downstream costs for those other things.

ZDoggMD: So we need less hospitals, and we need specialists who practice at the top of their license, not a billion of them. So in order to do that, we need to again focus on this idea of prevention. Now, when we talk about increasing life expectancy in the U.S., most of what we do in medicine doesn't do anything to accomplish that. So, this question is a tough one, because in order to increase life expectancy to the middle of the pack, we need to address where the actual problems are. And that is the non-medical determinants of health: genetics, your zip code, socioeconomic stuff, nutrition, education. Those are things that in this country, we do a very poor job relative to other countries of actually addressing.

ZDoggMD: Medical care may only address 10 to 30 percent of actual life-expectancy stuff. So, the way that we can help is by first of all improving care, focusing on prevention, education, primary care. Keeping us out of trouble, and then taking the savings and funding education, nutrition, built environments, schools, violence prevention, poverty amelioration, those sort of things. If you're going to use a medical system to address it, primary care is the perfect vehicle, actually, for doing the best you can to address those issues. One way to do that is that you start with a ... First of all, getting rid of this sort of perverse incentive of fee for service. So, make it a capitated sort of fee, to take care of people and keep them out of trouble.

ZDoggMD: That's what we did at Turntable Health. Focus on a primary-care doctor, but whose staffed up with a team of people who can help. So, these are not necessarily all clinicians. They can be health coaches drawn from the community that speak the language of the community that are trained up to do motivational interviews, to look at shopping lists, to actually go to the patients' homes to look at the social determinants of health, to teach an elderly woman how to use the bus, so she can become independent again. It doesn't take an expensive and highly trained physician to do that.

ZDoggMD: And what that does, is it frees the physician to spend time doing what they do best, that high level intuitive care, that is evidence informed, but never evidence enslaved. Using technology, instead of as a billing apparatus, or a data acquisition apparatus, but as an actual apparatus to free us to have that relationship, yto have clinical decision support, to flow chart out not just the

patients problems and diseases, but who this patient is as a human being. And then empower that whole team to accomplish change. So, well resourced, team based, relationship based primary care, which means capitation, it means teams, it means tech that actually enables that human relationship that focuses not only on managing the downstream care of a relationships with specialists, hospitals, long-term care, emergency care like community-parent medicine, and those sorts of things.

ZDoggMD: Yes, we have to be deeply integrated in that sense, and integration is a key part of it. But also, managing the upstream causes of disease which are those social determinants. And the best way we found to do that is with on-the-ground health coaches, who are deeply involved in the patient's care and who come from the communities that they're serving. That's a lesson we learned from Turntable Health. If you're starting then to talk about how you're going to increase quality outcomes, well, first of all, NCQA is a great idea. The truth is, what it's done in practice is the measurement industrial complex has turned doctors from doctors into data acquisition clerks.

ZDoggMD: And we're teaching to the test. We're gaming the numbers, and a lot of these quality measures don't really measure quality. And so what we want to do is be measuring the processes that we're doing in healthcare. So, focus on processes that work. If you're trying to reduce maternal mortality in hospitals, focus on processes that are proven to work. Whether it's a checklist to look at maternal blood loss, to make sure that we treat blood pressure quickly if it's elevated, and prevent preeclampsia and possible stroke and death. Those are the processes we want to focus on. Not so much the click, click, click, click, click that is destroying the quality of care that we currently have, by taking away so many processor cycles from the actual relationship and the delivery of care.

ZDoggMD: So, that's a key part in terms of quality measures. If we're gonna decrease the cost of care, most of the evidence that we've acquired so far is that if you really focus on that 5 percent of patients that are costing 50 percent of our healthcare dollars, to people with chronic disease, it's gonna take, again, well resourced, integrated primary care, that's team based, that's technology enabled. And we've shown that we can drop costs by about 12 percent, at least on the sick populations. That's a huge amount. In addition, by reducing the number of specialists of hospitals, but increasing their quality and their volume level so that they can do really, really good work, we can reduce costs even more, take that savings, spend it on programs that actually improve the social determinants of health.

ZDoggMD: If you're talking about improving service and convenience, the best way to do that is simple things like end of life discussions had by people that don't even have to be clinicians. There was a Stanford study that showed patient satisfaction, and end of life documentation, improved when you have a lay health worker who has these conversations. Go where the patients need us: telehealth, visit, phone, email, Skype. All those things are where our patients

want us, but instead we're stuck behind a clunky EHR that looks like it was built in the '90s, or worse. It looks like it has a DOS prompt. Go where they need us.

ZDoggMD: Also, not everybody needs a doctor. Sometimes a health coach, a licensed clinical social worker. The team: the nurses, the respiratory therapist. Those are the people that are on the front lines, as well. So, we need to encourage that team work where everybody's practicing at the top of their training. And listen to our patients. And that requires time and resources, and tools to do that, so that we're not pandering to them with hokey complementary medicine programs that a lot of hospitals are putting in place just to increase revenue. If they think these sorts of acupuncture, or those kinds of things are helping them, we need to listen to why that is, and support them without encouraging magical thinking. So, that is not a useful part of patient satisfaction.

ZDoggMD: If we're gonna improve professional satisfaction for clinicians, okay, I'll tell you at Turntable, our clinicians were supremely, supremely satisfied, because they weren't conflicted with moral injury. And that's what's hurting us. This idea that we have one foot in a fee-for-service world. One foot in a capitated world. One foot trying to please the administrators and the NCQA people, and one foot trying to help our patients. We went into it to help our patients. If we have good physician leadership, that can help us cohesively organize around these principles, give us the tools, the resources, and the latitude, some degree of autonomy to take care of our patients with clinical decision support from an electronic health record that is not just a glorified cash register. We can transform that.

ZDoggMD: That's how we do the care part of it. How do we pay for it? Well, partially it's gonna matter less because it's gonna cost less. You're paying for something that works. If you're talking about single payer, you're talking about paying for something on a grand scale that already we've proven, Robbie, doesn't work. So this is what I would propose, and it's based on some ideas from a frontline, direct primary care practitioner, Dr. Neuhofel in Kansas. We have a personal health account that everyone is required to have to the tune of about two grand ($2,000). That can be funded by individuals if they're capable, or the government, or employers. Once that money is spent, and that can be spent on a good integrated primary care to start with. That's a flat fee per month, so they have access to that.

ZDoggMD: And it has broader application than a health savings account or something like that. After that's done, you have a deductible. And that deductible depends on your income, and your ability to pay it. Once you reach the deductible, and it may be that the government subsidizes it. It may be that employers, like Chase, Amazon, Berkshire's new thing, funded if you go in their highly proven networks. Then the last thing is, catastrophic insurance with new Medicare for All. That is what insurance was meant to be, which is a catastrophic insurance. High deductible pays for things like if you get leukemia, if you're in an accident, etc.

ZDoggMD: And it is obviously paid by the government, but individual companies compete to administer those dollars in a way that is competitive. And so I think my 10 minutes are up, but that's my vision on how we can fix healthcare.

Robert Pearl: It's tremendously exciting, Dr. ZDogg, and I'm particularly pleased that you separated out the coverage, the insurance piece for the delivery system because, as you pointed out, if we can't address the quality, the service, the cost in the delivery system, the insurance companies become very irrelevant, and can't do much about it anyway. Let me take your agenda, which is very comprehensive and excellent, and try to ask you to break it into pieces. Let's start with the first one, which is prevention. Can you explain to the listeners what you mean by that? How many measures are you looking at? How do you think about accomplishing it? What's possible if we really work to focus on prevention through the model you talk about it, using the teams that you described? What can we expect to have delivered as a consequence of that?

ZDoggMD: So think about it this way. If you have a team that's taking care of an individual and let's say the cats already out of the barn. They have chronic disease. Now you have a health coach, and a doctor, and a social worker who are all optimizing around this idea of chronic disease. How do we help a diabetic to take their medications? How do we help them to get off medications? How do we help coordinate the care, with their down stream specialist and hospitals? How do we know when they're in the emergency department and can help figure out how to prevent that in the future? You have huddles every morning. When they come in, you're actually part of their lives. You are not an episodic transaction of care. You're part of a relationship with them, which means they ... It's interesting, we had feedback from our patients that say, "I came to love my health coach. I cared about them. I didn't want to let them down. So, I took my medications. I came to my appointments. I learned about my disease, because they made me care about them, and also care about myself, and I didn't want to let either one of us down."

ZDoggMD: So this idea that relationships can actually help in terms of prevention, particularly with chronic disease. Opioid epidemic, instead of knee jerk giving out opioids; we can actually sit and get to the root causes. Was there trauma? Is there PTSD? Are there emotional issues that we're medicating with these drugs? And that requires again, relationships with our patients. If you're talking about preventing disease in people who are well, that means you have to be a part of their lives. Many of us don't think about medical care until we need it. So, if you have a health coach who is like, "What are your goals? Are your goals to run faster? Be able to bike? Are your goals to be able to hang out with your grand kids?"

ZDoggMD: And then functionalize a plan around that, so that even when you're not in the office, your kind of thinking about that. They're texting you. You're coming to our classes in our teaching studio. You're a part of this bigger movement. You're learning how to cook in our teaching kitchen, on a food budget in a food desert, without a lot of sugar, without going out to eat all the time. These are the tools

we can give our patients to actually prevent disease. And for the sick patients, it keeps them out of the ER. We showed about a 50 percent reduction in urgent care and ER admissions. And for the well people, it can keep them out of trouble.

ZDoggMD: Now documenting that Robbie, that's the challenge, because if you ask me for evidence of keeping a well person well, it's a lot harder, because it can take years before you're gonna show that you prevented a case of diabetes.

Robert Pearl: When I was CEO in Kaiser Permanente, we did some study on it, about somewhere on five years it takes to see the improvement and outcome when you measure ... When you manage blood pressure, blood lipids, and other aspects that help people, to cut down smoking. But it's not forever and it clearly happens scientifically, and once you accomplish that, it grows across time. So, I understand exactly what you're saying. Let's move onto the second part, which is the hospitals. Hospitals are one of the most expensive parts, maybe the most expensive part, of the American healthcare system today. I was really please to hear you reference the maternity data. Some interesting stuff came out this week.

Robert Pearl: Forty percent of women in the United States are not getting the maternity care they need with thousands of people dying unnecessarily. We think we have the greatest healthcare system and, here we are, young healthy women dying in child birth. It's really unfathomable to me. How would you restructure those hospitals? How would you downsize, consolidate centers of excellence? What are you thinking about how you would restructure that hospital system in the United States today?

ZDoggMD: Well I'm glad that we're having this discussion because I'm a hospitalist, and this is sort of my specialty, and what I would say is that a single hospital, trying to be everything to everyone is very, very hard. Toyota would never do that if it's trying to build cars, because you'll never be able to isolate failure points in the process because the process is so chaotic And maternal care is a great example of that. You have all these different hospitals doing different things, with different processes. Look, everybody on the front lines bristles at the term cookbook medicine, and algorithms, and checklists but the truth is, there are some things that it has just been shown, if you just follow this particular sequence of things, like a pilot would and Atul Gawande and others have talked about this, you can reduce mortality and human suffering. It's unconscionable that we have this.

ZDoggMD: So, the first thing you do is you take everything that has been shown to work, and really apply it as a standard. Then what you want to do is take hospitals, and kind of break them into their bits and bites. So, a surgical hospital that does elective procedures very, very well should really optimize towards that. And it should be geographically accessible to a triage, or urgent care, or emergency center that can send patients to those places maybe even faster than they would get transferred within one single hospital. So, I think transforming that,

and then ultimately realizing that, that probably 50 percent of what we do not only doesn't work, but causes harm.

ZDoggMD: And so really focusing our research efforts, and our implementation efforts on getting rid of that 50 percent. Isolating it and saying, "You know what? It doesn't work, we're not going to do it. You know what works? Washing our hands. You know what works? Weighing maternity pads to see how much blood is actually lost and acting proactively instead of reactively to blood loss." Those kinds of things are, I think, are gonna be crucial. And it's gonna take a quality-improvement culture that hasn't really existed. And it can't be at the expense of physician sanity. So, we have to weave it in from medical school in our training as part of our culture.

Robert Pearl: Would you achieve the very difficult process of, I'm gonna say "closing," because if you're gonna downsize the demand, you're gonna need fewer facilities. You're gonna maximize the volume in each, you need fewer facilities. Would you see this happening through a group like Leapfrog? Setting a minimum number of procedures, deliveries, surgeries, whatever it might be, for hospitals. Those that can't meet that standard by having enough volume would have to give up doing that, or at least give up the reimbursement for it? Or do you see some other third-party, maybe even medical-group led in some fashion, determining which facilities should be closed in order to improve the quality of care we provide to people in the United States today?

ZDoggMD: That's a great question, and I'm always uncomfortable with third parties making these decisions on clinical matters, but I'd say this: If it's led by physicians ... And you know what, at Turntable we had what we called our "good guys list." And it was an internal thing because, look, we're doctors, we go to these facilities, we work with these surgeons. Everybody in a facility, every nurse knows one doctor or two doctors who they would never send anybody to, they wouldn't let their worst enemy go to. And it's not transparent to patients. It's not transparent to organizations that regulate us, but it's known to the staff. So, here's the question: If the staff know, why can't everybody know?

ZDoggMD: So there's a means by which we would pick the hospitals that we like working with, the specialists that we thought wouldn't do a cardiac catheterization for GERD, and would communicate with us and we would help select those. So, I think this idea of medical people, medical groups helping with that ... The other idea is if you have a big self-funded employer that's part of a big consortium, like what Amazon, Berkshire, and Chase are trying to do, if you have clinicians working with them that can help feel these things out, their gonna vote with their money. There not gonna have their patients, their employees that are valuable to them, go to a place that doesn't do enough cardiac caths. They would rather put them on a plane and send them to Cleveland Clinic, or Center for Excellence because it's actually cheaper and more effective, and more humane in the long run to do that then to send them to a community hospital where the docs just don't do enough of it.

Robert Pearl: When it comes to specialists, how would you evaluate them? And would you establish a minimum annual volumes in order to allow them to continue to perform the procedures they're doing today, with the hope of increasing quality through added specialization and added volume?

ZDoggMD: This is a great question, and again I feel a little unqualified to answer this, and I think it would be a little disingenuous because my specialist colleagues are probably better equipped to understand how volume relates to surgical skill set. As a hospitalist, I know that the more lumbar punctures I do, the more central lines I place, I'm vastly more competent, and with less complications. So, I imagine the same thing is going to translate, and I'm sure there's some evidence that shows this, that higher volume providers are better at this. What's interesting, too, is that higher volume providers often tend to be less expensive.

ZDoggMD: So, it's almost an inverse correlation of cost with outcome in healthcare, and that's true value. Cost, convenience, outcome. We can generate that. So, I don't think I'm particularly morally qualified to answer that in real depth though.

Robert Pearl: Something you left out of your summary that we read about a lot today, is the pharmaceutical world. What are your thoughts on the rising cost of drugs, which now are past half the cost of hospitals that are going up at double the rate at the current time?

ZDoggMD: It's tricky because I agree that our pharmaceutical industry does a lot of great good in the world, and especially the medical affairs people who are working really hard to cure and treat diseases that have afflicted us for millennia. The downside is, of course, we have an enterprise now where this is becoming vastly unaffordable. There is huge abuses on the business side, and costs continue to inflate. So, what we need is an ability to collectively negotiate with huge leverage so that we can keep prices under control. We may need to change the length of patent expiration. Generics need to be encouraged, and we focused on that a lot at Turntable because, to some degree, we were being measured on that by one insurance company we were working with, generic administration. So, those sort of things, and also changing the requirement process to get drugs approved.

ZDoggMD: Right now we use surrogate markers and those aren't great. But the truth is it's so expensive, and so complicated, and so much overhead to get a drug approved, that no company's willing to take the risk. And so we need to change that calculus, and we need to more research on doing research, on how we can make our science better. I suspect, Robbie, a lot of the drugs we use don't really do much good to be honest. And we're looking at incremental numbers needed to treat, you need to treat a thousand people to have an effect. That's not cost effective, and it comes with a price, which is complications, side effects, etc.

Robert Pearl: So I would like to move into an area that for our listeners may be unclear, which is you noted the fact that only 10 to 30 percent of medical outcomes is related to the medical care that's given. That means at least seventy percent relate to

these other factors that you outlined. You spent a lot of time, and I agree with you, focusing on the social determinants of health. I talk to physicians, they often use this as the excuse, "Our medicine is the best in the world. It's the social factors that are not." And yet you have a very integrated notion of how you'd address both of those problems. Can you really expand on that? Because it seems to me that it's very central to what you're saying about the solutions to American healthcare.

ZDoggMD: Yeah, and I think this is. You're right, this is the central crux, which is if you look at Great Britain, they spend 9 percent of their GDP on healthcare and arguably have better outcomes. Yeah, sure people have to wait and you talk about socialized medicine, and I'm not advocating socialized medicine. I'm saying that I'm advocating not medicalizing our social problems. In the U.S., we take a social problem, homelessness, drug addiction, poverty, poor nutrition and we medicalize it. We say, "Now it's the medical system's problem." And the medical system pushes back and says, "Well, we can't handle all this but we have this very expensive technology that we can throw at it and we will." And that in itself is not correct at all. It's not a good way to manage this.

ZDoggMD: What we should be doing is going, "Instead of putting in the 4 Tesla (MRI) magnet to scan a bunch of people who have headaches that don't need to be scanned, we should take that money and those societal resources with some will, and say, "Now, we're actually gonna figure out what's a better way to level playing fields so that people can get jobs, look at nutrition, look at those kind of things." And we don't necessarily do that very well in this country. But, then what happens, is that it all falls on our shoulders in healthcare. And so you have an event like what happened in Baltimore, where a patient was pushed out into the street with mental illness and it became a national scandal of, "How could this University of Maryland-related hospital push this patient out on the street? It's patient dumping."

ZDoggMD: Well, those people working the front lines there in that emergency department are seeing the failures of our political will to manage social situations all the time. And when one thing went wrong, and clearly something went wrong, they are all blamed. Even though it's their life's work to take care of this patient population. That's not fair either. So, we need to come together and say, "How can we solve these problems?" And some of it may honestly be, and people are gonna hate this, shifting money from healthcare, to the social determinants directly. Which means the same doctors that are complaining that they can't handle it because of the social determinants ... There's going to be a fewer of the specialists in hospitals, and more focus on those social determinants.

Jeremy Corr: So, one of the things that we're kind of hoping for with this show is to bring on people that are just your average healthcare consumers. Earlier you talked about capitation, and that's something that I don't know that a lot of them would necessarily understand what that is if they've never had experience with it before. Can you explain capitation versus fee for service, and why you feel it's superior?

ZDoggMD: Sure, so fee for service, which I think has really no place in primary care in particular. Maybe it has place in high-end, specially consulted of care where you don't know what's involved. But, even that's debatable. Fee for service means I charge you for every little widget I do. You are no longer a relationship to me, you're a transaction. So, in other words, if I were ... Robbie uses a great example of remodeling his kitchen. If you're remodeling your kitchen in a fee for service way, the contractor wants to do every little thing to your kitchen, to rack up as much payment as he can. It's an unconscious thing. Doctors don't do this consciously, but incentives do drive behavior to a large degree.

ZDoggMD: Now, capitation, think of it this way, it's like a prepaid Netflix plan. You pay twenty bucks a month for Netflix and you get to watch the videos that you want. In healthcare, it means that you pay the clinicians, or the health system, a flat amount of money, and their goal is to keep you healthy for that amount. Now, I think that in itself may not be enough. I think what you need is some incentive to continue to work really hard, and improve your efficiency and care so that you can share some of the savings that are generated when you actually do the right thing for patients. It should be that by doing good in the world for patients, we do well financially. I think capitation and its variants are the closest to that, especially for primary care.

Robert Pearl: Let me ask you a really tough question. You ran a tremendous organization, Turntable, for four years and then ultimately went out of business because of the financial realities that you faced in that environment. You've just outlined a very aggressive, and I think very optimistic plan, for how we might be able to solve it. What didn't happen in your Las Vegas experience that you think this new model will do in order to become successful?

ZDoggMD: I think the main thing we were missing ... There were many failures, Robbie, that I take responsibility for. One is that at Turntable, we tried to bring the model I talked about to as many people as we could. So that meant there was a direct-pay component, where people were spending $80 a month to have unlimited access to us and our healthcare coaches, and our classes and those kinds of things; and the doctors. That was one bag of patients. Then you had the patients who were part of Nevada Health Co-op, which was an insurance plan that was not-for-profit that was started under ACA loans, etc. And they said, "We'll give you guys a per patient, per month, capitated amoun to take care of our patients who are on the exchange. So, they are getting federal subsidies to have access to you."

ZDoggMD: And that was great. So, we had a big bag of patients from them. The problem is trying to care for two different schizophrenic groups of patients. Meaning, for the people who are paying out of pocket, some of them were uninsured, some of them had insurance. Which insurance they had? Who do you refer to? How do you coordinate their care? Which lab do you send them to? It's all the same fragmented nightmare that we're dealing with in general. And then for the insurance side, when that insurance company went out of business and closed, we lost 3,000 patients, and that really prompted us to have to close.

ZDoggMD: So, this idea that you don't have a value network that's actually gonna provide a payment for progressive model that works, that we show saves cost in the long run and in the short run, and that may cost a little bit more right up front, because primary care, we're spending more on it. We're spending three times what they spend, maybe four times what they spend normally, in Las Vegas. Eighteen dollars per patient, per month or something maybe is what United spends for patients for primary care, and they get what they pay for. Fragmented, crappy care with lots of specialists. It's specialist heavy.

ZDoggMD: So, this idea that we didn't have a value network ... Now if you had a value network of patients also who are a bit empowered with a little bit of skin in the game, where they have this two thousand bucks, and it's like, "Well, I can spend it on a really good primary care doc who will keep me out of trouble. Keep me from spending it down stream." That's helpful. So, having that support structure, and the Medicare for All component of it, is again, a very high deductible, catastrophic plan that keeps people from medical bankruptcy. Because honestly, Robbie, we felt this taking care of people. There was a moral injury that occurs to us when we feel like we have to treat patients differently because of their insurance status, when we have to treat an undocumented immigrant differently for dialysis. They can only get it emergent in the ER, than somebody who has insurance.

ZDoggMD: When we look at transplants and things like that, it creates moral injury, and therefore quote unquote "burn out", it's really moral injury in our physicians, and that's not a sustainable thing. So, I think the difference is that caused us to fail, is we didn't have that structure. We were a little too early with the model. Oh, one more point, Robbie, and you guys at Kaiser had this and we didn't: integration. Being able to say, "Our specialists and our hospitals and our ERs all have their skin in the same game." Instead of each pulling at cross purposes. And sharing an electronic health record, having intraoperability. And that would help our patients too, because if they have access to their record, they have access to their record everywhere, and that's true portability of data. So we didn't have that either.

Robert Pearl: Let me turn back to what you raised on moral injury, because I think you touched on a very, very important point when we talk about burn out. When I wrote the book "Mistreated: Why We Think We're Getting Good Healthcare-- and Why We're Usually Wrong," I went on the various talk shows and TV shows, and people were calling in, I was sure the physicians were gonna say, "This is terrible. You're saying negative things about our profession. You're telling patients about all the problems that exist." And it was exactly the opposite. I heard about the depression. I heard about the suicides. I heard about the burnout. I heard about all the factors people had from the current system. And if you and I both agree that the current system is inflicting damage on physicians, not just patients, how come physicians are so resistant to embracing the kind of model that you're describing?

ZDoggMD: So this is a million dollar issue that if we don't address we're gonna fail.And this is why I think physicians and front-line healthcare practitioners that are a big group of my followers. We have a tribe of 1.7 million people that they've come together because they have had it. They've had it. Their tired of the moral injury of feeling pulled in multiple ways and being devalued. I think, Robbie, it's because of this: When we start in medical school, our conditioning begins. We're conditioned to take facts from above, that are passed on by generations, 50 percent of which probably aren't true, and they don't tell you which 50 percent.

ZDoggMD: And then in the second two years of medical school, you're taught to obey authority. It's really a guild apprenticeship that's bypassed the enlightenment. The enlightenment was all about questioning authority. Galileo standing up and lifting a middle finger to the church and saying, "You know what? The sun goes around the earth? It doesn't, it's the other way around." And, what we do in medicine is we say, "No, no, no, we don't question authority. We don't ask questions." It's about the Greek system of fealty to authority and learning to kiss the ring of the attending physician, so that one day the bargain is, yours will be the ring that's kissed.

ZDoggMD: Well that is a recipe for inertia, for risk aversion, for compliance with hierarchy. I think that happens, it pulls us into our careers where we are told to be resilient to a system that yeah, the systems broken, and this and that. But, you need to adapt to it, you don't change the system, that will never happen. It's too big, it's $3.4 trillion dollars, whatever it is. And so that I think is our fundamental conditioning. In order to break that conditioning, we need voices and leaders who are willing to stand up, like yourself, and write a book that you would think would make people really angry, but actually it resonates deeply with our moral outrage as clinicians. And you can then start to make a dent in this inertia, and this lassitude.

ZDoggMD: It's immoral what we're allowing to happen and we know it. And that's why we use the term burn out. It's not that, it's a moral injury.

Robert Pearl: So, we've left out the most important part of the healthcare system, whose the patient. So, let me ask you, what do you see is the role of the patient? And how do you as a physician work to change people so that they can improve their own health?

ZDoggMD: This is it again, and you kind of nailed it, we can talk wonky about the system, but if you don't put the patient at the center of this, then none of it matters. You tell in your book stories about being a patient, about your father being a patient and going through the system. I've been in the system myself, with my parents, with myself. The minute you get that experience, all the training and everything goes out the door, and you realize exactly how powerless you are, how confused you are, how fragmented the system is, how poor the communication is, and how bad the technology is.

ZDoggMD: So, in order to empower patients, first of all, we have to listen to them. We have to give them time in our relationship so that they develop and continue trust with us, and that we understand who they are as a human. And people like Dr. Abraham Verghese, many people accuse him of being a Luddite, and fearing technology because he wants to get back to the bedside. Talking to him in person, really what it is, is no, he just wants technology that allows us to listen to our patients better. If you had an EHR that told the patient's story in a visual chart, not just how sick they are, but who they are as people, and the patient had access to that and could contribute to that in a meaningful way, they could understand if we spoke less in jargon.

ZDoggMD: That's why we use health coaches, because health coaches are drawn from the community. They speak the language of the patients. They don't speak Latin, and doctors learn from them. They learn, "Oh man, I've been saying this the wrong way." Now there's data out of Stanford that patients hear, especially through interpreters, they hear totally different things than what we think they're hearing. And until we listen to what our patients are hearing to begin with, we're never gonna understand how to actually prevent disease, to have a therapeutic alliance with them and actually reduce bad outcomes and improve costs. It's never gonna happen. So there the center of all this.

Robert Pearl: Do you ever engage them with any of your musical talents, or rapping?

ZDoggMD: Well that's the fun part, Robbie, because ever since I kind of unplugged from the Matrix of full-time hospital medicine, I'm not worried about losing my job. So, I can make these rap videos that really focus at educating patients and we can be a little edgy. So, we did a parody called "Can't Feel My Face," which is a parody of a song called "Can't Feel My Face" by The Weekend. And he was doing it about drug abuse and cocaine and so on. It was a pretty edgy tune. We did it about, what are the signs and symptoms of stroke? And how can you recognize them, and understand that young people have these symptoms, and young people are increasingly having strokes, and people blow them off thinking it's nothing, or that it's stress?

ZDoggMD: And you need to act fast with the acronym (BE FAST), with the facial droop, arm weakness, speech slurring, time to act, and add balance, be fast, balance and equilibrium, and that sort of thing. So, you can do a song about that. You can do a rap that educates patients because education is, again, a key component of dealing with some of the social determinants. What happens when someone collapses out in the street? Are people gonna do CPR? Many of them are scared. They don't want to get a disease by doing mouth to mouth. They remember the teaching form the old days, and they remember things like, "How fast am I supposed to push on the chest? I don't know."

ZDoggMD: Well here's the thing. Young people won't remember "Staying Alive" as a you know, as a way to keep pace, you know, "You can tell by the way I use my walk." Yeah, that's 100 beats per minute. But, you know what else is 100 beats per minute? It's Usher's "Yeah," which goes, "Do-do, do-do. Do-do, do-do," and

that's about 100 beats a minute. If you're pushing on the chest like that, we did a song about hands only CPR, forget about the mouth to mouth, and you come up with the wrap and you go, "Look out, mouth to mouth's ridiculous, in the club when the mouth's vesiculosus, and yo, the protocols all out of date, putting air down this pipe is so 2008. So forget about that, I'm a squeeze the chest, CPR hands only when you're homey arrests." So, you can do that sort of thing and people will remember that.

ZDoggMD: They'll remember that, oh, that was actually a Stanford trained physician doing that, so maybe there's credibility, and the songs stuck in their head. So, innovation and patient education is a crucial part of building what we call Health 3.0.

Jeremy Corr: You talk about Healthcare 3.0. You mention that on your website, and some of your speaking. Can you explain what Healthcare 1.0, 2.0, and ultimately what 3.0 is?

ZDoggMD: Absolutely, and I'll do it very briefly. Health 1.0 is that cottage industry that Robbie and I trained in. Where it was about a doctor and a patient. There were a lot of little community hospitals everywhere, little private practices. And it was about this unfettered relationship that wasn't fettered by regulation, or electronic records, or anything like that. It was also not fettered by evidence based medicine, randomized control trials, electronic technology, and that relationship was also very hierarchical. It was paternalistic, the doctor held all the cards. There was a lot of abuse of other people in the system, like nurses. So that Health 1.0 was not our highest game. The reaction to 1.0 was 2.0. 2.0 is what I call the Measurement Industrial Complex.

ZDoggMD: So, we're now trying to apply all the principals of business to medicine, but we've somehow lost the heart of it. So, electronic records, boxes to click off quality measures that maybe don't necessarily measure quality, more commoditization of physicians, and everybody's equal, but not necessarily in a good way. So, we give patients information, but we don't give them the heart and soul of what that information actually means, what we would do for our loved ones. So, that game has led to a lot of burnout, and the moral injury has come from the conflict between 1.0's old fee for service, 2.0's mechanization and assembly line medicine, and this push and pull between.

ZDoggMD: So, what 3.0 is, it says, "Look, 1.0 and 2.0, stop fighting." If 1.0 is the shore, and 2.0 is the boat, let's stop pretending that the boat is the destination. The destination is a new shore where we re-personalize medicine using technology and electronic records that actually serve the relationship. We're paid bases on outcomes that actually matter to our patients. It's mostly team-based. We treat everyone like they're the most important member of the team, including the patient. And we do all that in a way that's scalable and sustainable, not just for the enterprise, but for physicians and patients both.

ZDoggMD: That takes the best aspects of one, which is physician leadership and autonomy, with the best aspects of two, which is quality improvement, business principles, integration, those sorts of quality science and technology. Then what actually emerges, is actually transcendent, it's bigger than the sum of its parts. And I think when people intuitively feel what that means, and patients experience it at Turntable, they go, "Oh, that's the answer. It's been sitting there. It's not that complex." But we need the value structure to actually support it, and that's gonna take some time.

Robert Pearl: Let me ask you one last question if I could, which is if you were going to move forward implementing this plan at a national level, what would be the first couple of steps you think we would need to do to start the ball rolling?

ZDoggMD: I think the first step, Robbie, is gaining a critical mass of physicians, nurses, respiratory therapists, hospital administrators, people on the front lines, in partnership with patients, standing up and saying, "You know what? We believe in this vision, and we think that we need this. And we're gonna help. We're gonna sacrifice a bit in the short run to make this happen, and we know it's gonna be turbulent, but we absolutely have to have this." And I think if we could at least have a general consortium and consensus of this, then the second step is to reach out to business leaders, and go, "Your skin is the most in the game on this. Okay, Atul Gawande, Amazon, the Zapposes of the world. This is good for business. It's good for America. It's gonna take an Albatross off our neck that is nineteen percent of GDP, and let's start moving with that." At that point it's gonna be incumbent on our political leaders to start listening to this really big ground swell of movement. Those would be my first two steps.

Robert Pearl: Certainly your 1.7 million listeners and followers is a good starting base to begin with.

ZDoggMD: It's a mob that's just ready to have some pitchforks.

Robert Pearl: Jeremy and I are ready to join on. So, Dr. ZDogg, we asked you a lot of questions today. What are some final thoughts that you have for this listening audience?

ZDoggMD: I think the main thing we need to realize guys, and I'm addressing everybody here, including my followers, the ZPac. It is going to take all of us to affect this change. When you have tremendous leaders like Robbie Pearl, who helmed an organization that's done a lot to improve healthcare and, again, none of these organizations are perfect. Now, coming out and saying, "Okay, I'm gonna tell you guys, I'm gonna highlight these bright spots." We can catalyze change in a way that's never been seen. Between social media, video, these sort of platforms. We can get these messages out to the world that would have taken a hundred conferences at stodgy Vegas casinos about two decades to reach critical mass. We can catalyze that. So, if you guys are on board, we're on board.

ZDoggMD: With good leadership we can actually transform our system in an amazing amount of time. It's not just something that is a nice to have. It's a must have if we're going to continue and survive. Even as a nation, we have to do this, it's a moral imperative. I also want to thank Robbie for everything that he's doing to spread the word about transforming medicine. I sense that this is a new mission for you. That's even beyond the mission you had for so many years working with The Permanente Medical Group that now you can really use everything you've learned to make things better for everybody.

Robert Pearl: Dr. ZDogg, thank you again for being on the show today. You were fantastic. I can't promise you that your approach and recommendations will be the one's our nation embraces, but for anyone who thought that solutions didn't exist, you've proven them wrong. This was also a lot of fun.

ZDoggMD: Robbie, thanks a lot for letting me on your first podcast. This is a hugely important forum that you've created, and it's an honor to be here. Thank you.

Robert Pearl: Next month our guest will be Dr. Halee Fischer-Wright, the president and CEO of The Medical Group Management Association or MGMA, and the best selling author of "Back to Balance: The Art, Science, and Business of Medicine." We're looking forward to having her on the show. Please subscribe to "Fixing Healthcare" on iTunes, or whatever other podcast software you use. Visit our website at www.fixinghealthcarepodcast.com and follow us on LinkedIn and Twitter @fixinghcpodcast. You can find our personal LinkedIn and Twitter accounts on the website. And for additional information on other health care topics that you might be interested in, you can check out my website, RobertPearlMD.com. Jeremy and I hope that you've enjoyed this podcast and that you'll tell your friends and colleagues about it, for together we can make American healthcare, the best in the world again.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.