Fixing Healthcare Episode 2 Transcript:

Interview with Dr. Halee Fischer-Wright

Jeremy Corr: Hello, and welcome to the second 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 the popular New Books In Medicine podcast and I have with me my co-host Dr. Robert Pearl.

Jeremy Corr: 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 the Stanford University School of Medicine and Business, and author of the bestselling, "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. It's 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 you have chosen to 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: This show's format is simple. Our guests will have 10 minutes to present their roadmap for fixing American healthcare's biggest problems and I will probe deeply based on my experience as a physician and healthcare CEO. I'll scrutinize the plan posing questions that challenge our guest and helping our listeners separate real solutions from hype.

Robert Pearl: Then Jeremy will dive in from the patient's perspective, ensuring their concerns are addressed, making certain the concepts are clear for listeners in helping to translate any medical jargon we may have used into normal conversational language.

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 are searching for a truly disruptive change, not just a few minor tweaks.

Jeremy Corr: Our guest today is Dr. Halee Fischer-Wright. Over the past 25 years, Dr. Fischer-Wright has been a practicing pediatrician, the owner of medical practices, the leader of a large physician group, a hospital executive, a chief medical officer,

the consultant on culture and innovation, the wife of a cancer survivor and the daughter of a chronically ill father.

Jeremy Corr: She is the author of the national best selling books, "Back to Balance" and "Tribal Leadership," and is the recipient of multiple national awards for leadership and healthcare. Since 2015, she has been the president and CEO of the Medical Group Management Association. Through its members, MGMA represents close to 50 percent of the healthcare delivered in practices across the United States.

Jeremy Corr: Inspired by her personal experiences and in her role with MGMA, she works to elevate the important issues and the best ideas from the frontline of medicine, from the people responsible for delivering healthcare across the country. These are the ideas she believes that can bring the art, science, and business of medicine into balance, and transform healthcare in America. Halee, welcome to the show.

Halee Wright: Thank you very much Jeremy and Dr. Pearl.

Robert Pearl: Halee, consider yourself an applicant for the job of "Leader of American Healthcare," you're being hired due to your experience and your reputation as a visionary and an innovator. You're being hired because after decades of talking about the un-affordability of healthcare, and nearly 20 years of lamenting lagging quality and over 100,000 deaths nationally each year from preventable medical error, our country's ready to make a major change.

Robert Pearl: As I said to the audience, we're not interested in small incremental fixes or simply trade-offs among cost, quality, and service. But instead, we believe that 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 that over the next five to 10 years, the American people will be willing to move forward. We'd like you to provide a plan to achieve the following.

Robert Pearl: One, increase life expectancy in the U.S. from last among the 11 most industrialized nations to at least the middle of the pack. Two, increase quality outcomes as publicly reported by organizations like National Committee for Quality assurance (the NCQA), and make sure it's by at least 20 percent. Three, decrease the cost of care by 20 percent on federally reported data. Four, improve service and convenience by 20 percent on patient reported satisfaction. And five, improve professional satisfaction for clinicians by 20 percent on physician satisfaction surveys.

Robert Pearl: Halee, you'll have 10 minutes or so to outline the system of healthcare you believe is capable of achieving all of these outcomes and the steps you will take in this role to get there. We can't wait to hear your plan.

Halee Wright: Thank you, Robbie. You know, it's hard for me to talk about being the leader of American healthcare without separating out the personal with the national. So, from a personal standpoint, I didn't have one moment where I knew healthcare was broken. Instead, it was a series of personal experiences that brought the deeper problems into the light.

Halee Wright: The day that I watched my dad get poked again and again for a spinal tap by residents and interns who didn't speak to him or even look him in the eye until it was my turn to poke him. From the moment I realized that my husband and I could possibly lose our home because of crushing medical bills after his cancer surgery. The night my mother convinced herself that she had ALS by Googling her symptoms and then double checking it with WebMD. The 24 hours after we told my dad he had pancreatic cancer because his test results weren't obvious in his EHR.

Halee Wright: The problem with talking about all these underlying problems is that we lose sight of what healthcare is: One human trying to help another get and stay healthy. And that's why most policy conversations about healthcare end with people walking out of the room saying, "Well, when I saw my doctor last week ..." Healthcare is human, personal, and intensely local.

Halee Wright: And yet we take an army of problem solvers and innovators and prevent them, daily, from making decisions that could dramatically transform healthcare. And I'm talking about every provider, leader, clinician, staff member, working in a medical practice, and to get to your point, the patients they serve.

Halee Wright: In my design of the future of healthcare, I'm choosing to ignore everything at the top and start with all the experience and brilliance and passion and, most importantly, the common sense that I see in medical practices every day. In fact, I'm recommending that we do the exact opposite of what we're currently doing. And I think that would actually help to solve most of our problems.

Halee Wright: But, let's do it in this framework with three fundamental questions: First, I'd ask, do we really know what we want out of healthcare? Now Robbie you gave me the task of five questions and gave me numbers around it. But the interesting thing is while we keep talking about cost, quality, and satisfaction, I mean, let's be honest we are all obsessed with the triple/quadruple aim.

Halee Wright: Is that really though what patients want? Meaning, every single one of us. Would that be what I tell you I personally want? Or do we as policy makers and professionals use it as surrogates because we struggle to deliver what patients really want: To be healthy and trust in all the institutions that are supposed to take care of them?

Halee Wright: And that includes not just the practices and hospitals, but also the insurance companies, the policy makers, and every other player in the system. To fulfill that desire, though, we have to do a critical second thing. Treat the whole

person and not just the disease. And we have some amazing practices in the country that are pushing really hard for that idea.

Halee Wright: And Robbie, you mentioned not just one practice, but let's take a look at systems, or I should groups of practices like Iora Health, or let's take a look at Methodist and their system in Nebraska, or the Mayo Care System. They are doing it by focusing on outcomes and not just the preconceived notion of almighty processes to get to those outcomes.

Halee Wright: In this, all we're doing is mechanically treating one disease after another, then the protocols and process measures from on high and the AI driven decision map we all need. We have it all here, right? All we have to do is execute on what we've been protocol-delegated to do. And then we'll fix everything, right?

Halee Wright: Well, I think that's really what the idea of what we need to do in healthcare right now is. But the problem is that none of those tools, and that's all they are, tools, would help someone on the front line figure out how to solve a transportation issue for our patient or try to help a patient who's struggling to take their medication regularly. Or, from my personal experience, a population of people who cannot afford to purchase their medication.

Halee Wright: If we want healthy populations and we want to be healthy ourselves, people on the frontline need the flexibility to focus on the person in front of them and make decisions that are best for them. And that feeds into the third piece of the puzzle.

Halee Wright: I believe that empowered partnerships in which the right people have the right amount of control over the right decisions are crucial to building a culture of excellence in the whole industry. If we all trust that every other player in the industry is making decisions with the same goals in mind, we'll be more collaborative in decision making and contributing to that progress. And we'll be more willing to share our ideas far and wide.

Halee Wright: We need that trust, though, and right now we definitely don't have it. In fact, it reminds me of a story of when I was asked to be a panelist at the University of Miami Conference called the "Business of Care." And what was really interesting is myself, the CEO of the American Medical Association, the CEO of the American Hospital Association, the CEO of the American Nurse Executive, and the CEO of the Healthcare Finance Association, an interesting thing is we all fundamentally agreed on what our goals are. And they're very much, Robbie, what you outlined: Increase life expectancy, increase quality outcomes, decrease cost, make service a priority, and make our doctors happier.

Halee Wright: And yet, we don't work together to get aligned on the goals. I think we should revisit a fundamental taught to both you and I, Robbie, when we were medical students. Primum non nocere, first, do no harm. It's essential to delivering good

and effective care to helping people be healthy. Every single one of us is a part of the system that helps deliver that care.

Halee Wright: So, let's all be held to that standard. Again, I'm talking about not just providers and practices, but also insurance executives, pharmaceutical companies, regulators, financial middlemen, every single one of us. And finally, what empowered partnerships can help eliminate is that tendency to hunt for silver bullets or so-called "disruptive ideas." Because when you have excellence, you don't need disruption.

Halee Wright: Excellence happens through a series of transformative ideas paired with study, progress in problems directly in front of us. I think the masters of the mindset are people like the leaders at Virginia Mason. But most in this industry seem to have abandoned common sense problem solving. There's so many solvable problems we keep talking about in practice, to your point, for the last 40 years. And yet we keep making many of them worse.

Halee Wright: Two of the biggest are administrative complexity and regulatory burden. Solve them and you rapidly save hundreds of billions of dollars, reduce burnout, improve frontline satisfaction, and free up amazing time and resources that actually could be used to improve life expectancy and improve the actual health of people leading to quality outcomes.

Halee Wright: Since 2011, just the direct cost for managing claims, billing, and collections for primary care practices have increased by 74 percent, which is ironic since we're supposedly at a time where technology and electronic transactions are supposed to be making everything more efficient. A journal article put the total cost of billing and claims at $471 billion in 2012. If we save just 50 percent of that, that gets us our decrease in cost that you're pushing for, Robbie.

Halee Wright: A recent AMA survey showed that practices spend 14.6 hours per physician per week on prior authorizations. If I gave any physician 14.6 hours per week, I guarantee you we would increase life expectancy and improve quality outcomes. A researcher using MGMA data from the practices spend $40,000 per physician per year to track and report quality measures. Not to navigate them, not to improve them but just to report. That number alone ended up being $36 billion a year.

Halee Wright: So, the solutions exist and they're actually right in front of us. With a little collaboration and common sense, they could be executed on in the next 18 to 24 months. And these simple things that are just right in front of us would have dramatic and lasting effects on our movement towards better outcomes.

Halee Wright: Now, here's the thing, they aren't sexy and they do seem to be complex. And I really thought hard about it in preparing for this podcast. And I thought, well, maybe I could ask Margot Robbie like she did in The Big Short, to sit in a bubble bath and explain it to everybody, and then we could get people to listen.

Halee Wright: I mean, it did work for that movie, but I'm not sure it would work for healthcare. In short, everybody in healthcare needs to be accountable to contributing to the solutions for solvable problems. Everybody should be accountable to our steady progress towards excellence. Again, we've made a commitment as physicians to do no harm. Because not moving forward is no longer an option.

Robert Pearl: Thank you very much, Halee. And first, let me express my sympathies about your dad. As you know, my dad died from medical error when he experienced the failures of the American healthcare system directly. It motives people like you and me and I suspect quite a number of the listeners.

Robert Pearl: Let me also though, touch on something else you said which is the issue of the bankruptcy that you almost experienced despite having insurance and despite being a very knowledgeable physician, practicing physician, and physician leader. And really hone in on a key question, which is, why do you believe that the people still embrace, the insurance companies still embrace a dysfunctional system, requiring the type of piecemeal service, billing and documentation, why do they do it if it doesn't work?

Halee Wright: I think you touched on a really important question there, Robbie. And I think we're seeing the intersection now of where consumerism is going to cause a change. I think in the last ... when healthcare was instituted in the 1970s really up until about mid, I would say 2008 to 2012, in a certain way, insurance given to people as part of their employment packages, you've made an intuitive assumption that it'll just be paid for.

Halee Wright: And so, it's almost, if you will, an entitlement program where people viewed, I go to my healthcare and it's covered. So, there was somewhat of a disconnect of the consumer's responsibility and the role for asking the right questions and being informed as far as the products they were receiving.

Halee Wright: Then all of a sudden, the cost started to skyrocket and more of that burden was shifted to the consumer. So, I actually think the question you're asking, why do we accept it? What I'm gonna say is, I think we accepted it because it was like boiling the frog, things suddenly shifted and the water just got hotter and hotter. But starting, really I would say, over the last three years, as the Accountable Care Act came into place I think people are becoming more aware of what their roles, responsibilities, and starting to become more informed consumers.

Halee Wright: I actually had a really interesting conversation with my dad at lunch on Saturday where he was talking about, he's on Medicare, his copays for drugs were $400 and that what he had to do, how he was making decisions, how he was gonna choose what Medicare plan was based on his medication copays. And that is not a conversation we could've had five years ago.

Robert Pearl: And why do you think the insurance companies continue to do this if it's so costly?

Halee Wright: You know, I think that ... so, in full candor, I work with several insurance companies to really talk about how do we become better care deliverers. And this is what I meant in my opening statement that we have to align the incentives.

Halee Wright: I don't tend to view any of the participants in the healthcare system as ... I don't see a villain. I think we all function with our true role. The role of an insurance company, particular a publicly traded insurance company, is to generate shareholder value. From a healthcare perspective we want to take care of people and make them healthy.

Halee Wright: So, how do we align those incentives so that we both win in that conversation? And I think that's where that intersection of provider and patient occur. So, I think what I see from the insurance standpoint, and I know from the larger health insurers, we have conversations with them about how do we approach this in a way to engage the physician and the patient in a more effective way to get to your point, increase our quality of outcomes and decrease our costs.

Robert Pearl: So, I don't know any group of individuals more motivated, more compassionate than physicians. Dedicated their entire life to training. And yet, when we look at performance, things like gaps in prevention. Colon cancer, 50 percent of the patients who die in the United States die unnecessarily because they don't get properly screened.

Robert Pearl: Or hand washing, a third of the time doctors go from room to room, they don't wash their hands. Or blood pressure controlling, 55 percent of the time do we achieve it across the United States. Again, let me ask you the same question, why do you think physician performance is, I'll call it, lacking that which, I'll say the best groups in the United states are able to achieve?

Halee Wright: Yeah, I actually think that's a great question. I think it is really what we're talking about is that physicians are overloaded. And so ... and I point to it in the statement I made. When you're spending 14.6 hours a week as a physician getting a prior authorization when you spend two hours on the computer for every hour you spend with a patient and that you're being measured, rewarded, and compensated, really on your productivity that is an engagement with a computer platform, I think these common sense, wash your hands, do preventive things get missed, because in a certain way, this system has tipped to really engaging our providers into documentation as opposed to provision of care.

Halee Wright: And I think that's really what is causing a lot of dissatisfaction with providers. But I also think we are seeing the quality outcome suffer from that, as well.

Robert Pearl: The question I will next pose to you is, if we're going to have each person individually take action, what does that say about the concepts that say, in the quality arena, if people say it's not individuals who are the problem, it's the system, how did we move from everyone having that personal ability to do that which they feel is best for specific patients to getting the best total outcomes by creating a system of care delivery?

Halee Wright: Oh, so, Robbie, I think I told you I was gonna be a disruptor here. I don't believe we have a system of care. I think we have an industry, not a system. I don't think our healthcare, and I'm using air quotes here, system, was every set up to be a system. So, I gotta push against saying that.

Halee Wright: What I can say is, I think we can generate systems of care locally. Not necessarily nationally. And what you talk about as far as taking what is best in class evidence based medicine, and then having point of contact physician, provider ... physician, and excuse me, a patient in a room using the evidence based medicine to act as a framework for decisions. But then being able to pull in all those pieces that at this point in time, so this is August of 2018, there is no AI system in the United States that I'm aware of that can take all the multiple factors that feed into the social determinants of health, healthcare, etc., Into one standardized care regimen.

Halee Wright: So, that's where we can use the data, use the AI and use those care pathways as the architecture and framework. And then use our sanity to make the best decisions. And I think that's how you set up effective systems of care.

Robert Pearl: If we're going to move from a fee-for-service system to what I'll presume is some variant of capitation in the model you're describing, it's gonna require that we change how we pay people for what we value. How's that gonna happen, who's gonna make the choices?

Halee Wright: In my system of the future, we are gonna end up moving to a variant of capitation where there's risk involved. But the risk is not just born by the physician. It's born by everybody in the system. And that's where the one partner that we haven't substantively engage, which is the patient, becomes a key player, and that's what I push towards as empowered partnerships.

Halee Wright: What we see in those type of capitations systems where the consumer becomes the engaged partner, is that consumers will basically take away that what we see right now in our current iteration of capitation where we view it's the provider's responsibility to be an enforcer and actually self-govern themselves because they have skin in the game, they have the finances in the game, they have their outcomes in the game.

Halee Wright: And so, that's where I think those variations in capitation are gonna move forward. Fee for service, I think, it's really interesting. We talk all about, and by we I mean nationally we talk about getting rid of fee for service, moving

towards value-based care, but to your point Robbie, no one's really clarified what value-based care looks like, and yet I can tell you from an MGMA data standpoint, if we take a look at major compensation drivers across the United States, it's still fundamentally fee for service.

Jeremy Corr: What are your thoughts on if there's any danger around if the payers be the one that end up defining value?

Halee Wright: They interesting thing is with the rise of consumerism and with more dollars for care being pushed over to the consumer, I actually think the yellow zone, the warning area, is that we have consumers deciding what quality of care is more than the payers.

Halee Wright: And I think that's where we as a system really have not done a good job anticipating the rise of consumerism and really navigating how we can create effective partnerships and influence our patients in a successful way to become healthier. I think that the role of the payer will diminish as more of that cost shifts to the patient.

Robert Pearl: So, let me ask you about five related but separate pieces. The first one I want to ask you about is about end of life and palliative care. Senator McCain, as you know, died this week in recording the program. I wrote a piece for Forbes, because I was really shocked when the media started talking about him giving up by not having another round of chemotherapy. How are we going to bring this crucial conversation, all the dollars that we spend on end of life that add no value, how do you see that happening in this system you're describing?

Halee Wright: Very much. So, I think it's a great and timely example. I'm gonna draw my experience when I was a chief medical officer and I was actually tasked with putting in a palliative care service line into the hospital. And what was really interesting to me as I went on that journey is how uncomfortable physicians are, and this points directly to the McCain conversation, in engaging in palliative care and really doing education around why patients have much higher satisfaction, getting back to one of the goals, when palliative care is instituted.

Halee Wright: And really, I think it's gonna be, to succinctly answer your question, it's gonna be the patient that drives to those conversations because as physicians, we view death as the competitor. And if we allow our patients to die if we've lost. Instead, from a consumer-driven conversation, having those conversations of what is your expectation? What do you want your end of life to be? How can we make you comfortable? Let's set all of that up.

Halee Wright: So, it's a much different focus on what the outcome is. And once again, I'm gonna poke on not what the process is, the process is we want to do everything possible, versus the outcome. Here's what I want at the end of my life. And I think that senator McCain was, I think, a great role model in having those

conversations and choosing the end of life on his terms. And that dignity we need to bring to our patients in the future.

Robert Pearl: I agree completely. Let me ask you, you mentioned before all the measures people have. A remember a conversation I had with a physician and I said, "Why do we have 80 measures in primary care?" And his response, "Cause that's all the rows there are in an Excel spreadsheet." The question for you is, how are we going to ensure quality?

Halee Wright: So, for the audience, a little education, currently, if you take the three major health insurers plus Medicare, for a primary care physician, there are over 4,600 necessary reported quality measures to ensure full reimbursement of your provider in practice. Of that, probably, so, this is best guess, not qualified data, probably 60 percent of them are redundant.

Halee Wright: So, what we take a look at data, I'll use diabetes data. The American Academy of Family Practice has guidelines. The American College of Surgeons has guidelines. The American Society of Endocrinologists has guidelines, Cigna has Guidelines, United Healthcare has guidelines and CMS has guidelines. So, as you look across all those, what's really interesting to me is defining what is successful treatment of diabetes, and then working forward, how do you achieve those goals?

Halee Wright: I'd advocate is that we actually need to determine what qualities, using, once again, evidence based medicine and setting a guideline. But then we have to as providers, define what quality is for individual patients in front of us. And some of that is actually having the conversations with our patients in regards to what defines quality.

Halee Wright: And because they are going to be the financial stakeholder, recognizing that if they choose not to participate with these guidelines, they may not receive medical care for the type of medical care that they have traditionally received for doing that. Quality is such a bucket because these little measures become the surrogate measure of actual delivery of care, the quality that's delivered care.

Halee Wright: And multiple studies have shown that they are not necessarily directly related to cost efficiency, patient satisfaction, physician satisfaction. In a lot of ways, they actually act as barriers. So, I think it's really honing down on what are the quality measures that actually matter and committing to that and then moving forward on achieving those quality goals.

Robert Pearl: Third question, has to do with what I see to be the most challenging part of the total healthcare cost conundrum, and that's pharmacy, where we see the cost rising more rapidly than anything else. Going up in double digits rather than low single digits. Many of the drugs that are being sold and advertised are ones that don't add much value. And as you probably saw this week, someone estimated that if all the drugs ... so they combine two other drugs didn't add anything else

except combining two pills, were in place, Medicare could save billions of dollars each year. How should we approach the pharmaceutical industry to get into align with the other things you're describing?

Halee Wright: Absolutely. It's really interesting to me, the business model of pharmaceuticals. So, the cynic in me, and I actually ... I'll just throw this out to basically put gasoline on the fire, would say the best way to deal with this is election campaign reform.

Halee Wright: But, we'll just take that offline and say, probably one of the best ways to take a look at navigating in the pharmaceutical cost, is to really move from a healthcare finance policy, which is what we're doing right now, to healthcare policy. Once we get really clear in what our goals are from providing healthcare with individuals, then I think that we're gonna have to have those crucial conversations with the pharmaceutical companies and define what we are and aren't paying for.

Halee Wright: Right now, we see players such as the insurance companies, Intermountain Healthcare, Amazon, are all trying to take out the intermediaries in the pharmaceutical supply chain, which will decrease costs. But it's only one more step 'til they start getting into the pharmacy business themselves.

Halee Wright: One of the things that I, in preparing for this talk, I found out is that even our government, unlike Kaiser ... Kaiser Permanente will go to, as you're well aware Robbie, will go to a pharmaceutical and say, "This one drug, and we want the best price," because you're providing care for a large number of people.

Halee Wright: Our government doesn't do that. Our government actually pays multiple different prices for drugs depending on if you are in the VA system, if you're in the military, or if you're part of Medicare. And that just, seems somewhat insane to me if you're actually purchasing drugs from one pharmaceutical company that you're paying multiple different prices.

Halee Wright: So, I think it starts with asking ourselves what we want. We want good health. And then we work backwards into how do we provide that. And then we basically leverage down the influence of pharmaceutical companies. And we do that by being smart business people and by saying, "If I'm your number one customer this is what we're gonna pay." And then we have to bring people into line.

Halee Wright: Conversely, I had the opportunity here, one of the former administrators of CMS, talk about one of the challenges we have is that we have new drugs that advertise. And so, we're going direct to consumer advertising. And I am actually a big advocate in getting rid of that advertising because I think it creates a false perception of what quality is, what the need is, and actually drive some of those costs way up.

Jeremy Corr: I think one of the misconceptions out there, and even an argument that I've heard is that part of the reason so much money goes into big pharma is that it goes into R&D for new and better drugs, what are your thoughts on that?

Halee Wright: It's really hard to take a look at the possibility of pharmaceutical companies and to really take that argument very seriously.

Robert Pearl: Let me ask you next about technology, which I believe offers tremendously possibility. I spoken about the possibility pf video replacing a third of what we do in the offices. And yet surveys say that physicians use telehealth, certainly under five percent across this country. And quite a number of physicians may not be particularly interested or even believe in the possibility of providing care over a not-in-person type encounter. What are your thoughts on technology and how do we make sure that we provide the technology that patients want?

Halee Wright: Well, I think ... so, I'm a big fan of technology in a way completely different than we've ever used it in healthcare. And I don't think we can talk about technology and providers in the same breath without really declaring the epic failure the EHRs have been.

Halee Wright: EHRs have been a huge failure with physicians because they're really designed, in this day and age, designed from a business standpoint to filter into administrative and financial systems, and not effectively to deliver care. So, when we use that, and it was forced on physicians, in a certain way against their will. It was really crucial for under "Meaningful Use" to get paid for.

Halee Wright: And so, when we do that to physicians, when we take away their independence and autonomy and we use healthcare technology, which up to this point in time, it is really financial administrative, we are not leveraging technology for its best and highest use.

Halee Wright: The best and highest use of technology, and Robbie, I think you and I agree on this from what I read about what you've written, is to really allow the physician to be at the top of their license and spend more time engaging in the meaningful relationship and really pushing for high-quality care. That's where technology has it's highest and best purpose.

Halee Wright: And so, what we need to do is almost give ... well, I think what we need to do is give physicians back autonomy and then really redesign our technological systems from the end-user standpoint. Basically, it was kind of funny, I was talking to someone and they said, "We have the Microsoft Windows XP version of healthcare." And really what everyone's looking for is a MacBook Pro.

Halee Wright: So, we're looking for someone anyone can do. You open it up, you just use it to be productive. And that's not how technology has shown up for providers yet. But as providers, and this is a point for us as providers, if we refuse to engage in systems that are purely designed from administrative and financial standpoint

and demand systems that allow us to leverage technology to be better physicians, I think it'll be hugely successful and live up to the potential and promise we've been talking about for the last 25 years.

Robert Pearl: We definitely agree. The challenge of course would be getting the manufacturers of today's systems to open their APIs, the Application Processing interfaces. 'Cause once that was there, then third party developers could step in and create what you're describing, but without that, and I think the companies are resistant to doing that because of the fear that people will move to a new company rather than their company, and they want to hold on to the patients. But that's a much larger conversation.

Halee Wright: Yes, it is.

Robert Pearl: The last question. Maybe in some ways, the most significant, particularly in your role in MGMA is, at least from my perspectives, we have an imbalance in the healthcare system. Too many specialist, not enough primary care. Some communities have too many cardiologists, too few orthopedists, vice versa, too many hospitals, redundant systems, redundant services, how can we right size the American healthcare system? How is it gonna happen, who's gonna do it, and how are we going to handle the fact that there will be both winners and losers as a consequence of decisions that are made?

Halee Wright: So, I think this is a really complex question, and I don't think it's about coming up with for everyone 100,000 people, we need 10 GI doctors, three CT surgeons, four neurosurgeons. And I think saying that there's a right-sized solution is somewhat indulging our appetites for a silver bullet.

Halee Wright: So, I think a way to approach this is to bring it down to the frontline of care. We agree the system is out of balance, but I don't think we know what the right number of specialists are. Because in all fairness, we're not leveraging them to do the right level of work. And we're focused on a disease system and not a well-care system.

Halee Wright: What we can focus on, and I think that this underlies the number of specialists we have, is as a healthcare industry, we focused on a capitalistic market approach. And I'll just put it out there, I became a pediatrician and practiced for 19 years. I had classmates that became GI doctors. Candidly, the GI doctors in my class made much better business decisions than I did. And let me put it this way as the CEO of MGMA where we put out the survey that talked about what physicians get compensated, I can tell you that with a significant force of data behind me, we have addressed the issue of medical students who graduate with debt.

Halee Wright: And so, it's really hard for me to engage in a conversation about the number of specialists until we really talk about the cost of medical education. Seventy percent of people graduate from medical school owing more than $300,000.

And they have a delayed start to their career. And one of the things I write about in "Back to Balance" is I saw a compelling analysis when I was writing that, that basically given the fact that they invest in their education and have a late start, really doctors end up making about the same hourly rate as teachers if you go into primary care.

Halee Wright: To really engage in the question of the proper number of specialists, we have to change the economics of our medical education, and we can't expect medical students who have to service the debt that they undertake to change their personal economic decisions to align with what we think our goals as a society are. So, I think that that question actually has to be answered before we get into the total number of specialists.

Robert Pearl: We could go on for hours. Let me turn over to Jeremy to bring the point of view of the patient into the conversation.

Jeremy Corr: In the plan you outlined earlier in the episode, you mentioned triple and quadruple aim. Could you please explain that for our listeners?

Halee Wright: Sure, the Institute of Medicine put out a report in the early 2000s that really talked about how much waste their was in healthcare. Basically, identified that first study, that there was about 30 percent of what we spend in healthcare is wasted money.

Halee Wright: So, to combat that waste, one of the techniques that was developed for healthcare providers was this band around what we call the triple aim. And the triple aim is a philosophy where you want to increase quality of care, decrease cost of care, increase patient satisfaction, that's the tripling. As more and more research has come out showing, really demonstrating that physicians are dissatisfied, we've moved into the quadruple aim where we add in there physician satisfaction.

Halee Wright: So, every conference over the last five years I've attended, regardless of what the conversation has been, ultimately leads back to the triple aim, how do we get back to the triple aim? Cost, quality, and satisfaction.

Jeremy Corr: You talked about the cost of attending medical school, what are your thought son what NYU announced in regards to the free medical school tuition?

Halee Wright: So, 60 percent of me says finally, and 40 percent of me, and that's the cynic in me, says, if we only have one medical school who does that, we're actually gonna ultimately defeat our goals. Because if that's only one medical school who decides to do that, then that medical school will ultimately attract the most competitive, the brightest, the best, and these are ... you know, we're smart, I mean doctors are smart.

Halee Wright: We'll say "Yes, we want to go into primary care. That's why we're choosing to go to NYU." And yet, as driven successful people, most likely we're gonna actually reinforce more specialists going out of that class ultimately than we would've thought. And I think that's one of the challenges of a lot of the things we do in healthcare is that we don't anticipate the undesired consequences.

Jeremy Corr: Earlier in the episode, you talked about the administrative burden that physicians are facing. This has been a big part of the reason for reduced face-time with a primary care physician, reduced eye contact, reduced relationship. And this is a relationship that patients really value. Do you have any advice for patients who want to take back their primary care visits and ensure that they're getting the face-time and the trusted relationship they value so much?

Halee Wright: A statistic that I write about is that every primary care visit has on average, 800 clicks on a keyboard. So, as a patient, one of the things that you can do, and I say it tongue in cheek and with half a grin, is to say, "My eyes are here."

Halee Wright: I think we really have to push our providers who have, in a certain way, as I mentioned earlier, boiled the frog, had this technology and the reporting issues buried on top of them, really demand that we have an actual interaction eye to eye with a physician while we're in their office. And vote with our feet. If we can't get our physician to meaningfully engage with us then we need to be able to find a new physician.

Halee Wright: In turn, that should drive our physicians to find better technological solutions for reporting than they currently have now. So, I think that actually is where the frontline can influence up into this. Into the industry more so than we've seen that before.

Jeremy Corr: Well Halee, we have taken up a lot of your time today. Can you please provide a closing statement with takeaways for both industry leaders and for the average healthcare consumer? You may also ask them to follow you on your social media channels.

Halee Wright: Sure. So, I would like to encourage people to follow me at DrHalee.com. But, what I really want to do is to leave this conversation with a message of empowerment and optimism. What can we do as practice leaders, providers and patients? Well, you know, as I've talked about for the last hour, we've been sold a victim mentality.

Halee Wright: But it's a myth. In fact, we are healthcare. And without all of us there is no healthcare. Our entire $3.7 trillion healthcare system ironically, is really built on top of what happens with a patient and a provider in an office. So, if you're a provider or practice leader, the only way to battle the things that cause dissatisfaction and burnout, believe it or not, is to become more engaged.

Halee Wright: You are not at the whims of the industry that doesn't care about you or the patients you serve. You are empowered, especially within your practice but also outside of it. To make the daily choices to improve your professional life, improve your ability to do the work you want to do and how you do it. Small changes can and do yield a lot of positive outcomes.

Halee Wright: For patients, as overwhelming as the demands of the healthcare system can seem, you have the ability to also become an empowered partner. In fact, it's a requirement in our current system and will be even more important in the future. The roles the medical practice once played in patients' lives has changed.

Halee Wright: So, educate yourself on the essential issues effecting healthcare. Learn what's happened behind the curtain. That knowledge will help you make a better decision and have a much better experience. And be a better advocate for the kind of care you want.

Robert Pearl: Halee, thank you again for being on the show today. When I was the CEO in Kaiser Permanente, I had a model that said innovate locally, and learn regionally. You've taken it up to another notch to innovate locally and learn nationally. Like you, I am optimistic about what could happen in the future.

Robert Pearl: I can't promise you that your approach and recommendations will be the ones our nation embraces. But for anyone who thought that solutions didn't exist, you have proved them wrong. And this was a lot of fun.

Halee Wright: Thank you Dr. Pearl and thank you Jeremy for the opportunity to participate in this podcast.

Jeremy Corr: Next month, our guest will be doctor David Feinberg, the president and CEO of Geisinger Health. He is also the author of "Proven Care: How to Deliver Value Based Healthcare the Geisinger Way." Dr. Feinberg is considered to be one of the most innovative and forward-thinking leaders in healthcare. We are looking forward to having him on the show.

Robert Pearl: To our listeners, please subscribe to Fixing Healthcare on iTunes or other podcast software. If you like the show, please rate the show five stars and leave a review. Visit our website, www.Fixinghealthcarepodcast.com. Follow us on LinkedIn and Twitter @FixingHCpodcast, that stands for healthcare podcast. You can find our personal LinkedIn and Twitter accounts on the website. For additional information on other healthcare topics, you can check out my website RobertPearlMD.com. We hope you enjoyed this podcast. Go tell your friends and colleagues about it. Together, we can make American healthcare the best in the world.

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