Fixing Healthcare Episode 3 Transcript:

Interview with Dr. David Feinberg

Jeremy Corr: Hello everyone and welcome to the third episode of Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. I am one of your host, Jeremy Corr. I am also the host of the popular New Books in Medicine podcast. I have with me my co-host, Dr. 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's a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book, Mistreated: Why We Think We're Getting Good Health Care—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 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: The show's format is simple. Our guests will have 10 minutes to present a road map 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 guests, and helping our listeners separate real solutions from hype. Then Jeremy will dive in from the patient's perspective, ensuring their concerns are addressed, because certainly concepts are clear for listeners and helping to translate any medical jargon we have into normal conversational language. 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 truly disruptive change, not just a few minor tweaks.

Jeremy Corr: Our guest today is Dr. David Feinberg. He is president and CEO of Geisinger, one of the nation's largest health services organizations known for innovation and excellent medical care. Dr. Feinberg earned his undergraduate degree at the University of California Berkeley and graduated with distinction from the University of Health Sciences, Chicago Medical School. He earned a master of business administration from Pepperdine University. Prior to joining Geisinger, Dr. Feinberg served as a CEO of UCLA's hospitals and associate vice chancellor of UCLA health sciences, as well as president of UCLA health system.

Jeremy Corr: With a focus on caring for patients and members, Dr. Feinberg caught the industry's attention by launching SpringBoard Health, a population health initiative to improve the health of an entire community. Geisinger's ProvenExperience to provide refunds to patient's unhappy with their care experience, and Geisinger's MyCode community health initiative, the largest healthcare system based precision health project in the world that is returning medically actionable results to participants while conducting extensive research.

To date, nearly 200,000 volunteer participants have enrolled. He also wrote the book ProvenCare: How to Deliver Value-Based Healthcare the Geisinger Way. Dr. Feinberg is nationally recognized as one of the top minds and leaders in healthcare.

Robert Pearl: David, please consider yourself an applicant for the job of leader of American healthcare. You're being hired due to your experience and reputation as a visionary leader and innovator. After decades of talking about the unaffordability of healthcare coverage, and nearly 20 years of lamenting lagging quality, and over 100,000 deaths nationally each year from preventable medical error, our country is ready to make a major change. So I told the audience, we're not interested in small incremental fixes, or simply trade-offs amongst cost, quality, and service. But instead, we believe that disruption is possible. Dr. Feinberg, you are the right person to make it happen. The deliverables are significant in size and scope, but let's see if we can achieve this level of improvement, we don't believe over the next five to 10 years, the American people will be willing to move forward. We'd like to provide a plan, have you tell us how to achieve the following.

Robert Pearl: One, increased life expectancy in the US from last amongst the 11 most industrialized nations, to at least the middle of the pack. Two, increase quality outcomes as publicly reported by organizations like the National Quality Assurance Committee, the NCQA, by at least 20%. Decrease the cost of care by 20% on federally reported data. Improve service and convenience for patients by 20%, on satisfaction surveys. And improve professional satisfaction for clinicians by 20% on physician surveys. 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. David, we can't wait to hear your plan.

David Feinberg: Well, Jeremy and Robert, what a privilege for me to be here discussing this with you, but let me start out by saying, I think your question is actually really easy, and fixing healthcare in America is the simplest thing we can do. The problem is, we've been looking at the wrong problem. So when we talk about healthcare, and if I even go over your five questions about how are you going to improve life expectancy, what are you going to do to improve quality, what are you going to do service, that's fixing a system that's broken. Really what we need to do is say, "Well, what does drive health, and what does drive mortality?"

David Feinberg: We probably get 20% of whether we live or die, whether we have life in our years and years in our life, based on going to good doctors and good hospitals. I will address that, but we're going to put all of our efforts in my plan, or the majority of my efforts is on all the other stuff. The stuff that really matters: your genetic code, your zip code, your social environment, your access to clean food, your access to transportation, how much loneliness you have or don't have.

David Feinberg: When we talk about American healthcare, all we talk about is make that pill less money. Seven out of 10 Americans are on a prescription medication, so we can beat up the pharmaceutical companies and say, "God, they're charging too much for medications," or we can say, "Why are seven out of 10 Americans on medications and can we get Americans off medications?" We talk about opiates killing people. We make up 5% of the world's population and we consume 50% of the illegal drugs. So those are expensive habits. My plan, you know, Robert and Jeremy, I'm 56 years old.

David Feinberg: When I was born, the chances of me developing type two diabetes was 1 in 100. If I were born today, the chances of me developing type two diabetes is 1 in 3. So that's not a genetic change. Something happened in our food that people born today have a 33 times higher chance of getting diabetes in America. We spend more on obesity than we spend on defense. Somewhere between 3% and 7% of GDP is spent on obesity, and that's a new problem. So if we're going to fix American healthcare, we've got to put aside American healthcare for a second and figure out how come people aren't exercising, having access to food, not shooting each other, not wearing their seat belts, not using alcohol in moderation, and not using substances? So my plan would affect all of those things.

David Feinberg: Now we know for sure that if we look at your genome now, which we can do for a few hundred dollars, used to cost about $10 million, we can find medically actionable conditions that we can prevent in advance. We can find half the people that wouldn't know they had BRCA based on their family history, and intervene early. We can literally save lives based on your genetics, and that's probably about 10% or 20% of my plan. The rest of my plan is around transportation, food, housing, loneliness, and behaviors. All of these behaviors that we need to change are actually simple. When you think about it, we didn't have these levels of obesity 50 years ago. So what happened kind of in that half of a century that got us in this bad direction.

David Feinberg: My plan, and I think it's actually pretty straightforward, is if you think about healthcare in America, it costs us on average about $10,000 per person, and in that $10,000 per person I would say, and you have said in your introduction, that our outcomes aren't that good. So we're not even getting a good bang for our buck. So what if instead we said to people, and most people who are working pay about 3,000 of that 10,000 themselves, through copays, coinsurance, premiums. The other 7,000 is paid for by their employer. That's what makes up the 10,000. But let's just take for example, three employees.

David Feinberg: Employee number one has a normal BMI. They exercise, they do all of their preventive screening, they're healthy, they're on no meds, they use alcohol in moderation, they wear their seat belt, they do all the right stuff. Employee number two is a little overweight, has a little hypertension, occasionally misses a preventive screen, like a colonoscopy or a mammography, and has high cholesterol and is too sedentary. Employee number three is a train wreck. A lot of lifestyle disorders have caught up with this person. They have a lung disease, heart disease, they're morbidly obese. They don't exercise, they don't take good care of themselves, they don't even manage the diseases that they have well. We call them, and I think this is not the right term, but we call them in healthcare a noncompliant patient.

David Feinberg: Let's take those three people aside. Let's bring them in a room, in a conference room, and that number of three, I don't care if it's three buildings of people, 3,000 people, three people, three people in a family, but let's give them this option. Let's say to those three people, "We got a deal for you next year. You three, employee number one, if you stay healthy and you can get employee number two to be as healthy as you are, meaning take that mildly non-healthy person and make them healthy. Employee number three, you have to become as healthy as number two. You don't have to get all the way there. You just have to get, you know, start doing some of your regular screening, manage your conditions, and lose a little weight. If the three of you can achieve this, because I think we got unhealthy as a group, but if the three people together can achieve this, we got something for you next year."

David Feinberg: They say, "Well what is that?"

David Feinberg: I say, "Well, we're going to give you free healthcare. There'll be no premium, there'll be no copay, there'll be no coinsurance. Your medications will be free, absolutely free," and we've done this, and when we do this, everybody looks at you and goes, "Wow, that's fantastic. I'll take that."

David Feinberg: Then I say, "You're actually going to get something better than that. Not only are you going to get free healthcare, you're going to get your health, you're going to get more years with your grand kids, you're going to be more active, your sex life's going to get better. You're going to sleep better, everything's going to get better. Actually, the gift is better than free healthcare." So how do we pay for that?

David Feinberg: Well, if you think about it, that employee, remember, each one on average costs us about $10,000. So that's $30,000 in healthcare, some from an employer, some from the individual, to care for those three people. But number one, if we look at their claims data, only cost us $5,000. Number two only cost us $10,000. Number three cost us $15,000, and you add the five, the 10, the 15 and there's your $30,000. But remember next year, two of them have become a number one and the number three person dropped down to a number two, right? We went from healthy, moderately ill, severely ill, to healthy, healthily, and moderately ill. So that's $5,000, $5,000, and $10,000. We just cut $10,000 of the $30,000 in healthcare costs away. That was the part those folks were paying themselves. That was the $3,000 or $4,000 out of the $10,000 that each was paying. So we can now say it's free.

David Feinberg: Now their employers still pay the six grand, but these people now have free healthcare at least from their own pocket. What does the employer think? "This is incredible. I got better presenteeism. People are coming to work. They're missing less work because they're ill," and if one of those people looks for a job down the block at a competitor, and everyone's paying market based wages, that employee goes to look for a new job. Yes, you pay me the same to do the same type of job and that employee says, "Well, what's the healthcare benefit here?"

David Feinberg: That other employer says, "Well the healthcare benefit here is there's a $2,000 premium and you pay $30 for certain meds and $10 for these meds, and there's regular healthcare."

David Feinberg: That employee goes, "Wow, I'm going to stay at my job because they pay the same, but I get 'free,' and I say free in quotes, because it's just free from the employee's eyes. Free healthcare. So you've got much better retention. Now all of a sudden we've got a healthier workforce and we've literally cut the cost of healthcare by 30%, and nobody yet has gone to the hospital, and just doing those things: eating right, normal BMI, not smoking, alcohol in moderation, not shooting one another, getting preventive screenings, we know we'll decrease healthcare costs overall by 50% in the United States. 50% of the disorders we're paying for are lifestyle disorders. That little group of three people took care of themselves and got themselves healthier. We know how to nudge people. We know social and behavioral cues that make people healthier.

David Feinberg: That group of three is going to say, "Hey, we're a team. Let's go on a walk. We're a team. Hey, let's not get dessert every time we go out. What's your weight? I'm wearing an Apple watch. Did you close your circles?" That's how people change

behaviors. So we've now cut healthcare costs in half. We have employers happy. For the first time healthcare costs aren't going up for employers, and I don't even yet have to worry about getting to let's get less errors in the hospitalization. We just decreased hospitalizations by 50%. So by definition, there's going to be less errors because there's less people going through the hospital, and then I'm happy to talk more about how can we actually improve quality and measures like that, but to me we keep talking about that and we're missing this big picture of understanding people's genetic code, their zip code, their microenvironment, and really what drives behavior. That's what's costing us so much in American healthcare.

Robert Pearl: So maybe David, you and I can start by just talking about this part of the plan, and then we can double back to the other questions of how do you take care of the 30% of cost that sit within the healthcare system itself.

David Feinberg: Sure.

Robert Pearl: Let me start with the following question, which is about the transition period. What we know is that it takes probably five years for these types of lifestyle changes to actually present themselves in terms of reduced hospital or medical costs, lower blood lipid, control blood pressure. You don't see it the next year, you see it over I'll say five years, somewhere between three and 10 depending upon the specific condition. How do you think about funding this during the transition period?

David Feinberg: I'm going to push back on that. So, I know we're not supposed to just focus on what we're doing, but let me give you an example of where we've seen that change happen in three months and not in five years. We screened all our type two diabetics, we care for about 3 million patients. All type two diabetics, and not type one diabetes, which is a genetic disorder, but type two diabetes, which by and large is a lifestyle disorder, very closely associated with obesity. We screened them all to see who in that group is food insecure. Food insecure means they said yes to one of two questions. I'm going to run out of food this month or I'm worried I don't have money for food. You say yes to one of those, you have type two diabetes that's out of control, meaning your long-term blood sugar, which should be, that measure should be a low six and a half, 7% or less, is 10, 11, 12, 13.

David Feinberg: We say to those folks, "Come on in. We want to give you some diabetic education and here's healthy food for you and your family, and if you're living in a hotel or a motel and you need a hot plate or a microwave, we got you covered. You come in every week and you'll always get seven fresh fruits and seven fresh vegetables to choose from. Lean meats, whole grains, just good stuff. Oatmeal and quinoa and carrots, skinless meats." What we've seen in that group, is those folks were costing us, and these weren't people that were not getting medical care. They were getting medical care from us. These were our patients. They were seeing our doctors, our nurses, our care managers. These weren't people off the street. These were people that were already accessing care.

David Feinberg: We saw hemoglobin A1Cs in three months drop literally from 13 to seven. We saw everyone's blood sugar get better and their cost went from about $200,000 per patient per year, within three months, their medical costs were running around $40,000 a year, $160,000 savings that we were able to start seeing take effect at month three. Now, your number of five years really is talking about a general population that's having medical issues or lifestyle issues and to start to

see those changes, but there's plenty of people, and we know it, that that small 5% that are driving so much of the cost of healthcare, if we can get those folks healthy, I believe that we can see those kinds of financial results in months and not in years.

David Feinberg: The other thing about that that I think is absolutely crucial, that we don't talk enough about, is type two diabetes. We were talking about one in three people born today is going to have type two diabetes. This is the biggest thing affecting us, is associated with poverty, because if you're poor, if you're really poor, you eat rice and beans. As you become a little less poor, you start eating high-caloric, non-nutritious food, right? You're eating fast food that gets you into the type two diabetes. Then when you get type two diabetes, you actually become more poor because you missed 17 days of work, on average per year. So, it's this vicious cycle. When you don't have access to food, that you end up getting sick and poor, and because you're poor, you get sicker.

David Feinberg: When you break the cycle with food, not only have we seen these dramatic results in improving their medical care, but in decreasing their healthcare costs, guess what? The poverty gets better. I just met with one of our patients, he's a commercial driver, trucker, couldn't get his commercial driver's license renewed because his blood sugars were already in the 300s. In our Fresh Food Pharmacy program, blood sugars get better. He's back driving. We got so many of those stories as we start treating the patient's medical issue that's really driven because of poverty. Not only does the medical issue gets better, but as the medical issue gets better, the poverty gets better, and that helps the economy overall.

David Feinberg: We think you can make these interventions in months or a year, and then you don't need to wait five years to see it. But even if you had to wait five years to see it, it still makes sense, particularly for populations that are stable, to make those kinds of investments because you're going to eventually get the pay off, and if not, someone's going to pay the piper. So that's why we're all in and in my plan, it would be all in that we really once and for all, solve the problem of people not having access to healthy food. Solve the problem around transportation, solve the problem around homelessness and housing, and we would see a dramatic decrease, not only in healthcare costs, but we would see an improvement in poverty, which would drive our economy.

Jeremy Corr: How realistic do you think it is on a national scale, especially in areas that are traditionally food deserts, to make healthy food as affordable and convenient as fast food, while providing education to the population about how to eat healthy?

David Feinberg: We've done it. I think it's pretty straightforward. I think it's actually pretty easy. There's so much food waste in America. We have great, great food banks. The food banks don't always provide healthy food. They would say they're closing the hunger gap, not the nutrition gap. It's not like it happens overnight, but next year we will serve 1.5 million meals to our patients that have type two diabetes that are food insecure. This program started within the last couple of years, and I think that 1.5 million number will continue to grow.

Robert Pearl: Certainly a lot of people have pointed out the social determinants of health. As you start to list them with housing, with jobs, with transportation, we're talking about an industry that's at least as large as the entire American healthcare system. Where do you see the partnerships, and more importantly, how would you shift the politics?

David Feinberg: So, for us, and now we're an integrated delivery system, so we not only care for patients, we insure the patients, what we've said, and somebody is paying for every patient somewhere. So there's always somebody that this would make sense for. So to me, the politics of the policy is you get to the person that's responsible for that payment, because if they're uninsured, everybody else in the community is paying for them. If they're commercially insured, the employer's paying. If they're governmently insured, the government's paying, and in our case, if they're insured by their own health system, we're paying. So what we've said is, "Wow, we think loneliness is probably as big of a risk factor for heart disease as actual coronary artery disease."

David Feinberg: So, if you live within 50 miles of where I am today in Danville, Pennsylvania, where we have a lot of hospitals and clinics, or 25 miles where we have a lot of hospitals up in clinics in Northeastern Scranton area. If you live within those areas and you need a ride to the doctor, to church, to your friend, to the supermarket, give us a call, we got you covered. No charge, we will get you to wherever you need to go because we wanted to eliminate transportation issues as a driver of increased healthcare costs. You said you don't want to hear about pilots, so we agree. We don't think it's a pilot. We're doing it across our entire system. I just think those types of interventions are so much more valuable in driving down healthcare costs and making people's lives better that somebody needs to be doing that everywhere. Take me to any town in America and I can tell you, and it's usually pretty much the same, that about a third to a half of the people are getting their healthcare paid for by the government.

David Feinberg: The government should be providing those folks transportation, the ones that don't have it. The other half of the people that have commercial insurance, meaning their employer's paying, should say, "For my low wage workers who don't have transportation, I need to provide transportation, or it's going to drive up my healthcare costs." That actually getting someone to the doctor is a lot cheaper than having the ambulance come two days later when they're really ill and putting them in the hospital. So these are just to me, very, very common sense. I think they make sense across both parts of the aisle because yes, you could say it's an entitlement, but on the other side of the aisle, it's a great driver of the economy, and it's a great business initiative to decrease healthcare costs by providing really some of these basic services.

Jeremy Corr: What are your thoughts on the whole body positive movement that's going on now where people are embracing and even sometimes being proud of unhealthy and overweight lifestyles?

David Feinberg: I'm a guy who says you can do whatever you want. I'm not a person that says you have to do this. We all make our own choices, but those are expensive, and if we're pooled in insurance, I get a discount on my driving insurance because I don't get speeding tickets. But if you and I have the same insurance and you don't want to take good care of your body, why do I have to pay for your insurance? Why do I have to subsidize your lifestyle choices? So, where I think it's, "Hey, every man for themselves," and if you want to be overweight, that's no problem. I got no problem, go for it, but don't make me pay for it. I don't think we should shame anyone for their choices, but choices have consequences, except in healthcare, because in healthcare, you get covered at work and it doesn't matter. The only places we see it a little bit is some places like us won't hire you if you're a smoker.

David Feinberg: But come on, in everywhere else, you got to cover yourself. Here we say, "No, you can totally disrespect your body and then you demand to be seen right away." It's like, "Whoa, whoa, whoa, that's hard." Now, I think there's some particular issues around obesity that are associated with some genetic disorder, so I'm sort of exaggerating, because I think some people do get a hall pass, but by and large, we're talking about lifestyle choices that are expensive. But hey, if you want to be a skydiver, you certainly can, but I shouldn't have to pay for the risk associated with that. So, I got no problem with folks that want to embrace their body however their body is, but it comes with costs. Some people like to do this, and some like to do that. I just don't want to be burdened with that cost.

Robert Pearl: When I was the CEO in Kaiser Permanente, I was able to lead the process of lowering hospitalization. In this case, we looked at Medicare patients nationally, spent 1,400 patient days per thousand Medicare members. We drove it to 700, under 700, less than half. When I went and told people about this expecting to get a positive reaction, they had the opposite. The hospitals were saying, "We couldn't stay in business if all of a sudden half the patients didn't need our services." Your plan will have the same impact. How are you going to address the current American healthcare system?

David Feinberg: Well, I run a health system and we have about 13 or so hospitals and I think my job is to close every one of them, and I would congratulate you on what you did, but I think there's even more work to be done and you could have lowered your hospitalization rate even further. A couple of things I think we need to do. I think a lot of those patients, even the ones that you managed well but ended up in the hospital, could be managed better at home. So we look at our highest utilizers, our sickest patients. We show up at their house in two cars, because we can't all fit in one car, and we got a nurse, a palliative care nurse, a community health worker, a pharmacist, a doc.

David Feinberg: We say, "Hi sir or ma'am, we're here to take care of you, and our goal is you never go in the hospital again and we know you've been hospitalized 12 times in the last year." Let's clean out the medicine cabinet. Let's make sure the house is safe. "Oh, you have a bunch of appointments that are hard for you to get to? We'll do them through telemedicine right now at the kitchen table." Just completely eliminate the need for those folks to ever go in the hospital again. Those are the ones that are driving a lot of the hospitalization. So I think even when you decrease utilization, and we say less got in, I think we can even do better.

David Feinberg: Now, I do believe that ultimately still people may get hit by cars or we may be doing types of procedures that can't be done in people's homes, but that really should become an exception. Or you could think of it as a failure. Worse yet, is they had to come to a doctor. Why do people have to come to a doctor now? I don't go to the bookstore anymore. I don't go to my travel agent anymore. I can actually do so much through my phone, why can't I tell you here what my symptoms are, and can you hook me up with someone who can help me? If I do need medicines, why don't you just drone them to my house?

David Feinberg: So those types of interventions I think are coming and those disruptions are absolutely crucial. Then we get to your question Robbie. Well, we got these big hospitals and we got 6,000 employees here and we're the big employer in town, it's insane. We need to repurpose those people out in the community to keep people healthy and out of their hospitals. Then we have to actually figure out what to do with the bricks and mortars, and I would say those of us in this

business that think we need to hang onto those bricks and mortars, we're going to start looking like blockbuster video and Netflix is coming. So I think the bricks and mortars are an asset that we need to get rid of as quickly as possible, because we take care of people in a way that they're used to in every other part of their life now. So everything you can get at home, everything you can get online, except good healthcare, and so we're driving all the care to home and we think if you went into our outpatient clinic, that's a failure of our home care and if you went into our inpatient, that's a failure of our outpatient, because we could do a lot of it in buildings that we kept 24 hours open that don't need to have the same kind of acuity as a hospital.

David Feinberg: So to us it's all a move toward home. It's all a move toward making communities healthy, and it's all in this time, because people have given this story before, I think there's two fundamental differences. One is we literally can't afford it anymore, right? So whether we're at 18% of GDP or tomorrow we'll be at 20%, it's unaffordable. It is really unaffordable, especially as businesses are pushing this onto employees to pay more of it. Second, and this is an advantage we finally got, technology is catching up, and we can use that technology as a platform to say, "No, you don't have to come in and fill out a clipboard." Actually, we know so much about you, we can anticipate, and that's what I would say we're doing with our genetics, we can anticipate your needs and what's going to happen before it happens so we can get into not precision medicine, but anticipatory medicine.

David Feinberg: We look at every one of our patients in our 3 million person catchment area, and we know based on how close they live to the forest, the odds of them getting Lyme disease. We know how close they live to concentrated livestock. The chances of them getting MRSA, an antibiotic resistant organism, because it's used often in livestock and gets into the ground water. We know how close they live to Marcellus Shale, that's what we have up here in Pennsylvania, the chances of them getting respiratory illness. We know their genetics.

David Feinberg: Now take that big data, do AI, do machine learning on it, and we can tell this person, before something happens, here's your risk of Lyme disease. You're actually pretty high. If you have the symptom based on where you live, there's a great chance that this is what you got, or you don't have a chance at that because no one in your zip code has got it and we know where you travel, et cetera, et cetera.

David Feinberg: So you start thinking, "Wow, we can start thinking in advance what's wrong with people or what could become wrong with them and prevent it. Wow, that just prevents an entire illness." One of your 700 folks that did get admitted, we just prevented that admission. That is what we need to do in healthcare and I don't think it's time for pilots anymore. I think we have enough evidence to say this is the only way that healthcare should be paid for and this is the only thing that it should be measured on. We should tell docs, "You're a primary care doc. You have 2,000 patients. You're going to get a bonus next year if the average BMI in your practice decreases." That simple. Those kinds of tools will change how we pay for healthcare and how people engage in their healthcare, and what our professionals do to make people's lives better.

Robert Pearl: You and I both agree on the power of technology. When I was leading Kaiser Permanente, we would offer ED physicians doing video at night and on weekends, 60% of the patients who otherwise would have gone to the ED had their problem solved immediately without an ED visit. The same for dermatology.

70% of the rashes were diagnosed not in six weeks or six months that dermatology often is delayed in the United States, but six minutes. So that opportunity you and I completely agree on, but we have a big advantage. We both led and lead integrated, comprehensive organizations. The question I'm going to pose to you is most of the nation is not in that way. You and I could probably agree that if we did what you're talking about, we're going to need far fewer specialists. How is that transition going to happen in your view for American medicine?

David Feinberg: To me, we can't afford to wait, and people's cheese is going to get moved, and there will be lobbying groups and special interest groups that will screen, and if we want to continue, if we don't want to bite the bullet, we will continue to have a very, very expensive healthcare system that is completely failing. For the first time in my life, life expectancy has gone down. We got infant mortality rates that are the same as some African countries that are completely third world. We have immunization rates in Santa Monica that are some of the lowest in the world. This is insanity, that we're not looking at the population based, we're not looking at those easy types of interventions that are going to save lives. So the question is, how do we get there fast? I think from a policy standpoint, all payment should be linked to these types of things, as opposed to if you can stick a tube in somebody or do some high tech thing, you're going to make a lot of money.

David Feinberg: As soon as we switched the payment to say it's all based on value, it's all based on keeping people healthy, it's all based on keeping people out of the hospital, everybody will get in line, but we've tiptoed around it. If we continue to tip toe around it, or we continue to have a bifurcated system where some of us think this way and some of us don't think that way, we will never get there. But you know who could really pull this more than anyone? Our patients. When you think about it, if this industry was required, if every patient said, "I won't go to you unless you can provide me online 24-hour access to a doctor. I won't go to you unless you can provide care in my home," the industry would change, but what we've been for so long is provider centered.

David Feinberg: We've been centered around hospitals and doctors, waiting rooms. Nobody ever in their life has gotten better in a waiting room, so all of our new clinics we're building have no waiting rooms, because patients should not wait when they're sick. Our goal in our emergency room is not to get you seen within 30 minutes, it's to get you seen within zero minutes, because if it's truly an emergency, you should be seen right away. Now let's put all the things in place to make sure no one comes to the emergency room unless it is an emergency. So those kinds of things I think Americans need to do and I think we have an opportunity, and the opportunity is, for the first time, Americans are starting to have to pay for some of this.

David Feinberg: Now, they always have been paying for it because their employer paid, and so they weren't getting the wage increase that they should have been getting because healthcare costs were eating it up, but now as the employers have said, "We're done with that," and pushing more and more of the cost on to the employee, hey, guess what? It's now a retail business, and once it goes retail, you can't make people wait. Once it goes retail, you can't serve bad food. So we've said, "Hey, it's retail. If we didn't answer the phone right, we didn't treat you with compassion, you didn't like the doctor, you didn't like the outcome, you didn't like your bill. Whatever it is, we'll give you all your money back. No questions asked." So we actually then give a little modifier, we do have two questions. We need your name and address to send you the money, but there's no questions

asked about why you're asking for your money back. That retail thing, people go, "Oh my God, that's so innovative in healthcare."

David Feinberg: What are you talking about? Have you ever gone to Starbucks, ordered the latte? I said, "Wait, I asked for almond milk and Sweet N' Low. You didn't make it right." Have you ever seen the barista take a sip of a latte and say, "No. That's how it is. You got to drink it." We would never stand for that, but that's how we treat people in healthcare. "Hey, I'm really sorry you came in. We don't have a bed. I'm sorry. You have to stay here in the hallway." That's what we do in healthcare. Completely, completely unacceptable in a retail environment. So as this moves to retail, it's going to require the health systems to either adapt, or they're going to go away, and those that can connect with people in a humane, compassionate way, where they understand what's going on, where things are explained to them, where they're treated with dignity and cultural respect, are going to win. So I think the move toward making people pay more for their healthcare instead of this amorphous insurer is going to help transition us much faster.

Robert Pearl: One of the things that interested me were patients, who based upon the disease level, the risk level, spent a lot more money in any given year. We studied this population in great detail and we found a few factors: poverty, mental health issues, and pain. What's your approach to mental health issues in the general community, and specifically for individuals and families?

David Feinberg: I'm a child and adolescent psychiatrist and an adult psychiatrist and an addiction psychiatrist. So this has been my career, and the worst thing that ever happened, and it happened during my career, was this idea that mental health should be carved out from an insurance standpoint from physical health. The reason it happened, if we go back to the '90s with managed care, primary care doctors were made a gatekeeper. And they said to the primary care doctor, "You're in charge of all specialists, and how many visits they get."

David Feinberg: Well, actually, primary care doctors were pretty good in managing specialists. They had trouble knowing how many visits they should give to a dermatologist, and they could never figure out how many visits to give to a psychiatrist. So a psychiatrist could call and say, "I'm seeing your patient. I need to see them three times a week forever," and the primary care doctor would say, "Why?"

David Feinberg: "Well, they're suicidal."

David Feinberg: What's the primary care doctor going to say? "No, you can only see them four times." They don't know how to manage that. So this industry got developed called mental health carve out, carve out the insurance. So think of this, if you take your kid to the pediatrician and the kid is tugging at their ear, and the pediatrician looks in their ear and goes, "It looks red. I think it's an infection."

David Feinberg: The mom says, "And he's coughing, does he have a strep throat? You know, my other child has strep throat."

David Feinberg: Pediatrician says, "I can't look in his throat. That's done by a different organization. There's a different number on your insurance card. They're down the block, call them, it's a different copay. We've carved out throats from ears." It's as crazy as carving out mental health from health, but that's the system.

David Feinberg: Three visits to a primary care office, if you just take a practice and you say to the person at the front desk, "Can you name every patient who comes in three times or more a year to see primary care?" Not what they come in for, just that they come in. If you come in three times or more to a primary care office, you have over a 50% chance that you have diagnosable mental disorder. Mental disorder is coming to primary care, especially the frequent flyers. They're either coming because their depression is masquerading as head pain, or they actually have a bonafide medical condition like heart disease or stroke, which has a huge co-morbidity or runs quite often with depression and anxiety, and those patients aren't getting appropriately addressed where they're coming. They're being sent to some other building down the block that's run by a different company with a different 800 number. Insanity. And those two systems don't talk to each other.

David Feinberg: So what we've done is actually make that pain point go away and in all of our offices, we have about 200 plus offices throughout Pennsylvania, New Jersey, in our clinics, we embed behavioral health experts. So you go in to see your regular primary care doc and the doc says, "Wow, I think this could be depression," instead of sending you on your way and telling you to go see a psychologist, they say, "Walk down the hall with me," and they literally are handed off, warm hand-off to one of our mental health people who does evidence based treatment for depression, anxiety, ADHD, memory loss, et cetera. Same building, same team.

David Feinberg: Now behind the scenes, for our patients it's easy, they're insured by us, but we see others that are insured by other payers. If they have a separate 800 number and are supposed to call somebody else, we make that happen magically behind the scenes because we think not putting it, not reintegrating mental health services back into medical services, it's crazy as treating ears and throats in different buildings.

David Feinberg: When there's a shooting in America, a mass shooting, I would say that most of the time it's a white male in their 20s, and they ask, "Well, what's wrong with this person?" The way they find out what's wrong, and they ask a neighbor or a classmate, and the neighbors or the classmates say, "Well, they were kind of kept to their own or they kind of seemed angry, or the mom said something." That's how we get the information. What I think we need to do with the next shooting, and I hope that it doesn't happen, is we need to ask who was that person's primary care or medical home, because they missed it. So think about it. I got 2,000 patients, I'm a primary care doc. I need somebody right next to me who understands mental health. I need somebody next to me who understands home based care, and in the morning, when I come in Monday morning, of my 2,000 patients, we should say, "Who do we need to make a home visit? Who's coming in today and what do we need to do to prepare for that visit?"

David Feinberg: You know what? We got two or three of these kids who seem to have signs that they're fallen out of the community. Let's find out why that kid dropped out of junior high school, junior high, junior college. Let's get that kid back in and engaged. Let's prevent that kid from being only explained by a neighbor, because that kid belongs to our medical home. That kid belongs to my practice. That to me is reintegrating mental health back into health, and to separate it, and I get why it happened, is to me a complete travesty both as a professional that spent my life taking care of these folks. But again, from a cost saving standpoint, we know that untreated people with anxiety end up with a lot of cardiac workups. It's a complete waste of time. It's a waste of money. We got to treat mental health and it's happening in primary care. It's happening in our communities. We got to be in the homes taking care of it, and it's another place where technology is a

huge accelerant. Actually, people will be more honest about suicidality to a computer, than to a psychiatrist. Great. Let's start using that to figure out who needs help and how we can intervene.

Jeremy Corr: How do you plan to address the stigma around mental health issues like depression and the people suffering from them?

David Feinberg: Well, I think stigma around mental health is something that I've thought quite a bit about, and I think it sometimes works against us. What I mean is that the mental health record in our electronic health records is oftentimes sealed off so the rest of the healthcare team doesn't see it because it's so private. Well, that's not good care. I can't even provide you good medical care unless I know what's going on from a mental health standpoint. I think, and I do think our new generation would agree with me, that this idea around privacy that we have is kind of gone away. Everyone knows everything about us, whether we know it or not. The more we're open about mental health issues and/or physical health issues, the better chance that it disappears and you're looked at like somebody did something wrong.

David Feinberg: I used to say, if a child is in the supermarket and they're bald because they have cancer, people see that family come up to them and give them hugs and bring food to their house. That same aisle, the mom's walking, but the kids not bald, but the kid has autism or some disruptive behavior disorder, and families go to a different aisle. They don't even come and hug you and they certainly don't bring food to your house. Just think about that. We have to make that autism, the same kind of emotional community response you get then when God forbid your kid has cancer. So then you get that support, and I think the way to get there is to hit the stigma straight on.

David Feinberg: First of all, I've never met a family that doesn't have mental illness in their family, ever. So we need to come forward and say, "Hey, we may not have this, but we got this," and it's in every single family in America. The numbers are just astounding. I mean, when you look at it, it's I believe, and my data could be a little off, but I believe six of the top 10 medications prescribed in America, or three of the top 10, are SSRIs, the Prozac, Paxils, Zolofts, and the new ones. So it's there. We absolutely have to bring it into the fold and out of the darkness.

Robert Pearl: A major contributor to the reason that more Americans are dying or are dying earlier because the age of death is becoming earlier in time as opposed to almost every other country, is around the issue of opioid addiction. We know that over 50,000 people die every year as a consequence. What we know is that quite a number of people are on huge doses of opioids, many of which were started by physicians and we could spend a lot of time looking backwards, but I want to look forwards. What kind of strategy would you want to implement in this new system in order to help people on opioids get off the opioids and diminish their risk of dying from overdose?

David Feinberg: I think there's a lot to do and I believe we're trying to do every single bit of it. Where I live right now, in rural Pennsylvania, the rate of death from opiates is four times higher than it is in New York city. We live in a town of 3,800 people, and I'll tell you once a week someone dies from an opiate overdose. We don't have that many people. So, to me it's about decreasing supply. We're starting next month, all of our scheduled elective surgeries that you're coming to the hospital for, we're using an advanced recovery after surgery protocol, which means five days before surgery you start drinking these three special milkshakes a day that have a lot of protein. We get you off smoking, we get you exercising.

Actually, two hours before surgery, you take a drink, which is kind of counter intuitive. Many of us we're told, "Don't drink anything after midnight." No, two hours before surgery, we want you in great shape for your surgery.

David Feinberg: We do 100 procedures now, 100 different procedures, that we used to use opiates on, opiate free. So we actually operate on those people without opiates. We use other types of pain, and then they get to drink after. So all those folks are not getting opiates. Huge, huge difference. We've decreased our opiate prescription from 60,000 prescriptions per month in our system to 31,000, almost a 50% decrease. But your question was about folks that are already having trouble.

David Feinberg: It's really straightforward. There's a way to treat opioid addiction. It's medication assisted predominantly along with great appropriate behavioral and supportive therapies. It works. Like many disorders, it doesn't always work the first time. It takes a few rounds. It's predominantly an outpatient treatment, but it can be very effective. The problem is that most of these folks, after treatment, the thing that's still missing is hope. It's a disease really of a broken heart. In our town, where I told you it's four times higher than New York City, and I think our town is typical of rural America. There's not a lot of opportunities. Sure you can get a job with us, but it's towns where families have worked for generations in coal mines and the coal mine is now closed. So let's not get political. Let's not talk about the environment, but that family needs to be retrained and have new opportunities. Otherwise there's not that much going on.

David Feinberg: So, I think we need to address the hopelessness for those that actually have come to the disorder. I think treatment can be pretty straightforward, and us in the medical profession kind of shame on us that we let this happen to start with.

Robert Pearl: High deductible plans were introduced on the belief that if the patient had "skin in the game", I'll keep the expression, but that was the one that was used, they would make better decisions. Today as you know, almost 50% of people have a high deductible plan and if they actually had to pay the entire cost, they'd have to borrow money to do so. What we know though at the same time is that the typical person, and I think the study was done in Boston, will drive by five lower priced MRI facilities to go to the one the doctor recommended, despite the fact they're going to pay out of pocket more money and, as you know, MRIs don't vary very much by location. Do we really believe, particularly for the very expensive patients, that the kind of financial incentives we're talking about will make a difference?

David Feinberg: Yes, but the whole is backwards, because going up by a gasoline and saying, "Wow, that one across the street is cheaper than this one," is an easy decision for somebody to make. But when somebody tells me I need an MRI, and my doctor says, "Have the MRI here," and they got you scheduled, I'm afraid to question that. That's a hard decision to make, but if that doctor is truly a partner with that patient, and their incentives are aligned, and they say, "You need an MRI and you can go anywhere on the list," or, "I want you to go to this place or go to that place," people will listen. The docs aren't armed with the right information, but that's a decision that you need a guide with. You can't make that decision on your own. Picking an MRI, which you don't do very often, is not like deciding, "Wow, this place sells gasoline cheaper than that place."

David Feinberg: It's a more complicated ... it's emotionally laden decision. You're not going into MRI just to fill up your gas tank. You're going because we're looking at

something. Well, do I want to get cheap on that? Now I can tell you, "Well look, they have higher quality and it's $400 and the place you're going is $2,000," and blah, blah, blah, but wait a second, my doctor sent me here. So we can't think that those types of consumer decisions are always applicable in healthcare, but if your doctor actually thought of these things or went through it with you, or someone on their team, I think people would make very rational decisions. We just don't give them that information.

Robert Pearl: How would you structure the incentives for the physicians to behave differently? I mean, most physicians first have no idea what things cost, and number two, they know what they're used to and comfortable with, even if the data says it doesn't add any value or it's much more expensive. Look at the data that came out of California on total joints ranging from 30,000 to 120,000, with no difference in outcome when looked in a very risk based way. How are we going to get aligned the doctors' and the patients' incentives?

David Feinberg: I have incredible respect for you, Robbie, and the work you've done, but I'm going to give an answer that's a little disrespectful. I think you're asking the wrong question. A lot of those patients who need hips, we could have avoided with lifestyle issues. A lot of those patients that are getting MRIs, we could have avoided with lifestyle issues. So the more and more ... and somebody will figure out the answers to your great questions, but it's the wrong question. The question is how do we decrease the demand, not how do we take a terrible system and make incremental improvements, and the way to decrease the demand will then force that system to get better. Yes, we can use technology to give doctors quality and yes we can tell them ... what we can tell docs, I would say the best way to answer it is let's bonus docs on decreasing BMI.

David Feinberg: Decreased BMI by definition we will end up with less MRIs and then you know what? I don't care if you go to a $500 one or a $2,000 one, because the units of service is going to be so much less than we could even afford those inefficiencies. Then if somebody wants to go fix those inefficiencies, I'm not going to stop them, but it's the wrong question. Let's talk about the stuff that matters. The 80% that drives healthcare cost has nothing to do with this MRI versus that MRI. Nothing. We're looking at the wrong problem.

Jeremy Corr: We talked about telehealth, but what are some of the other technologies on the horizon in healthcare that consumers can look forward to and that you're personally excited about?

David Feinberg: I don't even like the term telehealth. I think it should just be called healthcare, that we can do healthcare over the phone, over the computer, or over Skype, in person. I mean, it's just another modality to provide healthcare. I think the excitement is going to come in areas that we maybe have not thought of before. I would talk about things like olfaction, smelling, ability to smell. You can take eight urine cups, put it in front of a dog. The dog can now smell those urine cups and sit down in front of the one that has prostate cancer. The dog then starts missing a few, and they're sitting not the one that has prostate cancer, and we can't figure out what it is, and that patient's urine didn't come from someone with prostate cancer and now we look more at that patient and we found out, "Wow, that dog just found bladder cancer and they haven't been trained on bladder cancer." They can smell somebody's neck and tell you who has Parkinson's.

David Feinberg: I think there's types of diagnostics and now can we get that olfaction, whatever that is that dog does, because it's better smelling than we have, can we figure out

what it is and get that into our smartphones? So can we use the smart phones or technology to figure out disorders in noninvasive (ways), and much earlier in their course before they show up in other ways. I think we're right on the edge of that and I think, again, that's not only a disruption, I think it's going to be a lifesaver.

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

David Feinberg: Yeah, you can follow me on LinkedIn. My closing comments would be it's not easy to take good care of you, but the results are not only the absence of disease, but an ability to bring joy back into your life and those that you care about. If you tell people, "Hey, I got a winning lottery ticket and I'll give it to you, but all you have to do this week is exercise three times and eat right and do all the right stuff and I'll give you this million dollar lottery ticket." Everybody would do it. Then if I said, "Well, it's actually $100 million ticket, but you got to do it for a month," most people still would do it. If I told you it was a billion dollars, but you got to do it for a year, a lot of people would still do all those things. Well guess what? I can give you that lottery ticket and something that's better, it's your own health. You just got to do it. If you do it, you're going to get a prize. You're going to get a reward that's better than a billion dollars. We have 2,000 patients in our Geisinger hospitals, tonight, and I know many of them would trade a lottery ticket to get out of the hospital, and you keep yourself out if you do the right stuff.

Robert Pearl: David, thank you so much for being our guest on the show today. I applaud your focus on helping everyone avoid problems in the first place, and not simply treating the complications. I think the system of healthcare you're talking about is mission driven. It's humane and it really brings health, not disease to the forefront of the American healthcare endeavor. My sister is the CEO of an organization in New York called God's Love We Deliver, that brings over 3,000 meals every day to people who are homebound, and her expression is "food is medicine." I think you've emphasized that amazingly well today, and something that all the listeners should be recognizing. 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 proven them wrong. Dr. Feinberg, this was a lot of fun.

David Feinberg: Thank you so much Robert and Jeremy. I had so much fun, too, and I don't think we can wait to get these things in place.

Jeremy Corr: Next month our guest will be Dr. Eric Topol, the founder and director of Scripps Translational Science Institute. He also serves as the chief academic officer for Scripps Health, a professor of genomics at the Scripps Research Institute, a senior consultant at the division of cardiovascular diseases at Scripps Clinic, and the author of the bestselling books, The Creative Destruction of Medicine and The Patient Will See You Now. He has been a leading voice for the power of technology to transform American healthcare, improve quality outcomes, and lower costs in innovative and consumer friendly ways. We're 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 liked 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. You can find out 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, and will 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.