Primary Care Cures

Episode 45: Chris Crow

Ron:

Most problems in healthcare are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and it's totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of costs and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with us, Ron Barshop CEO of Beacon clinics, that's me.

Ron:

A few months ago I spoke with a guest, Dr. Paul Thomas of Plum health and I truly misunderstood what their primary cares value was. I thought it was something for the rich, something for the 1% 10% club. I hadn't realized that it's something that's spreading all over America rapidly and helping employers with a new benefit that allows them to have a direct relationship with the physician and their employees and not have any copay or deductible. So I was turned around and today I'm hoping to do the same thing with value based care because I don't understand it and I want to understand it.

Ron:

So today is not a debate. It's trying to get clarity around something from an expert that we've had on the show recently and I'm going to welcome Chris Crowe back to the show again with Catalyst Health Network. He's a founder and CEO and he's connected and aligned and network of more than 650 PCPs with nearly a million patients and the way he describes himself as he sort of the league commissioner and they're the teams and a good league healthy league, healthy teams, healthy teams, healthy league.

Ron:

His work with Catalyst has led them to be the first North Texas Physician Network to hold value based contracts with the top four major private carriers. And today since 2016 he's performed with significant savings totaling about 55 million to the communities that are served in North Texas, Oklahoma and East Texas. Stratify Health, another division serves over 1300 providers between their population health and practice service offerings. And these practices managed well over 1.25 million lives and over 5 billion in annual medical expenditures. And Chris tells us he's going to come on this show and announced he's doubling the size as he moves South of Texas to increase his offering. So Chris, welcome to the show again.

Chris:

Thank you.

Ron:

I'm trying to get my arms around value based care. Can we just talk from 20,000 feet first and understand that in healthcare the driver of healthcare is a primary care physician, sitting in an exam room with a patient and those two if they have a good interaction and have a lot of them that's going to reduce downstream costs enormously. You and I both I think are big fans of what primary care can do for healthcare costs in general. Right?

Chris:

Of course. Well I think your question is the one that is semi an answerable around what is value based care. To me it's in the same category as asking somebody what is quality. It's certainly in the eye of the beholder, value based care in healthcare, certainly from a trajectory standpoint it's far away from what the status quo is. Right now we have a what we call the fee for service healthcare industry, completely transactional, not coordinated, not based on outcomes. It's based on some of the fabric of America which is capitalism, which has been great for us as a country and that the more of what you do, the better you get at it and the more money you make.

Chris:

Unfortunately that doesn't necessarily translate into taking care of people in a way, in a holistic way that leads to better health and less resource allocation to their health. They could be then traded off for other things like we said last time, whether that be city services, more R and D and products and companies, better schools, more teachers after school programs, more opportunity for philanthropy. All these things that are really important for a community. Healthcare, of course being one, but it's hogging too much of the resources right now that we have and the trajectory is unstable for sure.

Chris:

So value based care comes along as a term is to say, Hey, how can we bring value to the community at home? And I like to think of it holistically, but if you broke it down into the components of value to who and a value to the stakeholders that are in this, and to me there's only three stake holders and there's almost only two stakeholders. There's certainly the patient, the human being who is receiving the care is obviously a stakeholder.

Chris:

We would argue that for them to get value, that there's also has to be a value transaction on the side of the physician. And the physician, in a world that is increasingly getting an industry that is burned out, we better find a way to make sure the physician has a value in their own terms, which is different from the value that's in the patient terms, but its a system that actually allows for both. And then the third stakeholder would be who is paying for that care? Sometimes the patient is paying for some of that or all of that directly. A lot of times the government is the payer of source and then many times in America, our corporations or our employers or the payer of source.

Chris:

But if you think about that, what's one degree from the government to the taxpayer? Go back to the people. And if you think about the employer, what would the employer do with those dollars

if it wasn't going to healthcare and more of it would go to the employee, which is the people. So the people of America either directly, indirectly are paying for this care. And so there has to be a value for that constituent in and of itself. And so the system needs to be built around where you have this win-win-win, where the value of each stakeholder is considered and actually met. Because if you only get two out of the three, you will continue down a negative path that our system has today.

Ron:

So value based care appears to me to be something generated, particularly for Medicare patients that allows physicians who are treating these folks to primarily deal with the chronic patients. In other words, 80% of the patients are just fine, thank you very much. Leave me alone, give me my annual physical, give me my vaccines. But some of these folks that have chronic conditions that represent maybe 10 or 20% of your patient population of Medicare patient population are needing lots and lots of love and attention that haven't got a traditionally through free for service.

Ron:

So what value based care appears to me to be in my under educated position is a chronic care plan for somebody who's asthmatic, a chronic care plan for someone who has personality disorders, a chronic care plan for someone who has a pre diabetes or hypertension or pre hypertension. So it appears to be someone that has an adequate medication so that they don't have an ER visit and they keep the heads out of the beds, that because it's headed off with the person primary care. Am I way off in my thinking?

Chris:

No, I think you're downstream in a particular example and I think it's a great one to talk about. I mean for the listeners who are learning or trying to understand about this, which is how you frame the show. I might take it back up one more level again, I don't think it's particularly about Medicare. I think it's about everyone is how we think about value for how we're going to deliver care to people in this country in a way that they get value and they describe value as a patient usually is, as the benefits that I received minus the cost is of some value to me. And similarly as whoever's paying for it, the government has something similar. A provider might be that the service that I provide is the transaction I make from a dollar standpoint is a value to me to provide that service.

Chris:

And so we have to think of it in terms of that way. And you mentioned the chronic care of the 80 20 rule and you are correct about that, but you've got to remember that the 80% that may not be chronic very much is subsidizing the 20%, so they actually have a stake in what's going on with the 20% because their premiums are going up based on how those 20% are getting managed. But I just want to make that connectivity of everything before we dropped down into what I think is a very good example that you've given.

Ron:

Yeah. The reason I thought of Medicare is because the ACOs, the Accountable Care Organizations that are now receiving X dollars per head from the feds. And if you can keep your

costs in $1 below that you make it a profit. In your position if you spent a dollar more then you're at risk. So this is I think one of the misconceptions that docs have, is that they don't want to get into a system that could penalize them for something they feel like they don't have as much control over.

Ron:

And in the last show you talked a lot about the strategies for med compliance, for adherence, for compliance to go see these specialists tell you handle that handoff beautifully. And I think a lot of physicians say, "It's the patient's stupid, I can't control them." And you're saying, "No, actually you can control that." And you can get your costs down and have control over your costs so that you can make a profit in say, an accountable care organization.

Chris:

That's exactly right. So ACOs are a middle step. A middle step in this movement value. The thing I think about is, the care delivery model that we have today is built for the financing model we have today. So if we're going to change the financing model to value and put more risk on the providers and it's not about a transaction, it's about a dollar figure for a population that you need to keep healthy, you've got to think about the care delivery model that would be required for that would be very different than the one that we have today. So what we're stuck here with is what in between moments where we have the majority of our financing model and this fee for service and our care delivery models in American had been built to do that, which is more.

Chris:

In value based care it's built to do better and have better value to all the different stakeholders. But the care delivery models are on the tip of the spear at Catalyst for example, in these ACOs of what's needed to be developed to actually be able to perform in a financial model that is rewarding value and has risk inherent in it.

Chris:

And so what we are doing at Catalyst Health Network is absolutely building and have built many of those capabilities that ultimately provide value to the patient and actually better care delivery, better outcomes, a healthier constituency. Which by definition does not cost as much as one that is unhealthy when you're proactive versus a reactive care all the time, and it's actually super satisfying to the primary care physicians who are now leveraging the relationship they have longitudinally to get credit for all the things that they do in a relationship with a patient over time to help them maintain health and have a system built that actually is longitudinal around that relationship, rather than the system that most primary care in right now is see 25 30 patients a day as a transaction in your exam room because that's the only place you get paid is inside that exam room.

Chris:

We are morphing that in these ACOs and you see that with with the dollars being paid out for Medicare, we'll go back to right to your example. Now that's exactly what Medicare is trying to do. They're trying to change the financial model so that the providers will change their delivery model and what you're finding is, in that data, Ron, is that the physician led specifically the

primary care led ACOs are having a much better success, like I think the data says like seven or eight times better than the hospital led ACOs and it's a really easy answer.

Chris:

Why? Because the hospital ACOs have a business model that fundamentally needs to have people in beds to make revenue. There's no other that's been the business model and for them to actually change their business model and get paid for having people not in bed is not going to work because those big buildings and all that administration, all that staff has to get funded some way and in their business model just doesn't work for that.

Chris:

However, for your primary care physicians upstream who have a longterm relationship, if the incentives are aligned to help them keep being healthier, and getting paid for that, that is actually exactly down the middle of the way a physician would like to care for patients, which is why the burnout can actually go down. That instead of practicing in a business model that is in conflict with the way they want to care for patients, you now have a business model as long as the resource with the tools and the technology to have this relationship based care be given, they're going to have a much better outlook of their career. The patients are going to have a much better outcome and how they live their lives and whoever's paying for that, whether it be the government or an employer is going to have a much better return on their investment of those dollars. That's the win-win we're looking for,

Ron:

Yeah, but it seems like there's a perverse incentive built in. If I may practice a PCP practice that just sold to who a major system and I'm being pressured to refer patients in to that system and at the same time I'm of the Hippocratic oath trying to do no harm but also trying to make patients lives better. It seems like those two goals are in conflict with each other.

Chris:

Completely agree. That's exactly what I was saying is that the health system, hospital system run ACOs have that inherent conflict that are direct, which is why you haven't seen them perform as well as the physician led, the ones that are outside the health system. Those ACOs like Catalysts are the ones that are actually making the move to value and having better success because for the exact reason you highlighted, they don't have that inherent conflict.

Chris:

In fact, it removes the inherent conflict that deeper service has had all these years on this primary care physician and moves them into a financial model that actually rewards them for the relationships they build with their patients and the trust they build [crosstalk 00:15:07] .

Ron:

Okay, so my next question is not meant to be argumentative. It's again, just totally trying to understand this model here is, it appears there's two big problems with value based care that I don't have my mind wrapped around. The first one is it does not appear to move the dial on outcomes. It sounds wonderful keeping heads out of beds but it doesn't seem overall to be

actually improving outcomes but your experience I'll bet is different from that or you wouldn't keep doing this?

Chris:

Oh yeah, agreed. It's completely lumpy Ron. I mean, the future is actually here and a lot of places it's just not evenly distributed so it depends on what you read and what you see. But there's certainly a lot of examples, especially now that we're almost 10 years into this and more examples of if you're going to call an outcome, a reduced amount of hospitalizations for a population reduced ER utilization for a population, higher amounts of preventive cancer screenings, higher amounts of control. Diabetics are asthmatic. There is plenty of pockets where that is happening. It's usually in those settings that I mentioned earlier. But it's absolutely is not happening everywhere and the reason for that is again at least three fold.

Chris:

One, the business models are in direct conflict. Two, there has not been enough resources invested into the infrastructure to actually change the delivery model to win in that type of financing mechanism. And then finally, the financing models have not put enough pressure from a risk standpoint, which is what you see the government trying to do now, put enough pressure on on the provider community to actually make those investments that are needed that are known from people and technology analytics and to do population health better.

Chris:

The financial model is having to push on the care delivery model. It's the classic chicken and egg. Will the care delivery model changed before the financial model? Or is the financial model required to change so that the care delivery model can follow? You're seeing that happen across the country in starts and stops.

Ron:

Yes. I love your lumpy mattress model. It really explains things that you have pockets of excellence. I was reading a director of Harvard [inaudible 00:17:29] Health Institute, talk he gave at AMA a couple of weeks ago, and he was talking about how people in America love to compare Denmark healthcare to American healthcare. And he says, let's remember the Denmark's about the size of Chicago that we really can't compare it. We can compare Hawaii to Denmark and we stand up nicely. But you can't, the averages of America to the averages or country with 6 million people, it's just not fair. You can compare Minnesota to Sweden or Denmark, but don't, don't play games.

Ron:

And so I think what you're saying is, people are lumping in the bad and the good results and saying DBC is not working and you're saying it works in pockets. So let me ask another question. So we know now from talking to you that outcomes are better in pockets. What about the cost overall of the DBC, has it got the same problem? Because every analysis that I've seen, and again this may be the [inaudible 00:18:23] service choir singing hallelujah here, but it appears that if every ACO added value based care that we would move the dial about three to $4

billion on a $500 billion deficit for Medicare. Is that true? Or are we again looking at averages incorrectly?

Chris:

Well if we did on that math it would be less than 1% and I think all of us we'll make 1% investments to potentially make longterm gains at that math. But yeah, there might be an initial but like anything worthwhile, if it absolutely has to be looked at as an investment. We do that with our own money. We do that how we save for college because we think there's a payment outside. So that's a normal thing for American capitalism is to invest in what we think is a better future. And that's exactly what has to happen. That gets into that chicken or egg thing. I do think the financing model has to come first and there has to be some investment to actually change the care delivery.

Chris:

And what I would say about value based care over the last 10 years, Ron, is that not only is it still lumpy as you said, but there's more of those pockets. The stories get better and better. What you find is that the story that was good in 2015 gets a little better than 16 and then it gets a little better in 2017 and it gets a little better in 2018 and so you have more ... five years ago there was very few stories, but then you're starting to see them come in and now they're more than a triple. You'd be hard pressed to not find most areas of the country have some good stories of value based care.

Chris:

Again, they generally have the category of a non-health system. I would tell you there's exclusions to that, like a [inaudible 00:20:08] places like that where they've actually, it's actually a physician led Mayo clinic. They've built in a model that it doesn't reward more, it rewards better and so those systems are better able to handle that kind of stuff.

Chris:

Also there's the velocity of news that's improving as well, but for it to come across the country in one year, while you and I would probably like for that to happen and maybe 10 years ago I thought we'd be there by now. I think we're still in for another five to 10 year march before you start to see the full, rapid utilization of this across the board and what happens in the meantime if there's probably going to be a lot of gnashing of teeth at the hospital level quite frankly.

Ron:

You should have it when you have your family reunion [inaudible 00:20:59] nurse for the Mayos and the Stratifies when you don't have your family reunion and don't invite the Hicks to bring the story down because the Yokos are messing up your stories, what I'm getting from this. So you guys need to get the message out that this is working and here's the numbers we're seeing when people do it right. And I think again, mixing bad results with good results is like taking a ... it's faulty logic.

Ron:

So, let me ask you a question to shift gears a little bit because value based care I think most physicians listening to this that aren't doing [inaudible 00:21:31] are saying this is too big and too onerous and too much reporting and too much software and I can't handle that. And I think you are making some pilot programs into working with some of the smaller physicians, so that you can bring your C suite to the smaller primary care docs and specialists now, aren't you?

Chris:

Yeah. That's the whole thesis of our business is that how can you bring the power and the passion of the independent physician, the primary care physician, who has these longterm relationships with the patients and support it in a platform that can serve all of them in a way that can lead to a better all, an augmented relationship for them and their patient that leads to better outcomes and a better value for all. That's exactly what we do. And you're right that an individual physician practice, a small practice would never be able to have the investment capital to put in, a pharmacy, a pharmacist, technology analytics an extra care coordinator. I mean that's just heavy.

Chris:

But also to your point, Ron, is that only 10 to 20% of their patients may need it at any given time, right? So what you can do in a business model like ours is create a scaled platform that can be shared by many that's 650 go into 700 and probably will go over a thousand in 2020 for sure. Then they can share in that and it becomes more and more powerful as more and more people come on the platform. And then so this story of value based care for the physician and the patient and the payer continues to then be able to be spread and felt until hopefully at some point soon we reach a tipping point. And to where there's a massive shift in the models across the country to where the next generation of kids that are going through grade school right now and become a physician, they just grow up into a model that's already built to provide value for all.

Ron:

Okay, well let me shift again into a little sightly different direction. In my grandfather's time 70% of all tricky lighting doctors went into primary care because there weren't as many specialists. And then my dad's generation, that number kept to about 30%. In my generation it was about 16% chose primary care and today the numbers look like they're in the two to 6% range so they just keep having. If your children came to you and said, "I want to go into primary care." Would you encourage them to do that with what you know from your lofty tower because you have a quite an overview of primary care that most of them have?

Chris:

I get asked that question quite a bit and my answer has evolved over time and 10 years ago I would've said no, but really in the last year or two I have evolved on that because I've seen the wave that's coming. I've seen the success that we've had, the impact it's meant to our patients. I hear the stories, I see them, the results are there. The physicians in their lower burnout discussions and how they talk about their satisfaction is improving. I just see the wave coming and absolutely primary care will continue to be one of the most irreplaceable pieces of the care delivery system. And if you look at what's happening with technology, the one thing technology can't do is replace a good long lasting relationship, a trusted relationship. We don't have that with

technology. Heck, technology moves so fast that the Ataris of yesterday, the Nintendos of yesterday are now the Xboxes of tomorrow.

Chris:

Technology moves so fast, but I still have the relationship with my old primary care doctor for 20 years. Right? And so that's not going to be replaceable by technology. However, many of the things in medicine will be replaced. But a relationship about how to care for yourself in the years to come with genomics and gene splicing and DNA te ... all this different technology that's coming down the pipe, you're going to need a trusted resource that's not technology that can be aided by technology augmented by technology, but you're going to need a trusted resource to help you through these decisions throughout your life. And a long lasting primary care relationship is going to be the core of that.

Chris:

And so absolutely. And let me tell you this, all of us that have meaningful longterm relationships, we know how that feels. And so to tell your child, "Guess what, you get to go to work every day and have a vocation that's a calling as a healer and you're going to get to have really good long lasting relationship with other human beings in this world, what's a better way to spend the one life you have than that?"

Ron:

I want to tie that question into my next question, which Chris is about shortages in primary care. I don't ... having talked to now 50 guests on the show this year, our inaugural year. I've concluded we're going to have a primary care shortage, we have an efficiency problem. We have about half a million PCPs and mid levels that are in our universe and we have 330 million Americans in this. That's About 660 patients per PCP.

Ron:

So it seems like we have shortages because the rural situation and the urban crime ridden areas where there's deserts of primary care, but the tele-health adoption rates to address your technology issue are only 1% right now. So you are not practicing anymore, but the 1500 that are in your universe, they can see a lot more patients than 20 or 25 a day if they engage by telehealth and they all now have a good patient record and they can have more of a personal relationship and an ongoing relationship, particularly with the chronic patients with technology. So do you see this shortage artificial or do you think it's real?

Chris:

I think this shortage is real in the current state of healthcare delivery that you touched on a couple of things. I would say it's got to be integrated care with a team based care model that is integrated and aided with technology. That's what I would say, and you were talking around that with telemedicine and [inaudible 00:27:57] . We used a team based care model to surround that physician patient relationship and then augmented with technology. We absolutely believe the primary care physicians of tomorrow absolutely can take care of way more patients they have today and an integrated primary advanced primary care team based model that's supported by technology.

Chris:

You would think of your panel as a dashboard and you would be able to modulate your day and your expertise and your teams based on the needs of that population. That day is coming, and it should be. But you're right, today it's super inefficient because remember the financing models are built for you to do transactions and not do population health. So the financing models are actually driving the care models. And so that's why there's a disconnect over value based care. We have to pay for that population health to where it rewards efficient, effective delivery for care for the many, which means you have to do it in teams. With teams always perform better than individuals, always.

Ron:

Are there. Chris Crowes in other metros around the country because again, for those of us who are concerned about what's going on with the burnout issues and the medical layers, as practices get acquired by big systems, it seems like you're sort of the finger in the dike to keep the floods at bay because there's been more acquisitions of primary care practices in the past seven years than in the past 27 years combined. So it's just been this furacious appetite for acquisition of referrals, and other than Catalysts and Stratify strategies, are there any other things to keep independence independent other than you in your opinion, what's out there that's making systems pause in their acquisition ferocity?

Chris:

I think there's lots of other examples, some that I don't know and some that I read about and some that I know personally. To give you some examples, there's village MD that's on several places across the country that it is all about empowering primary care. They're in multiple States, their lead position Clive Fields is someone we know well that does some great things. I think of another geography outside of my own, Central Ohio primary care up in up Columbus, Ohio is doing some marvelous things and they are continuously independent. In fact, they're helping the rest of the state become more on their platform to be able to remain independent for their community.

Chris:

So those are two off the top of my head, there's other pockets of new primary care delivery that are more private equity backed type things that I worry about because they're all going after the Medicare advantage patients and that private equity has a clock on it that needs a return. So I'm not sure about how that plays out is a longterm business model.

Chris:

But then there's just other stories coming out of North Carolina this year is a big group that has left the system and they're creating a big group of independent physicians and they're doing well in a state that's really pushing value based in a state and private type of coalition. So yeah, there's certainly good stories out there. I'm on the board of a company called [inaudible 00:31:33] that just is independent and works in the Medicaid space for pediatrics. And they're the largest private provider of Medicaid in the state of Texas. And, and they do great work and are being successful in that as a private company.

Chris:

So there's lots of them out there, most of us are too busy to actually do and don't have a marketing budget, quite frankly. And if you think about the health system, especially the not for profits, they got their tax exempt. They've got to spend a lot of revenue. For their massive marketing machines. The stories that are great generally aren't marketing. They're out there just doing the hard work. And so that's, that's why you don't necessarily hear them as much.

Ron:

Well there's always more to talk about. Unfortunately. We've got so much of your time and have used it all. I look forward to future discussions and I'm glad we keep [inaudible 00:32:25] this one out because I think I have a better understanding now that I didn't before about value based care and it's clearly something that's part of our future when done correctly and it's sounds like it's being done correctly all over the country now with the pockets. So thank you again Chris. If people want to find Catalyst or Stratify, how do they go to the web and find you guys?

Chris:

Just like that, you go to the web and find Catalyst or Stratify and you and you will absolutely find us. And there's, there's lots more other videos and other informational items about us. And Ron I just want to thank you for your continued dedication to primary care in this country cause it's important work you do.

Ron:

Well it's easy to do it when we have good guys like Clive and you in the field. So thanks for what you do as well.

Ron:

Thank you for listening. You want to shake things up. There's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcast and subscribing and leave us a review. It helps our megaphone more than you know, until next episode.