Primary Care Cures
Episode 112: Dr. Zeev Neuwirth

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

Ron Barshop:

So direct primary care, also known as digital-first care, which includes virtual care as a branch of it, it eliminates burnout, waste, fraud, abusive over-testing and over-treatment, and saves employer costs by somewhere between 30 and 60% depending on its deployment, with direct contracting as a center focus of at all. Not to mention, the patients finally get off the factory medicine treadmill, with visits that can be now 60 to 90 minutes, which makes the docs happy, and they get near immediate access to their provider or at least to a provider. That means direct deals with employers, with surgeons, imaging centers, labs, local pharmacy and grocery chains, and primary care, of course, which is at its best iteration leading much of the steerage, but the best TPAs can also lead it into these lower costs partners. So, everybody wins, the employer, the doc, consumers, cost, population, health. Some say the triple aim is impossible, but I see this as the quintuple aim, and it's achieved every day by over 15 million patients and about 5,000 doctors. So, I live in a future where everyone wins. You finally get it when I keep saying that over and over again?

Ron Barshop:

I'm super excited to introduce you to Zeev Neuwirth, who is a doctor who serves as a chief of clinical innovation and transformation and strategic services at Atrium Health, which has 70,000 employees and used to be known as the Carolinas Health System with over 10 billion in revenues. He wrote a book that sort of woke me up to what consumerism can be in healthcare called Reframing Healthcare: A Roadmap For Creating Disruptive Change. The book holds an average five-star rating in Amazon, and I would highly recommend it. So, Zeev, welcome to the show.

Zeev Neuwirth:

Ron, thank you so much.

Ron Barshop:

Hey, Zeev, do you agree with me that we can achieve not only the triple aim, but more with some of these new models that are out there?

Zeev Neuwirth:

Absolutely. There's no question about it.

Ron Barshop:

I sat on a panel with a guy and he said, "Triple aim is impossible." And when I said that not only is it quadruple aim, but quintuple aim achieved, he looked at me like I was crazy, but this model wasn't as pervasive as it was maybe even a year ago.

Zeev Neuwirth:

Yeah. I mean, Ron, first of all, I think the person who said it's impossible is partially true. It's impossible if you keep on doing the same things you're doing and just try to do it better and if you're still in the same frame mind, yes, then it's impossible. But if you're reframing, if you're thinking about it differently and coming out about it differently, we know it works. In fact, I've been studying this for the last few years and have been like you looking at exceptions to the rule where we're actually seeing a phenomenally different outcomes.

Ron Barshop:

When you have 70,000 employees, a lot of them physicians, what experiments can you run on things like direct primary care to see if it works? Are you toying with different ideas to see what is giving value to not only the patients, but to providers?

Zeev Neuwirth:

Yeah, I think in large healthcare systems, I think there are variations on that theme, so we are working with... It comes down to this. I mean, I think there's the clinical care model, which I think is... It needs to be fundamentally reframed and particularly in primary care. There are, again, rampant examples of that. I think it's not so much that I think it should change or I think it can change. It is changing and we're seeing radically different models of care being created. Yes, we're participating in some of those and plan to much, much more in the coming months and years.

Zeev Neuwirth:

I think the other part of it is the business model. And so, a lot of innovation and transformation, great ideas, even great execution, but not a great business model. So, we are also participating in different business or payment models as well, and it's really marrying those two together that is really critically important. I think with direct primary care, when you're dealing with smaller practices, in some ways they're more nimble, much, much easier to steer those small boats when you're talking, as you mentioned before, with large healthcare systems where you have thousands of providers and tens of thousands of employees and literally hundreds, if not millions of patients. It's a larger ship and you have to think about steering it in a different way.

Ron Barshop:

Where do you get your... I'm not going to say energy. Where do you get your ideas from to innovate and create new ideas for primary care in your system? Do you get ideas from CVS and

Walgreens or from other competitors out there that are hospitals? Where are you getting your inspiration from?

Zeev Neuwirth:

That's a great question. I think it's like all high-performers in any venue, whether it's the arts or in sports, what I've heard from people who are at the top is that they're always looking to the left and the right. They're always looking to see what others are doing and you have a vision and you have a mission, but you... What was it Picasso said? That the really tough people don't borrow, they actually just steal. Yeah. So we steal ideas from everywhere and bits and pieces, and then we curate and put it together. I think the other part of it, too, is you're seeing in the market a lot of partnering going on. So it used to be that you either you built it yourself, which is predominantly what large healthcare systems did. It's that model that had to be built here and that's sort of a legacy idea.

Zeev Neuwirth:

And then you saw the other only option was to buy things and purchase them. But I think increasingly, what you're seeing is really very, very creative partnerships, where people are bringing assets together to develop ecosystems of care and either just bringing them together, but then co-developing them. Really, it's about curating and then combining and then coordinating these into delivery systems that, again, are viable financially and most importantly, obviously, makes sense too. The other factor too, is they have to be doable for providers and their staff.

Ron Barshop:

I'm going to ask you for an example of what you just describe. But before, what are you most proud of all the innovative strategies you've brought to primary care in the last several years since you've had this job?

Zeev Neuwirth:

Oh my God, that's a tough question. It would be so much easier to answer the question like, "How many mistakes did you make? And tell us about those." There's a couple of fundamental reframes that I'm very, very proud of. I wouldn't take credit for them. Because very much like I just said to you, I don't know that I come up with ideas so much as I really recognize great ideas and great people. And then I just listened to them and try to share their thoughts with my colleagues. And so, I would say that the thing I'm most, most, proud may not be the word, but excited about and enthusiastic about and supportive of is the recognition of the so-called social determinants of health that we, in the medical field, have been trained and focused and get paid for doing clinical work. This is medications and surgeries and diagnostics and things like that. But we know from the literature, and this has been known for quite some time, but validated over and over again, that the vast majority of health outcomes have more to do with the psychosocial aspects of people's lives.

Zeev Neuwirth:

So, do they have education? We know that is such a huge part of it. Do they live in safe neighborhoods? Do they have safe housing? Can they get food and buy healthy foods or not? Do they have transportation? Are they upwardly mobile? These are really the factors that determine

so much of health. I think that what I'm so excited and I would say actually proud of my organization is we've recognized this in a tremendous way. We've been working on this for a while, for years, I would say, but it's really gotten to the point where it is a major part of our strategy, recognizing the importance of the social determinants of health, and more than just recognizing it, actually making it a major part of our strategy and taking action that I would say is on a scale that is unprecedented for our organization and maybe unprecedented even on a national scale. And so, that is one.

Zeev Neuwirth:

I think part and parcel of that is also the recognition of the racial inequities and disparities in care, as well as in health outcomes. Again, we've recognized that I think in large part due to what's going on in our society right now, but have made a major commitment to doing something about it. When I say major commitment, I mean, we have now task forces that are focused specifically on this area. We are putting together education and training modules. I've never seen anything like it. Again, you use the word proud, I will say I'm super, super proud to be part of an organization, Atrium Health, that is focused on the social determinants of health, that is focused on doing something about racial inequities and disparities in healthcare and in health in general. I would say that's probably the number one thing I'm proud of. I can't take credit for it, but I am part of it and proud to be.

Ron Barshop:

You can't talk about social determinants of health and not talk about diabetes, type 2 specially. Is there anything or any experiments or innovations you're trying that allow you to reverse diabetes or at least maintain the A1C levels?

Zeev Neuwirth:

I will say this, as everyone's aware of sadly, we've been in a pandemic for the last year or so. And so, every other agenda we've had has been thrown off course. And so. We've been very, very focused on taking care of folks, of people in our community. We serve a large, large community, well over a million patients that come to us and a population, which is multiple that size. So, we've been just immersed in just taking care of folks who have been sick with COVID and now, of course, with vaccinations. And so, that's really been our focus. But we're getting back to what we were on track with before, which is exactly what you're talking about, chronic disease. It is epidemic in our country, again, unprecedented prevalence of diseases, like obesity and hypertension and diabetes and continuing to grow. Of course, the consequences are terrible in terms of strokes and heart attacks and early mortality. So yes, we are absolutely focused on it.

Zeev Neuwirth:

I think where chronic disease is moving is much more in the realm of digital health and also really engaging people in their own care. And so, the notion that in the past, if you had diabetes, you would go see your doctor once every few weeks or once every few months, depending on how serious it was and the how unstable your condition was. The doctor would look at some numbers that you scribbled on a piece of paper in terms of your sugars in the morning and your sugars in the evening and this and that, and give you a prescription and then see you back and do a little bit of education. And so, that legacy model has got to undergo a major sea change.

Zeev Neuwirth:

Again, this is what you and I were just talking about a few minutes ago in terms of the reframing. Sure, we won't achieve triple aim if we continue to do what we did and have been doing for the last 50 years. We have to completely reframe that. Some part of that is actually now using remote patient, what they call remote patient monitoring. So using biometric devices where the patient or person is able to see their own sugars, if they have a question or concern to be able to get in touch with us virtually 24/7 and get feedback on that. And so, we've been doing virtual care for a number of years now, actually probably for a decade in multiple ways. And so, I am proud of that and our leadership that had the foresight to actually start that years ago, but we're moving rapidly into the digital era and the digital health era, and I think that's going to completely overhaul, completely change care. I think it'll be so much better for people and make it so much better for providers as well.

Ron Barshop:

Are you a little surprised how much everything has shifted to virtual and digital health with this past year's pandemic? It seems the adoption rate was about 1% and now it's a thousand fold that.

Zeev Neuwirth:

Yeah. Yeah, it's astounding. I interviewed dozens and dozens of folks around the country during the first few months of the pandemic. Literally, what I heard was, to your point, virtual, they'd been doing virtual less than 5%, some far less than 5% of their patient visits. Literally, within a matter of weeks, sometimes days, flipping over into over 80 or 90% of patients essentially being treated virtually. Now, granted most of that or a lot of that was by phone, switching over to phone calls instead of in-person visits, but some of it was video visits as well.

Ron Barshop:

Doesn't that tell you that the 80% of visits are unnecessary in-person when a lot can be done over the phone and by a screen?

Zeev Neuwirth:

That's a great question, and I think it deserves a very, very thoughtful response. And so, by that, I mean a one-liner answer is not going to suffice. But I would say this, the short answer is I think a significant percentage of in-person or face-to-face visits can be done virtually, either synchronously, through video or at the same time, or asynchronously through, let's say, something email, which is asynchronous, or some sort of texting or something like that. So, the estimates I've seen is somewhere between 30 to 40% of primary care visits could be done in a, let's say, virtual or digital way.

Zeev Neuwirth:

The caution I would say here is that we also saw in the pandemic as a result of people not being able to get to their doctor, we saw a rise in worsening of some chronic disease. And so, people weren't coming in and people weren't being seen appropriately enough. No one's fault. It was just a consequence. We, for one, we're actually early on, and I remember these conversations literally in the first week or two, we recognize this. In fact, I actually posted an article about this back in March or April, calling it the second wave, that if we didn't figure out a way to reach out to

patients and see them, and if they didn't come in, their chronic disease would get worse. You might, as a result, potentially see increased morbidities, such as strokes and heart attacks and mortality.

Zeev Neuwirth:

And so, we actually started combing our electronic medical record and physicians were combing their schedules looking for patients with chronic disease and particularly those who were sicker. We began to do triage, proactive triage, and actually reach out to patients and say, "Listen, you need a visit. Whether you come in for a visit and we created COVID safe ways for that to happen both in the hospital and the clinics, or we do it virtually, but we need to see you." Again, going back to your question about 80%, I would be cautious about the percentage that can be done virtually, but there's no question that a significant percentage can and should be.

Zeev Neuwirth:

Again, I would argue, if digital health has done well and virtual health has done well, it's not just as good as, but it's probably better than an in-person visit because with digital, you open up all the doors of machine learning and artificial intelligence, which can predict and tell you things about patients that you cannot do without it. For example, the technologies now around remote patient monitoring, you can monitor patients. Whereas with heart failure, let's say, someone, the heart is not pumping strong enough and you get a backlog of fluid and pressure in your lungs and your heart and in your body, you get swelling of your legs, we don't know persons going into acute heart failure until we start to see a gain in weight, they're retaining water or they're swelling in their legs. By that point, now we're just trying to get rid of it.

Zeev Neuwirth:

Well, with some of the technology now, you can actually see things for instance, like heart variability, days and days ahead of time. Those things will change. Without that technology, you would never notice. And so, you can proactively jump on that. The same as true, for instance, things like falls. We can predict people having falls or being prone to falls way ahead of time now. So I actually think the world of digital health is going to be far, far better than the traditional way we've seen patients.

Ron Barshop:

Well, the next few years, we're seeing projections of 120,000 primary care providers that will be short of. If your numbers are accurate and we have 30% of about half a million PCPs that are now able to see people digitally, we can basically eliminate the shortage. I don't know that there's a shortage. I think we always have an efficiency problem.

Zeev Neuwirth:

I completely agree with you. I think that's exactly right. I think that digital and virtual, again, largely this asynchronous care, the use of chat bots, which sounds science fiction now, but it's not, it doesn't have to be that you have doctors doing a lot of this. In fact, I would argue by having... We're using community health workers now. We're using community paramedics, navigators, care managers. So there are other people, but then there's also automation, between that more team-based care and between the automated care and the digital care. Quite honestly, a

lot of it can be done self-care. I'm sure you agree with me too, that prevention is still the best thing. Of all things, I think that is the hill we have yet to really point ourselves towards. As an American society, it's still very much about, "I'm just going to live my life and then take a pill or have the surgery." I think that part of what we're hoping, I think, to do I think as a healthcare system is to start to be much, much more proactive and preventive.

Ron Barshop:

In your book, Reframing Healthcare, my favorite two pages talks about the difference between a patient and a consumer. Can you talk about that? I thought that was powerful medicine.

Zeev Neuwirth:

I asked this question in some of the talks I give. It's whoever in the room, particularly people who have had experience with the healthcare system... And again, I use the word system because the one thing I want to be very, very careful about, the critique I have and others have is not about the people who are working in the system. I think that the nurses and PAs and techs and administrators and physicians and the support staff, just absolutely brilliant, passionate, committed people. I've got my closest friends. My wife's a doctor. My brother's a doctor. I mean, these people give their lives for healthcare. So, it's not about the people, but the system. The system is completely dysfunctional. Anyone who's been through the system understands what I'm talking about. Thank God for the people who try to bend the system and work around the system and just duct tape the system, because they're the ones that are saving our lives, but the system really sucks.

Zeev Neuwirth:

And so, I asked the question, "For those of you who've had any serious interaction with the healthcare system, how many of you like being called a patient or like being treated like a patient?" No one raises their hands, right? And then I ask the question, "How many of you would like to be treated like a VIP valued customer, to be known as a customer and to be connected as a customer, a VIP?" Everyone raises their hands. And so, the difference is stark. Actually, I wish I could pull up the page because you're right, it took me a while to research this and the difference is stark. I mean patients get told what to do, right? Customers don't. You don't tell a customer what to do. Could you imagine going in somewhere and someone telling you, "This is what you're going to do." No, they asked you, "What do you want, sir or madam?" Right? I mean, "How would you like it? How can I be of service to you?"

Zeev Neuwirth:

I mean, no one labels a customer noncompliant, but that's what you call patients. I mean, think about how insane this is. In every other industry, it is not the customer's job to be compliant. I mean, it's your job to sell them your product and your service and to keep their business, right? That's what you get paid to do. You go out of your way to figure that out. In healthcare, we blame the customer if they don't listen to us or they don't come to us. It's absolutely insane. And so, I mean, it's beyond insane. It's ridiculous. And so, I think that taking... This is why I argued in the book and I continue to put this out, that we need to have a marketing mindset. We need to think more like marketers to say, "Listen, our job is to..." If you think about marketing, the principles of marketing, and I'm not talking about public PR, I'm not talking about sales or

advertising, I'm talking about the essence of marketing, marketing, it's about understanding your customer. Okay?

Zeev Neuwirth:

Marketing is about understanding their needs, their real needs and what they value. Marketing is about figuring out how to fill those needs and meet those needs and then figuring out if you've actually done that. That's the science and art of marketing. You know what, I'll tell you something, Ron. When I was teaching internal medicine residents for the first 10 or 12 years of my career, that's exactly what I taught them. At their job, the profession of medicine is for you to understand your patient, understand what they need, understand what they think, connect to them, understand them as a person. You take the textbook learning you've gotten, and then you have to translate that and customize it for that individual person and their family in front of you, because anyone could spit out a textbook. That's not what the practice of medicine or the art of medicine is about. You've got to make sure you connect to them and follow through with that. That is the essence of marketing, and that's why I think we need to have a marketing mindset in healthcare.

Ron Barshop:

This is where I give props to direct primary care, because they are indeed of that mindset. They don't take anybody for granted. Everybody is a paying member because they bought a service, but their whole philosophy basically is consumerism and customer orientation versus patient orientation, even just indicated by the amount of time they're able to spend with the patient, so they're not in that factory medicine machine.

Zeev Neuwirth:

Yeah. No, I think that makes sense.

Ron Barshop:

So if you were king for a day and could change primary care so that it was designed exactly to your wanting, as you indicated in the book, what would that look like?

Zeev Neuwirth:

There are a number of things I would change, but the first, and I think what's really decimated primary care and I think it's actually at the core of direct primary care, it's actually at the core of all good primary care is the compensation issue and the payment issue. Primary care and the vast majority of all healthcare in our country is paid for with what we call fee-for-service. So you get paid for what you do. So you get paid if you have a visit. You get paid by the amount of things you code, you do when you code during the visit, so if you do more tests, those sorts of things, if you have more follow-up visits, if more referrals. I mean, all of this is fee-for-service. Again, you get paid. It's piecemeal medicine, right? It's just exactly like piecemeal selling, right? You get paid by the number of pieces of cloth you stitch together.

Zeev Neuwirth:

The problem with that is that it leads to this sort of... First of all, it leads to volume medicine. So, it leads to over-utilization, unnecessary utilization, and it leads to volume medicine. So again,

from a purely financial perspective, if you're... And by the way, I may be the most noble, ethical, professional person in the world, but you put me in a game where the only way I can get compensated is by doing more, over time, we're all human beings, you can't fight the system, right? And so, fundamentally, the fee-for-service system in my mind, because it's not allowed primary care... Think about what primary care is. Okay. Let's just go back to that first before...

Zeev Neuwirth:

Primary care is all about... It's not about someone has had something happened to them and they need... The gallbladder's infected and swollen and they need to take it out, that's a different story. They just broken a bone and they needed... Primary care is about prevention. It's about proactive care. It's about all the things we talked about before getting to know the person as a person, getting to know their social context, getting to know all those needs. It's about thinking about the person, not just in front of you today, but what do we need to do so that you're healthy five and 10 and 20 years from now. All of that takes time. It takes time to get to know the person. It takes time to get to know their context, their family, their job. It gets time to actually know what they like, what they don't like. It takes time to build trust.

Zeev Neuwirth:

If you put someone on a treadmill where they get paid by volume, and the only way they can survive, and I mean survive, the only way that can make a living, the only way they can keep an office going, the only way that... I mean, they literally can have a business, stay in business to do medicine is by doing volume medicine, and that's what they're going to have to do. They're going to have to see you every 10 minutes and just look at your chart, see what medications are missing, write those prescriptions and get you out the door. I think that is the wrong thing. Clinically, it's the wrong thing overall for patients. By the way, I'll tell you, I've yet to meet a primary care doctor who likes that way of practicing. Primary care doctors went into the field, because they wanted to spend time with patients, to get to know them, to build trusting relationships and to do all that preventive proactive care I was talking to you about.

Zeev Neuwirth:

When patients come in with a problem, they want to spend time and diagnose the problem correctly, not send the patient off to half a dozen specialists or to all these tests. And so, I think that the fee-for-service payment model has literally destroyed, almost completely destroyed primary care in our country. It's decimated it. It's driven people away from primary care. It's driving people out of primary care. And so, the one thing or the one change I would make immediately is to change how primary care is paid for and how primary care physicians, providers, and staff are paid for from a fee-for-service to some sort of capitated model where you get a certain amount of money per patient per month, and that's also based on outcomes, such as patient satisfaction, patient experience, trust, and population health outcomes so that we know that you're actually doing the job of primary care in terms of things like-

Ron Barshop:

Value-based care. You just described a nutshell value-based care.

Zeev Neuwirth:

Absolutely.

Ron Barshop:

Yeah. If we have more time, I would want to talk to you about the CVS model, what you think of the Walmart model and what Walgreens is doing now with VillageMD. We're not a time, unfortunately, so that's whole nother conversation. I'd like to plug different models in front of you and just let you go on about them and see how your mind works. But I do have two final questions. If people want to reach you, Zeev, what's the best way to find you?

Zeev Neuwirth:

Happy to give out my email. It's zneuwirth@gmail.com. Neuwirth is spelled N-E-U-W-I-R-T-H, zneuwirth@gmail.com.

Ron Barshop:

Thank you for that. If you could fly a banner over America saying anything, what would that message be?

Zeev Neuwirth:

Treat each other with kindness.

Ron Barshop:

Very nice. By the way, we took a two-hour pause. You have to come up with the best one. We thought about 30, and we had to edit them all out.

Zeev Neuwirth:

I think I could-

Ron Barshop:

We can't wait to get you back again. I really love the way your mind works. I love what the Reframing Healthcare is all about and how you think. We look forward to our next visit soon.

Zeev Neuwirth:

Thank you, Ron. It's been a pleasure.

Ron Barshop:

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