Primary Care Cures

Episode 140: Bill Bestermann

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

We pause this pandemic to get back to really the most important healthcare story that hasn't been covered because the pandemic took all the air out of the room in the press and as it should. We have really two healthcare systems. We have wealth care and poor care. Poor care, in my humble opinion, represents well over half of 185 million American workers, plus the 10 million employed, plus 30 million uninsured. So that's 130 million who are functionally or actually uninsured thanks to high deductible insurance, out of the reach of most. We also have 44 million on Medicare, 80 million on Medicaid and 19 million veterans in Defense Health. So 57 million of us basically are in wealth care, which is maybe more, maybe less of 17% of Americans that are getting what they need. And there is no bigger healthcare story that isn't covered. The abandonment of the hourly class to poor care is the big story of 2021.

Ron Barshop:

Deductibles have only been rising since 2009 and most people don't have that kind of cushion to use their deductibles. So they're out in the cold. They really don't have insurance if they can't use it. What is the answer? The answer is not in Medi-crap care for all, and it's not in reforming the bigs from EBITDA addiction, forget that. It's not creating a new era of manifesting unicorns and fairy dust dreams either. It's here actually upon us and it's holistic and it's proven, and it's called direct contracting or Digital First Care, paid for by employees on a monthly subscription basis.

Ron Barshop:

And currently, just through the folks on my show, we know there's 25 million patients, perhaps as many as 30 or 40 million, we don't know because we haven't had everybody on the show, which is just not getting Wall Street's full attention because a couple of these have gone public. Well, who wins in the new way of new way care? Consumers win, doctors win, employers win, costs win, outcomes win. It's an unstoppable win, in fact, for everybody, and it's a future where everybody's a winner.

Ron Barshop:

Today, I'm excited to introduce you to a guest. Bill Besterman is a board-certified internist who practiced preventive cardiology for 20 years. And he's got quite an interesting resume, so I'm going to take that rare time and actually read you some of this because it's prescient to what we're talking about today. He's been heavily involved with health care reform and quality improvement. So I think he's going to have a lot to say about the new transparency initiatives that are busting out all over. He wrote the very first article in America on systemic approach to the metabolic syndrome. And he also is a senior clinical advisor for one of the Blues in Louisiana. And that initiative saved $27 per member per month at the one-year mark while reducing hospitalizations, length of stay and specialty referrals.

Ron Barshop:

Again, that's a future where everybody wins. He's currently the president and chief medical officer of Epigenetics Health. Bill, do you have anything you want to say about what I brought up in the top of the show?

Bill Bestermann:

Well, sure. Our healthcare system has all the problems that you went over, but it's even more than that. So if you look at countries where the evidence is really followed and they use best practice, like Singapore, they live longer and their impact on gross domestic product is one fourth of what it is. So in Singapore, they live a little longer and they only spend a little less than five GDP on healthcare. Here, we spend a little more than eight. The value in our healthcare system is not very great and there are all kinds of reasons for that. And by the way, everybody in Singapore has healthcare coverage.

Bill Bestermann:

So if you use best practices to provide healthcare, it's a lot less expensive and you can cover everybody. So in the United States, we don't provide coverage in the early game where you have high blood pressure and diabetes. But then if your high blood pressure and diabetes go on to put you on dialysis because you didn't get the attention you needed, then you automatically go on Medicare and you're covered. So it's just an upside down, crazy system. And optimal medical therapy for cardiovascular and related conditions is one part of the answer to that problem is what [I've heard 00:05:03]

Ron Barshop:

Well, you said something that stuck with me. You said success is going to require a combination of new science, new systems and a new payment model to involve all the stakeholders that I talked about at the top of the show. Do you think that this direct contracting might be an answer that does all of what you said?

Bill Bestermann:

Well, new payment models are definitely part of what needs to happen, and specifically in cardiovascular and related conditions, the fee for service model of payment is just a complete [barrier 00:05:25]. You can't get any headway as long as that's in place. But if you pay people to get the blood pressure down, the cost dropped down, [and the sugar 00:05:39] down using best

practices, and then you reward them for reducing ER visits, hospitalizations and other complications, it's not that hard to do. You can definitely make progress.

Ron Barshop:

So you're a fan of value-based care, I'm assuming.

Bill Bestermann:

I'm all about it.

Ron Barshop:

Okay. Got it. All right. And that does make sense if I see it as full risk. ChenMed is a full risk VBC, but there's a lot of VBC that are just making more profits and they're not moving the dial on the areas you're talking about.

Bill Bestermann:

ChenMed's a great example. So I've actually [spoken 00:06:20] to one of their leaders, and the example he gave to me is a COVID hospitalization costs about $60,000. But their patients have five, six or seven chronic conditions. They're disadvantaged people and so they hear from their doctor once a month. They hear from the [inaudible 00:06:45]. And one of those weekly conversations encouraged those patients to get a COVID shot. Well, disadvantaged patients, many times, aren't the prosperous people you're talking about. They're in poor care and they don't have two cards. They present that as a barrier to getting into the clinic to get the shot. The ChenMed people just say, "Okay, let us get an Uber ride to get you to the shot and we'll take care of that. When can you come?" And then they set up the Uber ride, the $6 Uber ride saves enough $60,000 hospitalizations.

Ron Barshop:

Yeah. If you put 10,000 people in an Uber, that's going to save one visit to the hospital.

Bill Bestermann:

Well, I don't know about that. It's more than that. It's enough that they're confident they're making money.

Ron Barshop:

Okay. So your core expertise is really around comprehensive solutions that reduce costs, reduce visits, reduce downstream costs by focusing on chronic cardio metabolic conditions, lifestyle diseases. Give us some of the ideas that have worked with your patients or patients that you've consulted with to reverse these cardio and hypertensive diseases?

Bill Bestermann:

Well, let's just start with the basics. So if you look at the way medical care is delivered in the U.S today, it's pretty much the way it was years ago. You get a doctor in an office and you have a shorter visit than you used to have. And the doctor treats you based on what he remembers from all he's read. Often, the doctor gets distracted because you got back pain and a rash, and the

dangerous risk factors that you have don't get the attention they should. That's what we call usual care. So usual care is care that most people receive. On the other side are people who get evidence-based care consistent with best practice. They don't just get their blood pressure lowered, they lower it with medications that are actually antioxidants, that are anti-inflammatory. They reduce the thickening of the artery, the enlargement of the heart and the core processes that cause the disease in the first place.

Bill Bestermann:

So if you look at medications like an ACE inhibitor for high blood pressure, like Lisinopril, it lowers the blood pressure, but it also makes the artery more normal. So when the diagnosis of high blood pressure is made, we already know that there's disease present. The artery is thicker than normal, and it doesn't expand as well when you exercise. And so when you take the Lisinopril, yes, you lower the blood pressure, but you also cause the artery to be more normal by thinning it and making it expand more easily.

Bill Bestermann:

Similarly, with Metformin for diabetes, if you lower the blood sugar to the same level or using another drug versus Metformin, the Metformin will lower their risk of heart attack 40% and their risk of all adverse diabetes out [inaudible 00:10:51]. And the blood sugar is the same. So it's not all about the sugar. And then when you combine all of those interventions, you go after aggressive goals for pressure, sugar, and cholesterol using medications that have benefit beyond their impact on the risk factor.

Ron Barshop:

Well, let me ask you a question. I love the medication solution because it's the easy pill, the easy button. In all of your years of working in this space, have you ever seen any comprehensive programs that have reduced obesity? If you talk to obesity researchers, they know what works, but nobody's doing it. Is anybody actually in the field out there reversing metabolism and teaching people how to eat the right kind of foods and how to walk more and how to sleep better? Are you aware of any models out there that are working on a larger scale for that?

Bill Bestermann:

I'm not aware of any that are really successful on a larger scale, but I think the answer's pretty clear. I've done that with my own patients. Of course, I treated a higher risk diabetic and hypertensive patient population for Eastman Chemical. And in the diabetic population, the type two diabetic child was all over weight. And 60% of my patients lost weight, whereas in most diabetic treatment, patients gain weight. That's, in part, because insulin and other medicines like Aerius, Glyburide, Avandia, those medicines all cause weight gain. So I steadfastly avoided those and I helped people understand 50 years ago, most people were slender.

Bill Bestermann:

Well, what changed? Food. Many of us are eating a lot more food that's prepared or we're eating outside the home in restaurants and so forth. Well, those people know how to put together fat, salt, sugar and processed carbohydrates in perfect combinations that are literally addictive. They're genes. And so the former head of the FDA, David Kessler, weighed 70 pounds more

than he does now. He figured this out. And he's been eating real food, lean meat, eggs, low fat dairy products, seafood, fruits, vegetables, beans, peas and nuts. I've been doing the same thing. He lost 70 pounds. Four of my patients lost over 100. So if you're eating real food that drives there so that you'll just keep eating when you're not hungry, the more you eat, the more you want. But if you're eating that food, you can't cut back on it any more than you can cut back on Coke.

Ron Barshop:

Do you believe in intermittent fasting where you give an 18-hour break from eating, and then you just eat in a six-hour, four-hour or three-hour window? Do you believe that is a possible solution for folks?

Bill Bestermann:

Sure. There's actually an article in the New England Journal of Medicine within the last year that talks about intermittent fasting. And this is the most fascinating thing about the whole thing to me, restricting calories, intermittent fasting, exercise, ACE inhibitors like Lisinopril, angiotensin receptor blockers like Losartan, statins, Metformin and drugs like Jardiance all activate the same metabolic pathway, gain the effects of increased oxidated particles that accelerate aging and make you get chronic disease earlier.

Bill Bestermann:

And so all of those interventions block that aim signaling. It's really funny. I got so fascinated with it just [inaudible 00:15:22], and it turns out that genes that you need to develop normally as a fetus and child are switched off pretty much when you're a healthy, young adult. Then they're reactivated by things like abdominal fat, cigarette smoke to cause cardiovascular disease and cancer. And all those interventions we talked about interfere with the products of those genes to slow aging and delay chronic disease.

Ron Barshop:

From listening to you, I think you're going to recommend your healthy patients and your chronic patients, everybody should be taking Metformin because there's a 40% less risk of heart... Why not, right, if you have nothing to lose and there's no real side effects, right?

Bill Bestermann:

Well, if you let these diseases run rampant for decades, like we tend to do, we have a medical system organized around rescuing people late. If you've got kidney disease and they're not working very well, Metformin can accumulate and that's bad. Most of the side effects otherwise are a nuisance. And if you take Metformin properly, most people can take it.

Ron Barshop:

Are you going to also throw on top of that stack a statin would be a good idea to take? Healthy or not healthy?

Bill Bestermann:

Yes, it's interfering with the pathways that accelerate aging and make you sick earlier. Let me just talk about Metformin a little bit because I think its benefits have very little to do with the level of glucose. So the evidence is it lowers heart... Just taking Metformin lowers your risk of heart attack by 40%. Well, I got very intrigued by that. You've got to explain that. It turns out that if you have a stent today in your heart artery, the stent has medication in it called Rapamycin. It's an antibiotic, but it's also anti-inflammatory and it interferes with scar tissue formation.

Bill Bestermann:

So Rapamycin [inaudible 00:18:07] and it keeps the stent from being clogged up again with inflammation and [inaudible 00:18:18]. And so instead of the stent lasting for six months, it lasts for years. So that's a very established part of medical practice. It does that by inhibiting one of these genes I talked about. Metformin does exactly the same thing. It inhibits a master genetic switch. And so it's used too little, too late. If you take it when you're pre-diabetic, your chance of becoming diabetic is reduced by 30%. That's just $4 per month.

Ron Barshop:

So clearly, everybody should be taking Metformin. I mean even if you're not borderline diabetic or if you're healthy, you should be taking Metformin, period.

Bill Bestermann:

Yeah. The ADA advocates taking Metformin in certain people with pre-diabetes. Only 3% of them are doing it. So I'd settle for getting diabetics and prediabetics on Metformin. If only 3% of prediabetics are taking it... It's so odd that that research was done by the NIH. I'm prediabetic myself and I take Metformin and I go into a doctor's office and they say, "[inaudible 00:19:50]."

Ron Barshop:

Yeah, it's interesting. We had a guest named David Sinclair. And for those of you listening that have heard this, it's one of our most downloaded shows, but David is a Harvard researcher. He's got the biological age of a 21-year-old, but he's in his 50s. And his research is basically that aging is optional, that you can actually reverse aging with Rapamycin, Metformin, a thing called NAD NMN is another one, and then Resveratrol, which you can all get on Amazon. And the quality is uneven when you get it on Amazon. But he takes all five of those and his father is reversing aging. His mice are reversing aging. His nematodes are reversing aging. His fruit flies are reversing aging. And now he thinks it will be part of our culture in another 10 years.

Bill Bestermann:

Well, you're interested in the disparities between poor care and wealthy care. Think about this. If you have had a heart attack and you combine the interventions that I've talked about, aggressive risk factor reduction, using ACE inhibitors or ARB, statins, Metformin, if you're diabetic, and an aspirin, I mean it's not that complicated. And you really go after it. In this study, 91% of patients were on a statin versus about half of this population in usual care and the impact... So this was done at Kaiser Permanente, 628 patients in each arm in the study, same institution, same buildings, normal medical therapy versus usual care. The OMT people, [inaudible 00:21:41] medical therapy people, a 90% reduction in mortality if they enrolled early. The savings was

$21,900 per patient, per year, or [inaudible 00:21:57]. The costs they estimated to be $1 a day. And the return was $60 a day, which is the best I've ever heard of in healthcare.

Ron Barshop:

Okay. So $1 a day versus $60 a day, that's impressive. I wanted to switch subjects because we've got a lot of ground to cover and not much time. I am fascinated with something that you brought up. When there's heart disease treatments brought out, procedures brought out for the population, you found out that they don't work on women sometimes, right. Can you talk a little bit about that?

Bill Bestermann:

Well, sure. I treated about 25 women like this. This might be something you want to look up. So it's called the Women's Ischemia Syndrome Evaluation. It's the WISE study, W-I-S-E. And this, again, was sponsored by the NIH, but the uptake on it has been pretty pathetic. And what they showed is that many women who have heart attacks don't have obstructive coronary disease. They don't have blockages. The whole system is arranged around opening blockages. That's not the way heart attacks occur. So yes, a blockage is a marker for the fact you have a coronary artery disease. So if you have a blockage anywhere, you have cholesterol plaque everywhere. But heart attacks occur usually in a part of the system remote from the blockage.

Bill Bestermann:

A cholesterol plaque will rupture or erode, comes in contact with the blood and causes a clot. And that's what causes a heart attack. That's why Aspirin prevents heart attack. It's an anticoagulant. That's why a clot [inaudible 00:24:02] stops a heart attack that's already in progress. It fits everything we know, but women are much more likely than men to widely distribute cholesterol plaque rather than having local blockages, local chronic blockages.

Bill Bestermann:

And so they are more likely then to have heart attacks with the absence of blockages. Well, to this day - I saw my last patient three or four years ago - but when I left practice, doctors were still doing stress tests and catheterization on these women. If they didn't have a blockage, they would tell them, "Your heart's okay. You don't have [inaudible 00:24:59]. It's probably your esophagus or your stomach," or worse than that, "Go home and take your Valium and Prozac. Everything is going to be all right."

Bill Bestermann:

And then when I took those 25 women and applied those interventions that we just talked about in optimal medical therapy, they quit going to the emergency room. They no longer had repeated chest pain and they were much safer from a heart attack. And these were some of the most great women I ever treated. And it's really amazing. I've talked about the impact after a heart attack. These women, on average, cost $750,000 over the course of their lives in costs related to their heart disease. And that's because it's not properly diagnosed. It's not properly addressed. They keep having chest pain. And they keep going back to the emergency room and being admitted.

Ron Barshop:

I have another big subject that I want to cover before we sign off today, Bill. The transparency initiatives that are busting out all over, we now have not all, but most hospitals are complying with the regulations to post 300 different procedures' costs on their websites, and smart people are digesting that and making it understandable for self-insured employers and for people that need to buy those products directly or indirectly, like third-party administrators. And a lot of hospitals are just saying, "I'll pay the $103,000 fine. I don't care. 300 bucks a day is a rounding error for our hospital." Then the insurance companies have the same mandate, but it's much more broad starting January 1 of next year. How do you feel about these transparency initiatives after working on this issue for 20 years in your career?

Bill Bestermann:

Well, I think it's just absolutely essential and it's incredible that we don't have that kind of information available for patients. We just talked about the disconnect. I mean what we know about heart disease and the way it's generally treated. And if you look at it, there's another whole body of 15 [inaudible 00:27:33] that show that operable medical treatment alone in stable cardiac patients is just as protective as optimal medical therapy [planned 00:27:43]. And talk about transparency, most people who go to a hospital with chest pain don't understand that. They don't hear a thing that really gives them informed [inaudible 00:28:08]. "You have stable angina. If we treat this with medication alone, you'll do just as well as if we use a stent. And by the way, within a year, 70% of patients like you are going to not have chest pain any longer."

Bill Bestermann:

And so the whole thing is not transparent. I don't think very many people who have a serious cardiac problem get the informed [inaudible 00:28:51]. Most people that I've treated thought when they had their stent, they were made safe from cardiovascular events like that. And that's just not the case. I think if you ask 10 people on the street, "What will keep you from having a heart attack or dying suddenly?" most of them would say, "Opening the artery." So there's not much about it that's transparent. And when you start talking with patients about how it all works and what they can do about it, they're much more trusting and likely to do what you recommend, so giving people straight information and developing trust protocol.

Ron Barshop:

Yeah, something that the big systems are not really remarkably good at. Let's talk about how people can find you if they want to reach out to you and ask more questions.

Bill Bestermann:

Okay. All right. Well, I've got a site on Substack called slowing aging and delaying chronic disease development that they can... If they just put those terms in there, they can easily get to that. It goes over all of this. And then my email address is whbester@gmail.com.

Ron Barshop:

Okay. And if you could fly a banner over America with one simple message for everybody to follow, what would that message be?

Bill Bestermann:

You can have better healthcare now. You can live longer and you can spend less money doing it.

Ron Barshop:

Thank you very much. That's a great message. Well, I enjoyed visiting with you. Your line has been fighting this battle for a lot longer than I have, and I always learn by talking to folks with the wisdom. So thanks for your time.

Bill Bestermann:

It's a pleasure to be here and thank you for including me.

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 podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.