Fixing Healthcare Podcast Transcript

Interview with Donald Crane

Jeremy Corr: Hello, and welcome to the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Group, the nation's largest physician group. He is currently 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. His new book, Uncaring: How the Culture of Medicine Kills Doctors and Patients was published two months ago. All profits go to Doctors Without Borders. If you want more information on the book and a broad range of healthcare topics, you can go to his website RobertPearlMD.com. Together we host the biweekly podcast Coronavirus: The Truth.

Our guest today is Don Crane, the President and CEO of America's Physicians Groups. APG is a powerful national voice for physician-led medical groups and doctors in Independent Practice Associations. As you will hear, he is a strong advocate for the importance of moving from a fragmented fee-for-service healthcare system to one that is integrated and reimbursed on a prepaid, capitated basis.

Robert Pearl: This is our sixth season of Fixing Healthcare. In our first season, we brought in nationally recognized leaders including Don Berwick, Eric Topol, Ian Morrison, and Zubin Damania aka ZDoggMD, and we asked them to describe how best to fix the American healthcare system. Their solutions were comprehensive, spanning across the realms of insurance, hospitals, the drug industry and physician practices. This season, rather than asking for comprehensive solutions, we're going vertical and deep, inviting leaders from each of these areas to come and explain their work, what their organizations are doing to address the current healthcare challenges, the problems they're encountering and their perspectives on the future.

Robert Pearl: Our first guest this season was Dr. James Madara, the CEO of the American Medical Association, who spoke about independent physician practices. This month, our guest is Mr. Donald Crane, the CEO of America's Physician Groups. Welcome, Don.

Donald Crane: Welcome, Robbie. Thank you for having me. This is a pleasure.

Robert Pearl: Don, APG represents more than 340 physician groups with nearly 200,000 doctors providing care to almost 50 million patients. Let me invite you to offer your perspectives on the contributions APG is making and your views and how physician groups can solve the healthcare problems of today and tomorrow.

Donald Crane: Well, glad to do that, Robbie. A couple further words about APG for the audience, so indeed, we are a professional association composed of physician groups and you were right, we're at approximately 340 groups now that employer contract with about 170,000 physicians that, in turn, take care of about 90 million patients across the country. I think we have groups now in 44 states. So we are indeed very much national. And indeed, we're in the business of advocacy, have an office in Washington, D.C., one in Sacramento where our roots are, frankly, in California. And we are also in the business of education, both intramural as we share best practices amongst our members and then also to support the knowhow of capitated integrated care outside of our organization to physician groups around the country that wish to learn this model of care.

Donald Crane: We view ourselves as leaders, basically the personification of the value movement in America. Like no other organization, we are engaged in Medicare Advantage. We are engaged in Medicaid, managed care, commercial, coordinated care, the new direct-contracted model and all of the programs and products available, basically we operate and do so in a capitated, integrated way. That indeed is our core philosophy. We believe that physician groups should be accountable for cost and quality. We're very much wedded to the payment model which is prospective, where the physician group is paid in advance per member, per month, a defined amount of money to care for the individual patients, but also the population of patients for a defined set of benefits for a period of time, perhaps a year.

Donald Crane: This prospective payment creates aligned incentives all through the physician group enterprise where everybody is trying to keep the patients healthy. Let me repeat that, we try and keep the patient healthy. It's a healthcare system and that is what distinguishes us from what we are really trying to move away, which is fee for service, which is basically a kind of a sick care system where doctors and other providers are paid per click to deliver care after the fact to patients that are sick. So the more work that is done, the more they are paid. So we're very much wedded to the payment model, but also the care model which is integrated.

Donald Crane: We're very much primary care centric, but where the physician enterprise includes by contractor, by employment, all of the specialties, but also psychologists, social workers, dietitians, etcetera, etcetera, so that we are proving care to the population across the entire continuum of care in an integrated, very non-fragmented way. And so that characterizes the APG members. We're passionate, as you may even can hear it in my voice, Robbie, about this care model, this payment model, that our groups are organized and have the infrastructure and the knowhow to do this because we frankly see it as the best hope and basically salvation for American healthcare, producing lower cost, higher quality, greater patient satisfaction, the triple aim that is often called, but also as we sometimes now even say the quadruple aim, better for physicians frankly, more gratifying, more professional.

Donald Crane: And then I might even add a fifth domain to it, which is we have the ability to address health disparities and health equity issues like no other model, like fee for service, can't do. Because whatever happens to our populations of patients, whether it's structural racism, whether its nutritional inadequacy, etcetera, those are of moment and importance to the groups to take risk as it were for the health of that entire population. So we have an incentive to eliminate disparities. We have the organizational capacity to do that. We see ourselves as, basically, the best vehicle for addressing those issues. And so you can tell we're proud of what we're doing. And we hope to proliferate this model across the country. We think when we're done with that, probably 70-80% of the work ahead of us will be accomplished, frankly. So with that, I'll pause, Robbie.

Robert Pearl: So Don, APG's tagline is, "Taking responsibility for America's health." Given the power of insurance companies, hospital systems and the drug industry, is it realistic to believe that physicians can drive the change?

Donald Crane: Well, yes, so let me speak to the tagline. Indeed, it is a rather maybe even conceited concept that we would take responsibility for America's health, but that captures who we are in terms of the payment model. When we're prospectively paid for a population, we become responsible for their health and must work within a budget. When we are given bonuses and incentive compensation by achieving various quality measures and improving quality and outcomes, we receive bonuses, so we become accountable for the quality of the care. So we see ourselves as accountable for cost and quality.

Donald Crane: Now, there are other players in the healthcare ecosystem, none of them really like physician groups in terms of taking that risk and delivering care. So we're, I think, uniquely able to say that. Now indeed, your question, I think hints at issues relating to political power, market power and all of those indeed, are important. We can talk about those in due course, but the way we see our payment model and our care model, yeah, we wish to be responsible for the outcomes we deliver.

Robert Pearl: I believe, Don, you've been the CEO now for 20 years. And at the start of that process, most of the physicians who were employed were employed inside medical groups. Yet today, the majority of physicians are employed rather than a minority, but a lot of them are being employed by health plans and by private equity groups. How has this impacted America's healthcare?

Donald Crane: Well, it's a process that is underway and I think, frankly, Robbie, the jury is out on that question. So indeed, you're right. I think we're looking at the some of the same statistics, the numbers have moved up and something, what, on the order of 60% of physicians are in some kind of relationship with a parent organization, whether it's a hospital system or a health plan. And so this sort of Marcus Welby of old indeed is a dying breed. We have that issue basically within my own organization, Robbie, and here's how we look at it, we treat it and I would propose it for the rest of America perhaps.

Donald Crane: We think the Pentium chip of healthcare delivery is the physician group, right? And so around our board table, for example, we allow only physician groups, each and every one of them wearing their APG hat. We do not allow into our caucus their parents, whether the parent is a health plan or the parent is a hospital organization or a private equity firm, because we feel that it is the physician group that counts. And we like to pretend, I'm using the word pretend, Robbie, that their parentage doesn't matter. Now, indeed, it does matter. We are concerned about the loss of independence of physicians. Half of my members are what are known as IPAs, independent practice associations, where the physicians retain a certain amount of independence, but they enjoy centralized support from the IPA or the MSO, the management services organization. They're centralized support data, data analytics, etcetera, etcetera.

Donald Crane: And so we find we have a blend there of independence, but also centralized support. So I think we're all trying to navigate this new more integrated care where physician groups are indeed well supported by centralized supports, but without completely ceding all authority really to non-physicians which is something we don't promote or propose. So hopefully, that's a start at answering your question.

Robert Pearl: So over a decade ago when the Affordable Care Act was proposed by President Obama and approved through Congress, accountable care organizations were seen as powerful forces to be able to improve quality and lower costs. Little over a decade later, they've done a good job of improving quality, but there's been a very mixed report card on the ability to lower costs. From your perspective, Don, why is that, what's the problem, and what's the solution?

Donald Crane: So I think your question relates mostly to the Medicare ACOs. So indeed, the Affordable Care Act gave rise to the Medicare ACOs, MSSP ACOs. And indeed, the results have been mixed. Actually, that's fairly generous, Robbie, to say mixed, but the great majority of the alternative payment models here did not deliver net savings to CMS. And so I have an answer to that and that I think the answer includes basically difficulties, I'll use that word, associated with the design of the Medicare ACO model. It remains on a fee-for-service platform. There's open networks. There's scant assignment rules, so patients aren't even sure sometimes to which ACO they might be attributed or not.

Donald Crane: So there's a looseness in the design there that unsurprisingly has not yielded very good results. But at the same time, I say this, Robbie, if you shift your gaze over to other areas, the commercial market or how my members are doing or how they're doing even in Medicaid and so on, there you see, and of course, the information is proprietary and I'm not in a position really to talk about my individual members profit abilities, but nobody's gone insolvent. I think the model, where it's well designed, again, where it's well designed, closed networks, assignment, lock in, those kinds of words, and so forth, the results are excellent, frankly, significant improvements in quality, significant improvements in cost.

Robert Pearl: You talk a lot about this movement from fee for service to capitation. And when I look across the United States, it's not that there's not a slow evolution in that direction, but I think it still represents when you look at the total dollars, a very insignificant amount, certainly not enough to transform the American healthcare system. How are we going to accelerate this? What's going to make it work for doctors? As you said in the COVID-19 experience, they benefited from it, but people seem to be not embracing it and moving forward as rapidly as you and I might believe. What's it going to take? Is it going to happen?

Donald Crane: Well, it will happen eventually. Cream floats to the top. I don't know if that's an axiom of physics or not, but I do think that a superior model will eventually win out as it were, but it will have to overcome a lot of entrenched barriers. So we'll get to that. So it will eventually succeed. My frustration of course, Robbie, and perhaps yours, is that it's moving slower than we would like frankly. The Affordable Care Act was, I think, enacted in 2010. MACRA, the Medicare and CHIP Reauthorization Act, which had a lot to do with eliminating SGR and trying to get rid of fee for service basically, that was a 2015 law.

Donald Crane: So at any rate, the progress has been slow and your question is, what is it going to take? Well, it's gratifying, I think, to watch the private sector continue to move along and it's gratifying to see capitated, integrated care grow within given states and the Medicaid program and so on. There is a broad recognition that this move to value must happen and it's shared widely. Now, the reason I emphasize that because 10, 15 years ago, Robbie, that was not the case. I used to go back to Washington, D.C., and talk to congressmen and senators and so forth and say, "Fee for service was bad and capitation was good." And they were looking at me like I had two heads.

Donald Crane: Now, when we're in, in Washington, D.C., talking about these subjects, the notion of a capitated payment or something budget-based like capitation is conventional wisdom. It's commonly accepted, we need to move there. But now to zoom in on your question on what is it going to take, well, if I had a magic wand, it would be federal legislation that would pretty much stop the slow walk towards value in original Medicare and make it happen overnight. That's not likely to happen, Robbie. I don't think because the healthcare doesn't typically evolve in such fast fashion ordinarily. But I think legislation is part of the answer and then I think we let need to look to employers clamoring for more value would be helpful and we're hearing their voices rise now and asking for that very thing.

Donald Crane: I would share with you one of my frustrations, Robbie, is that these subjects that you and I are discussing right now are a wee bit esoteric, right? So I don't know that John Q Patient on the street thinks a lot about how his physician or physician group is paid, capitated, fee for service, whether they know, whether they care. So indeed, it is a problem for us all that our customer base, the patients, don't fully recognize the value of the model that I'm talking about right now. So if I had a magic wand, I would fix that as well. So as I'm sharing with you some of the challenges we've got as we try and move in it, a nation that's

entrenched in fee for service to a far better model and it's going to be hard. Other nations have done it. Europe's there and most of the other Western developed countries have something in the nature of a budget-based system and so on. So we'll get there. But if you're hearing my impatience, then we're in agreement.

Jeremy Corr: Don, at the beginning of the pandemic, everybody viewed doctors and frontline healthcare workers as heroes. That admiration has waned a bit due to COVID fatigue, confusing public health messaging and the politicization of the pandemic. And I've heard many refer to the post-pandemic as the second wave where we finally really addressed the mental health issues, addiction problems, loss of education, economic devastation, etcetera, that happened as a result of the pandemic and it's happening or it's handling. Do you feel we, as a nation, from a medical standpoint, are ready to not only address this for patients, but the mental health issues and burnout that many of the frontline healthcare workers are facing while not feeling nearly as appreciated as they once were?

Donald Crane: Well, I hear a couple questions in there. No, I don't think we have yet acquired the ability and the knowhow and the resources to eliminate burnout. In short answer, I don't think we're close enough to there yet. When I think about mental health, behavioral issues, there again, we're woefully unprepared. So post-pandemic, if you look at the opiate crisis, it's actually gotten worse and these diseases of despair they're now called, addiction, alcoholism and suicide, those trend lines have risen ever-higher all during the pandemic. So the situation's actually gotten worse. Now, an answer to your question. My hope is that we get our nation vaccinated and we put Delta and COVID in the rearview mirror, that we triple down on our efforts to address mental health.

Donald Crane: And the big sub answer I would give to you on that, Jeremy, is we need to wake up and reintegrate behavioral health issues, mental health issues with medical. So in most jurisdictions, California, for example, has a law on the books that requires mental health to be fragmented away from medical health. And clearly, the two need to be integrated. Physicians frequently remind me that you really can't treat and solve diabetes, for example, without dealing with mental health issues. So I look forward to the day when we integrate behavioral and medical. And I think that recognition that I'm talking about now is upon us and so I'm looking forward to laws, regulations and practices that fix that problem.

Robert Pearl: So you mentioned telemedicine as something that happened extensively during COVID-19 with as much as 60 and 70% of doctors' practices in some cases becoming virtual. What are your observations about what we've learned, the challenges that exist and the future that is virtual medical care?

Donald Crane: So it happened overnight. I like to think about one of my members who's talking about, "Oh, they had a plan to usher in telemedicine across their whole organization and they've been working on it for over a year and a half, right?" And I think many of my groups have been doing because everybody could see that it was a good thing to do, but there wasn't a lot of impetus to do so until

one night when we had COVID. And across my membership group after group after group went to 100% telemedicine in many cases over the space of a weekend, right?

Donald Crane: Necessity is the mother of invention. So indeed, almost all of their visits went from in person to telephonic in a very short period of time. Then what we saw Robbie is overtime, particularly as the social distancing rules and stuff were relaxed. I think the sort of water level has found a more maybe appropriate level and we've watched telehealth recede into areas where it really looks resilient and permanent, right? It depends upon different specialties. There's not a lot of telehealth going on in surgery. There is a fair amount in endocrinology. Depending upon the specialty, you'll get different levels of telehealth.

Donald Crane: It has now, I think, receded back to ... I don't know really where it's at now, maybe 20% of the visits, something in that range, that are now telephonic, but it looks durable because though that percentage has come back to this lower number, it looks permanent, because it is very much appreciated by patients and physicians. It's incredibly useful in psychiatric visits and other behavioral medicine. It's an important adjunct. It looks like it's the conventional in-person visits, saves money, patient satisfaction. There's much that's good about it. And I think it's going to be with us in the future. We've got to work out details. How much should physicians be paid for? Is it included in risk adjustment?

Donald Crane: There's a lot of wonky kinds of issues that have arisen out of it that have not yet been solved, but I think there's no question about it we're going to have as a permanent fixture of American healthcare. We're going to have a significant percentage of our care via telehealth which implies telephone, but I think other remote monitoring and associated technology has now really been given enormous boost and it's going to be with us permanently.

Robert Pearl: Don, as you know, burnout is a major challenge for doctors, with 44% reporting symptoms of fatigue, dissatisfaction, lack of fulfillment. What do you believe are the greatest contributors and how is APG working to overcome them?

Donald Crane: First, I'll just chime in with you, it is really a huge problem. The volume of the basically cries of despair from physicians has risen year over year and it's at a high pitch right now. So an answer to your question, to my way of thinking, the single biggest cause is the fee-for-service payment model. So meaning no disparagement to anybody, there is references to the hamster wheel. So physicians needing or wanting to make more money, whether it's to put children through college or whatever, need to work more in order to make more. So they're on the hamster wheel, they run faster and faster and they work longer hours and then they work on Saturday, and indeed, this is almost a Sisyphus kind of a model of working more, working harder in order to make more money. That is the nature of fee for service.

Donald Crane: Capitated models, however, are very, very different. It's going to be team-based practice to keep patients healthy. And it isn't about doing more work, it's about smarter work and work done in the right site of care, maybe at home, outpatient, inpatient, etcetera, etcetera. So the payment model makes a lot of difference. So that's part of my answer to your question. The other part then, though, Robbie, moves into administrative areas. Indeed, physicians not fortunate enough to be employed by well-staffed and well-resourced groups, they're having to do a lot of administrative work and they're trying to keep up with quality measurement programs that vary from payer to payer to payer. There's a lot of reporting requirements.

Donald Crane: And so the amount of time they spend in nonpatient care has risen year after year and it's burning them out. And we need to fix that and fix this payment model. And the fix is also support from organized groups that have the infrastructure and knowhow to support physicians to relieve them of some of this pretty noxious administrative work.

Robert Pearl: Another big problem is the challenges to primary care. We're seeing less interest. Physicians going into it, are feeling increasingly overburdened. They're often feeling burned out. What does APG see as the best solution to reversing what has been a decline over the past couple of decades in both the esteem and respect accorded to the primary care specialty?

Donald Crane: Well, before I propose the answer, let me raise you one on the problem. The problem is bigger than we all know here because really the health status of the nation now is characterized by chronic disease, multiple chronic disease. I think 80-90% of the spend nationally, certainly in Medicare, is for service related to patients that have multiple chronic diseases, so think of diabetes, hypertension, cardiovascular diseases, and the like. Those are illnesses chronic in their nature that are principally treated by primary care physicians. So at a time where we have this crisis about around primary care to which you refer, we have an even greater need for primary care. So we really have a problem on our hands.

Donald Crane: But the solution lies there as well because the studies have made it clear, and I don't remember the precise ratio, but it's the bang for buck ratio. So for every dollar spent on primary care, there's multiple dollars saved in terms of reduced costs. So primary care is also a "bargain" if I may use that term frankly. So that's the backdrop. And an answer to your question, yeah, you would like to see the fee schedule in Medicare and proof such the primary care is better recognized and paid for more, that we get into some very technical issues as to how the fee schedule is constructed.

Donald Crane: But to race forward to where I think the answer really lies is that when my members, Robbie, and capitated models are paid capitation, and as you know very well as the seat CEO of Permanente Medical Group, the CEO, you, for example, can turn around and pay two primary care doctors far more than what might be going on the Medicare fee schedule or the Blue Cross fee schedule. And so indeed, a fair number of my groups pay primary care doctors 150, 200,

250% more than they would find in other commercial fee schedules and do so because the value of their work is so high frankly.

Donald Crane: So the payment model to which I continue to refer, capitation, that's at the group level and then the CEO can turn around and pay sub-capitation, can pay fee for service, can pay whatever form of compensation makes sense and at what levels make sense. So this is the opportunity to pay primary care more to basically recognize its value to the system. And what I've just described, that dynamic is common across the APG membership. So there, again, the model when constructed is a big part of the solution. It goes on and on. I think we need to be educating more primary care physicians. There needs to be more emphasis on really modern healthcare in medical schools, their curriculum is still very specialty weighted, heavy and so I think there's an element to medical education that should be addressed as well. Long answer, sorry.

Robert Pearl: It's a big problem. Continuing on what you said, Don, where does the expectations of physicians end and those of society begin when it comes to the areas of health?

Donald Crane: Well, I'm not sure I understand your question, Robbie.

Robert Pearl: Social determinants of health, responsibilities of the individual patient, to manage their own health, socioeconomic determinants of access. There's a whole series of ways that doctors bear the brunt, but the problems are beyond at least the traditional definition of what doctors were responsible for. And from my perspective, increasingly they're being asked to take on where he'll be held accountable for many of society's shortcomings.

Donald Crane: Very good question. So my answer starts with advising you what you already know, the health status of an individual or a population is thought to be determined maybe 10, 20% most by way of medical care. In the main, 80 90% of the health status of a person or a population is the result of social factors, environmental factors, work factors, genetic factors, etcetera, etcetera. So the expectation of what physicians can do needs to conform to the reality of the influencers and determinants of health. So this is really more recent think learnings that in order for us to really improve the status, health status of our nation, we're going to need to do much more in terms of social issues, nutritional issues, transactional or transportation, housing. Those kinds of factors really help determine this health status of populations.

Donald Crane: So who then, the question might be, is going to be responsible for those social factors? Up until now that we have this hodgepodge of social agencies and health departments and churches and the like and it's fragmented completely. And it isn't integrated into medical services very much at all. So what do we do with this? So we can't really expect I think an individual physician, a Marcus Welby going through medical school, to all of a sudden be responsible for the nutritional needs of all of his patients. We couldn't possibly do that. Who then might do it?

Donald Crane: So I happen to be of the view, Robbie, that organized physician groups, where they ask to take more responsibility for social factors, social work, we'll call it, could indeed do that. They would need probably to be compensated a little more and perhaps a little differently to do that, but good examples in Medicare Advantage and allowing risk adjustment to include social factors. These are all really, I think, nascent issues that we now need to work out. I think this is sort of a new topic. My pitch is that physician groups, organized physician groups are probably best positioned to take on some of these social determinants of health issues up to a given point.

Donald Crane: They're not going to be able to deal with violence in communities or the existence or absence of playgrounds for children to get some exercise, but there's certain things that are within their reach were there funding, where they ask to do so. And I would include among that nutritional support for the diabetic population. But whether we give it to physician groups or not, we do need a significant reallocation of American dollars and resource and energy into social determinants. And here's what we would want to see happen, Robbie, more money, effort and resource goes into things social that will improve the health status of the population such that the medical spend can actually be decreased.

Donald Crane: So as we shift our gaze to Europe, for example, right now, we know that in the United States, we pay about twice as much for our healthcare and we get results that are about half as good in terms of quality. So that's axiomatic and all public health students know that. In Europe, it's the adverse. They spend more on social, but they spend less on medical because social yields better results, so ultimate results. So we're turned upside down on this now and I would hope and advocate that over the course of the coming years and decades, we rectify that imbalance, just as we usher in the payment model and care model to which I've described.

Jeremy Corr: Preventative health is super important. During the pandemic, we saw just how much more dangerous COVID-19 was for people with severe comorbidities. With the Delta variant now, it seems like the pandemic isn't going to be going away anytime soon. Why isn't more being done to essentially shout from the mountaintops about eating right, getting exercise right alongside masking, social distancing, vaccines, etcetera, as a way to help prevent severe illness? And not only why is this not being done, but if you were the nation's health czar and you had a megaphone to raise awareness on this issue and add focus on it, how would you handle it?

Donald Crane: So I'll start with the latter question. If I were the czar, we'd have a much better diet across the country and we'd have a whole lot more exercise. We'd do other things in terms of the personal responsibility, but I would put diet and exercise at the top. Food is medicine. Frankly, I think that this is probably not an exaggeration to say that the American diet is almost toxic for the American population. You just see what people are eating and the results. Obesity continues to be a problem and so forth. A healthy diet is a whole story and is obviously controversial, but we know what's unhealthy, that which they're

buying out at 7-Eleven. People, we need to fix that. Exercise, everybody's seated and looking at their screens, whether it's TV or their computer. And so there needs to be a whole lot more exercise.

Donald Crane: If you dealt with those two things perfectly, they were completely dealt with and everybody had a healthy lifestyle and then also seatbelts and didn't smoke too much and drink too much or didn't smoke at all, our health picture and this span and the quality and lifestyle would be improved remarkably. So if I were the despot with a magic wand, I would mandate that in a hurry. In some fashion, I have to salute people that try to eliminate soft drinks and so on by increasing the taxes on them and so on. These half measures are well intended, but indeed, if I was the czar, that's what I would do.

Donald Crane: There is a call, Jeremy, no one has forgotten that these issues of self or personal responsibility are at play. I think we've been eclipsed basically by the pandemic for a little while now. Hopefully, when we get back on an even keel, there will be an increased voice along with an increased awareness that these "issues" of personal responsibility, diet, exercise and the like, will get greater attention and we need probably to learn new ways to incentivize healthy behaviors and disincentivize unhealthy behaviors. And that might be done through insurance design and other programs, so it's a whole area of interest that I think has to be pursued aggressively going forward.

Robert Pearl: Since I published Uncaring: How the Culture of Medicine Kills Doctors and Patients, I've had the chance, Don, to be on about 50 other podcasts including your own. And the most common question I've gotten has been how medical education needs to change. And I've often pointed out that really for up until 2007, if you wanted to carry with you all of medical knowledge, you needed at least a 50-pound backpack, but the smartphone has now made that possible to carry that into your pockets. And being able to stop focusing and testing on memorizing arcane facts and focusing on opportunities to use this new technology is probably the area that I would start for up to me changing medical education. How do you see it and what does the APG groups believe needs to be happening to train the doctors of the future?

Donald Crane: Agree with you completely, Robbie, and we're in an entirely different world now in terms of technology and it's moving ever faster. Just think about artificial intelligence, the big databases that harbor so much knowledge which can be tapped digitally via algorithms that spit out basically good information, good advice to physicians, no single physician could possibly know the totality of information now that's known in healthcare to state it very obvious, but we've got the technology to support them. So their medical education needs to train them on how to use that kind of technology frankly because it's coming very fast.

Donald Crane: I think also medical education needs to train physicians to operate within organized groups in a collegial fashion, team-based practice. It won't be Marcus Welby taking care of all problems. It'll be Dr. Pearl perhaps supervising a team

of what might be called midlevels or extenders, but including a pharmacist and a psychologist and a dietitian, all of the kind of services that are going to be needed to take care of a population that now is bedeviled mostly by chronic disease. And so I think that medical education needs to catch up with technology. It needs to catch up with the new demand basically in healthcare in terms of lots of chronic disease, needs to catch up in terms of the capitated integrated delivery systems to which we've been referring. It is not going to be one doc in one office on one street corner in the future and medical education probably needs to speed up to recognize that reality.

Robert Pearl: To that end, Don, if we did as a nation, everything you're describing, changing from fee for service to capitation, moving more to teams-based care, introducing technology, do you believe like some other organizations that we have a major shortage of doctors in the United States or do you believe on the other hand that maybe we have an excess number, at least an excess number focusing on the healthcare problems that doctors address today?

Donald Crane: Well, I think there's too few primary care doctors, I will say that, number one. Number two, when we get to the end state to which we aspire, which is truly team-based practice, we will be able to make better use out of the physician population we have. They will be supervising the work of others to deliver the care. And the seeming shortage of physicians we experience now might be ameliorated significantly when we use physicians correctly, doing what they should be doing, supervising others, dealing with only the most difficult case. So when we finally get to the point where we've got organized groups using team-based practice, the shortage will be less severe. I would say those are the dynamics. And that's probably where I would end. I don't think that we have too few physicians, but I do know that we're not using them optimally.

Jeremy Corr: I think for a while the nation saw the light at the end of the tunnel when it came to the pandemic and I think again, now with Delta, the nation's collective optimism has more or less disappeared. What are you seeing in healthcare as a whole, and maybe that's lessons learned from the pandemic or technology or policy changes that may be coming in the future, that you want to share with the patients of America to give them a little ray of sunshine or a little ray of hope about the future of American healthcare?

Donald Crane: So we should first again take heart the amazing vaccines we have right now. So efficacious, relatively speaking, and so rapidly developed. When you think back to early 2020, January, February, March, we were being told we might not get a vaccine for four years that we hadn't had an approved vaccine brought to market in less than four years ever before. In our instance, we now had one within, I don't know how many months it was basically, at high levels of efficacy at least against COVID. So we should take stock of that and congratulate ourselves and our science that was able to deliver such excellent vaccines.

Donald Crane: Now we have problem with partisanship and those that don't wish to be vaccinated. And now we have a basically pandemic of the unvaccinated and we

have a fairly well-protected vaccinated population which gets us all the other issues that I don't think you're after. The balance to your question was, what do I find hopeful about American healthcare? Well, science for sure. Vaccine, good example. Technology, for sure, many examples. The use of data analytics allows us to know things we never knew before in an instant. We're only learning how to harvest them sort of at the bedside now. So there's lots to rejoice about in terms of technology and science.

Donald Crane: I'm less delighted with the personal responsibility, which we just talked about. I'm concerned about the political divide and our ability of our country to enact laws that work for the benefit of all. We seemed rather divided and it seems difficult to do those very things. So those are the concerns, but there's the answer as to what I'm most hopeful about the future.

Robert Pearl: Last question. Last season, we talked about physician culture. What do you believe we need to keep and what do you believe we need to evolve?

Donald Crane: Well, I'll tell you, first thing, at least around my world, is we honor physicians. We do and we feel they should be honored and well compensated. The talk we hear out of Congress about sequesters and reducing physician compensation and physicians are overpaid, just makes my head spin, Robbie, frankly. We need the best and the brightest. We need to compensate them accordingly. If we don't, we won't have the best physician workforce in the world, which I think we presently do. But we're going to need to take better care of our physicians. We're going to have to do a better job with burnout. We've got to fix that. We've got to fix that fast.

Donald Crane: I look forward to a world where physicians find satisfaction in their work and I think also where we bend the trend into the right direction. Right now, it's shameful where the United States is in terms of population health. So we have the best research, some of the best specialty care. There's no question that if you have an organ transplant, you're going to want it done somewhere in the United States. Where we really stumble is in the population health statistics, some of them, I think about infant mortality and maternal mortality and so on where we're basically on a level of a third world country. And that is because we really haven't addressed social determinants in an intelligent way and integrated them into medical care.

Donald Crane: So we've got a lot of work ahead of us, Robbie. I think we have a lot of work ahead of us.

Robert Pearl: Don, is there anything else you'd like to tell our listening audience?

Donald Crane: Just again, as we really try and re-transform our system, I would remind us all that patients have relationship with physicians, not with health plans and not even really with hospitals. So the core of our system is the patient-physician relationship. Those physicians do best when they're operating in an organized

group, where they're supported by others, whether it's nurses or nurse practitioners or data analysts, etcetera, etcetera. So we think we do know what works best. And so my hope and I guess request or prayer would be that we proliferate this capitated, integrated organized group model across the country just as quick as we can and we will be far better off for having done so. That's how I would conclude, Robbie.

Robert Pearl: Thank you so much, Don. You've given us a lot to think about and a powerful optimistic view of what might happen in the future. So thank you very much for coming today.

Donald Crane: My pleasure. My pleasure.

Jeremy Corr: Robbie, what do you think about what Don said?

Robert Pearl: I concur with Don that the current fee-for-service method of physician reimbursement that rewards volume, not value is broken and a source of major problems for doctors, patients and the nation. I believe that when doctors are paid a defined payment to take care of a population of patients not only does the care provided improve, but also the physician culture evolves. More specifically doctors become more focused and committed to prevention, avoidance of complication from medical error, patient safety, convenient access through telemedicine and addressing medical issues appropriately the first time. When done well, it can increase quality by 20% compared to a fee-for-service reimbursement model, raise patient satisfaction 20% higher and lower costs 20% lower. We won't make American healthcare once again the best in the world until we make the transition.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on physician culture, you can find it at RobertPearlMD.com. Congratulations Robbie on the success of your recent book. I know it will stimulate discussion and debate and improve healthcare for all Americans.

Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook, and Twitter @FixingHCPodcast.

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