Fixing Healthcare Podcast Transcript

Interview with Tom Lee

Jeremy Corr: Hello, and welcome to our Fixing Healthcare podcast show Breaking Healthcare's Rules. 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 books Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong and Uncaring: How the Culture of Medicine Kills Doctors and Patients. All profits go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can go to his website RobertPearlMD.com.

Our guest today is Dr. Tom Lee. He was the founder of Epocrates, one of the earliest technology-enabled healthcare applications for doctors, and One Medical, the primary care first healthcare company recently acquired by Amazon for 3.9 billion dollars. He is currently the CEO of Galileo, a telemedicine first healthcare startup that he hopes will make medical care affordable for all Americans.

Robert Pearl: Good morning, Tom, and welcome to Fixing Healthcare.

Tom Lee: Thanks, Robbie.

Robert Pearl: This is season number seven and it's focused on breaking healthcare's rules. The rules we're talking about aren't the ones written in textbooks or found in lecture halls. They're the unwritten ones, the ones we believe about how to act. They're what you and I learned as medical students and residents by observing senior residents and the attending physicians on rounds and throughout the day. This season focuses on the rule breakers, people like yourself, who rather than continuing the practices of the past, see a different path and head down it. Let's go back to your career path from medical school, to business school, to entrepreneur. Can you describe the steps along the way and why you decided to march in a different direction than most doctors?

Tom Lee: Yeah, no, happy to chat. And maybe just for the record, let's call it norm breaking rather than rule breaking. I think that might kind of resonate more for me, I guess, because we do like to be compliant, obviously, working within the rules and boundaries of the regulatory landscape. But from a norm perspective, that probably is thematically consistent with most of my career because everywhere I looked, there were norms that nobody could explain to me. And even as a med student and resident, we did a lot of things that didn't make a lot of sense. Our mission was to care for patients in a thoughtful manner, but what we were doing seemed antithetical to that. So even as a young physician in

training, I just started noticing dissonance with what we doing from what we thought about why we had joined the profession.

Robert Pearl: When you and I trained, there was this unwritten norm that memory was the most important skill a doctor could possess. We memorized hundreds of drugs with indications, dosages and complications. If we couldn't remember them, we found a huge book called the Physician Desk Reference or PDR. But you broke that norm by creating an application called Epocrates. Can you tell listeners what Epocrates is and how you decided to create it?

Tom Lee: Yeah, no, happy to. And probably just dates us a bit. But back in the day, pre-mobile phones and pre-internet really, most people were really using these kind of very thick reference books to look up drug information in advance of prescription. Unfortunately, a lot of the monographs that were available were just typically regulatory manufacturing type of monographs. They weren't necessarily clinically relevant and or outdated, often the time you were looking at them. So at Epocrates, which is one of the first companies we worked on together out of business school, it was really an intent to take that information and make it actionable at the point of care. And back in the day, this is in the early formation of technology and internet, the form factor was the PalmPilot at that stage. So that gives you a sense of how old we might be from our medical training and or our technical backgrounds. But back then, most people felt that docs wouldn't install any software, particularly that clunky, but we found that docs were doing this quite readily if it was useful and helpful.

Tom Lee: And we found out that technology was a huge enabler to allow for this to happen. And even just to step back a bit further, the reason why I ended up even being in business school and working on Epocrates was back to the kind of question while I was a resident in training. Why are we doing all this stuff? Nobody could explain it. And one of the norms or just implied messages in medicine was we do what we do. It is the profession of medicine that matters the most and the environment, what we call the economic environment, the business environment, the management environment, particularly where I trained was somewhat diminished or dismissed.

Tom Lee: And to me, they were heavily influencing the environment in which we practiced, the economic factors, the management and administrative factors that I wanted to better understand. What were these mysterious forces driving the systems of care that I felt as a clinician were inappropriate or certainly suboptimal? So that's what ended up leading to my business career. And this was not something that was considered very vogue or sexy among doctors. In fact, it was viewed as a negative trait. And most of my other colleagues were going into specialist kind of training, but my specialist training ended up being business, and it allowed me to see the world more broadly than where traditional medicine typically is looked at.

Robert Pearl: As you point out in 2007, the iPhone comes along and now we're 15 years later and we still choose, train and evaluate medical students on this ability to

memorize. We give them these tests like STEP 1 and step 2 that require knowing 10,000 facts about arcane diseases around the world. Should we be elevating computer skills above memory skills? Should we be requiring that people bring iPhones to exams and test them on their ability to apply that? Or is that too much to expect the medical students and medical schools to change and to incorporate?

Tom Lee: It's a great question. I do think that if you're saying, hey, what are the other ways that we need to reexamine how we do things? Medical training certainly is one of those areas where the knowledge and data and information is so overwhelming, that relying on clinical memories or human memory to make any kind of judgment, I think is unwise, particularly as we look at the future. So we need to reexamine what we reward and train young physicians in training and clinicians in training in general.

Tom Lee: I do think that some ... It's just like anything. If you completely get rid of your memory muscle, then there may be some detriment to that. So there is some balance of appropriate memorization probably, but I personally never found memorization to be that inspiring or helpful in my medical training. And the best teachers and where I learned the most, and frankly, durably, are the principles. The principles, and logic, and judgment that shape clinical thinking. And to me, those are the enduring principles that I would like to see frankly, more medical training to reinforce. And unfortunately it's picked up through osmosis and not through a formal kind of discipline. And I do think that's something to reconsider as we start to examine the workforce and frankly, the profession of medicine.

Robert Pearl: Tom, after you made Epocrates successful, you took on another norm. The norm that said the best place to get medical care was in a independent physician's office. And you started One Medical in San Francisco. Can you take listeners back to the beginning of that journey? What is One Medical and how did you decide to begin it and how has it evolved across time?

Tom Lee: Yeah, the inspiration behind One Medical was really what catalyzed my career arc. As a young physician in training, I was like, I don't want to practice in any of these broken models. I had worked in almost every environment, whether it be academic institutions, private practice, capitated HMO models, native health service organizations, all really great organizations with well-intended providers and leaders, but the care model just didn't make any sense. And so I knew that there was a better care model that could be designed, particularly given how much we were spending in healthcare overall. And this is back in the late 90s. So for me, the inspiration was to kind of say, hey, primary care is a broken layer. Everybody recognized this 20 plus years ago that primary care was broken. Nobody wanted to invest in reexamining how to improve primary care. And so the real impetus behind One Medical was, can we validate that a higher touch, better primary care model can be built and scaled in an economically viable fashion? Most people thought that primary care was an unsustainable part of healthcare services and nobody was really paying attention to it.

Tom Lee: And so that was really the inspiration, and to validate if you look way back and I know Don has been on your show, but a lot of that work about reexamining workflows and looking at micro practices were some of the early inspiration for me to start One Medical, which is what do you really need to run a high touch medical practice? And can you do it within traditional reimbursement? And so what had been told to me was primary care doesn't make any margin, you need all the staff to support it. You certainly can't open it downtown in a high real estate rent market. Everything about the concept of One Medical made no sense to traditional norms. If you talk to consultants at that time, the focus was, hey, you got to protect the physician times. You have all this staff doing all the pre-work and then the doc spends 10 minutes with the patient. And that way you increase the "productivity" of the doctor. And that was the norm.

Tom Lee: I mean, if you talk to any business management administrative practice consultant expert, that was the norm. And I remember something that Don Berwick said way back when I was a resident saying, "The thing that patients want is time with the doctor." It's not a unit, it's the time with the physician. And so a lot of inspiration with One Medical was how do you actually enable that with a fixed reimbursement model for the most part? And the key innovation there was administrative redesign. So we just remanaged and redesigned the administrative workflows to be more effective, more efficient. The average practice in primary care is overwhelmed with administrative burden, but they don't have the sophistication, particularly as the complexity has been layered in over decades to redesign that.

Tom Lee: And so I had the luxury of starting from scratch and redesigning it. And now that technology was more available, I wanted to design it using technology. So that allowed us to 10X the service at about a third of the administrative overhead of a traditional practice. And then that allowed us to give more time back into the physician exam room, which allowed patients and providers to have more time. And we got all the other people out of the way. So it wasn't that radical in terms of what we were trying to do, but it was hard to do. The thesis at that time was you just can't make it work. And we validated that you can make margin in primary care, and scale it, and attract professional capital, which was the intent, to really reshape the assumptions about the importance of primary care.

Robert Pearl: The clientele, at least in San Francisco, that I'm well aware of often are in the high tech world, they're often moderately high in income. Is the model as applicable to people in Medicaid and people in lower socioeconomic strata?

Tom Lee: Yeah, that's a bit of the challenge here when people look at One Medical from afar, they say, "Oh, it's just for young and healthy people." And that's because it looks like a modern, clean website with an easy to use appointment booking system and convenient workflows. So that's the veneer of One Medical. And people presume that is only designed for what I call, urban professional patients. But the reality is that the clinicians are comprehensively trained much more so than any traditional primary care practice. They're given more time to interact with patients and we accept Medicare. That's always been the premise

of One Medical. So it is a bit of a misunderstanding of how One Medical is architected. So we take care of plenty of seniors and complex patients in One Medical and physicians have more time to take care of those patients. So all things being equal, it's a better model for anybody because there's more time.

Tom Lee: That being said, fee for service has limitations in terms of its economics as we know. And so making the economics of office based medical practices work effectively within particularly low reimbursement Medicaid is not as sustainable. And so at some level we have to make those trade offs of how do you build a viable economic model against the mission. And so my focus is always, how do I improve quality and affordability of care for everybody? But you can't do it in your first cut. And the first attempt was One Medical. And we got as far as Medicare fee for service, but obviously now working with Galileo, that is the intent. But it takes an extraordinary amount of innovation to really make the Medicaid reimbursement architecture work, particularly given the complexity of a lot of the Medicaid populations. If you really want to do a great job at caring for Medicaid, the current office based reimbursement framework just doesn't work. And so you really have to reexamine the care model. And that's obviously the inspiration behind Galileo.

Robert Pearl: Obviously the big news was Amazon's purchase of One Medical for $3.9 billion, how do you see this acquisition affecting the care delivery process?

Tom Lee: Just say, full disclosure, I'm not involved with the deal nor has it closed. And so there's a lot that still remains to be seen. But from afar, I think what this basically says is the healthcare system as we know it is clearly not working well. I think everybody knows that. And it's large enough and broken enough that it's attracting interest from what I call nontraditional providers or non-healthcare provider entities into the space. So that can be a good or bad energy depending on how productive and how thoughtful it is. I do think that people tend to not understand the nuances within the industry itself. There's a lot of rhetoric around healthcare that can be misleading and people can form judgements that I think are not necessarily well founded. So I think you have to look at the industry dispassionately, understand how it's architected, how it's financed to really solve it.

Tom Lee: The rhetoric and the simplified lens that come from the political left and the political right are just unproductive. So when we start to see large companies like Amazon in our healthcare, I think it could be a good or a bad thing. But from what we know about Amazon, I think is they're very deliberate and have a little bit more of a mindset towards getting it solved. And so I think it'll be interesting to see how that gets translated within the One Medical construct. My sense is that One Medical's got a strong identity and operational model that I think these things will augment and complement each other, but we'll see. It's still very early to tell. And independent of that, from my lens, there's just so much work that remains to be done, that we need more folks trying to solve the problem.

Robert Pearl: As you know, I'm a big proponent of both One Medical and the customer focused nature of Amazon. And when I look at this, I see Amazon having acquired PillPack, and it opens clinics, then it starts telemedicine. Now with One Medical, it has 188 clinic sites in 25 different markets. I see this as a truly disruptive force for the benefit of customers or the patients going forward. I can see the same type of access, convenience, greater affordability that Amazon has brought to retail into medicine. Do you see this as being as great a disruptive force as I do?

Tom Lee: I see the potential as potentially disruptive. But I think I'm also just aware of what it takes to get there. So I think you look at a lot of large entities today, they have a lot of components and ingredients that in theory, offer the potential for disruption. But I do think it's more complicated. So the word, disruption, I think is a little bit challenging in a healthcare space that is so fractured and consolidated at the same time. I just think that the dynamism of typical industries is misleading when you kind of look at the same dynamism in healthcare. So it just has a very different dynamic. So yeah, I think it has potential. I do agree that Amazon, One Medical share the same mindset of patient centeredness, consumer centeredness, a focus on value and efficiency and using tech. So those are strongly in alignment.

Tom Lee: And certainly, I think some of the challenges with Amazon are that it is Amazon. And so it adds some asset strength, but it also has some charge, and that charge can potentially create some risk. So I think there's just a balancing act here where I think the nuance that's an unknown is that healthcare at some level, particularly in primary care is a private, personal, trusted space. And at some level, you see a little bit of turbulence around it right now, but we'll see how it really shakes out is, do you feel comfortable with a non-clinical entity kind of having that as the ecosystem and backdrop? So I think that's going to be to born out over time, and a portion of the population I think will gravitate towards that. And I think other portions of the population may not. But like I said, there's a lot of work to be done in between the theory and the practice of it, but certainly it is an energetic movement in the industry right now. And I'm more than anything, just kind of fascinated to see how it shakes out.

Robert Pearl: Let's go to the present. And now, as you've mentioned, breaking another norm in the creation of Galileo. You're combining sort of the best parts of Epocrates with the best parts of One Medical. As I see it, medicine does not have to be, as you said in person. Can you tell us about what you're doing with Galileo and where you see it going in the future?

Tom Lee: Yeah. At high level, we are reexamining the norms of how should care be delivered, and this had started pre-pandemic, but there are some strengths to an office visit, there's strengths to a video visit, but there are a lot of weaknesses to that form factor. And we believe in a more data oriented, evidence oriented approach to how care is delivered. So from a quality perspective, how do you redesign quality into the care model. And then in parallel, designing affordability into the care model. And so being more capital

efficient, more labor efficient, and covering a broader range of services and scope is really kind of the thesis of Galileo. How can we be more radically focused on higher quality care, more affordably to what we call kind of [inaudible] populations? Patients that are either too complicated for the traditional model, too underserved, or too geographically disparate and dispersed.

Tom Lee: And so what we really wanted to do was design a care model for everybody that represents the highest standard of care. So it's just building upon my prior work and thinking through how do you build that? And then how do you make it economically viable in the current system? You have to work within the current system, but then how do you navigate that to build a more radically future forward model? And so that's what we're building at Galileo.

Robert Pearl: How does it combine the virtual with the in person?

Tom Lee: We're more deliberate about what needs to be done where, and so we have a digital first element of care that's accessed through mobile device, and then we have a home based care model that's in and around the community for the most complex and intensive. And so almost think about it as a mirror image to One Medical. One Medical's office first with expansion into digital. We're really digital first and home first, and refer into office as appropriate, which allows us to be leaner, meaner in scaling across the country much more quickly. So we're already scaling much more quickly than we did at One Medical. And we're taking care of a much more diverse population than One Medical was ever intended to care for. There's a limit to what the care model was designed for. When we started One Medical, it was mostly, hey, can you actually make primary care economically viable and scale a better traditional experience? Galileo is a more radically different experience and it's designed to scale against all lives.

Robert Pearl: What percent of total medical care do you believe can be provided virtually when done optimally?

Tom Lee: It depends on what type of care. We kind of typically slice things primary care, specialty care. At Galileo, we really think about knowledge based care versus procedural care. And so we think the vast majority of knowledge based care can be delivered digitally. And the vast majority of procedurally based care should be delivered in the office. And so that division is how we look at things. And so I think we've just had this antiquated model based on traditional training norms, and specialization, and the brick and mortar silos that exist today. And our vision is, that's antiquated. Let's design a normative model that represents what's possible using technology today.

Robert Pearl: And obviously during the pandemic, we achieved levels of 30, 40, 50, 60, 70% virtual care that have now dropped back to exclude mental health across the U.S. To around 10%. How are you going to get patients to be willing to continue in a virtual model if at least today they're not?

Tom Lee: Yeah. I think people will ebb and flow, and different demographics will try out different services over time. That's just kind of a normal thing. So the hype cycle of the pandemic is just that. It's a hype cycle that'll ebb and flow. But there are what I call structural forces over time that will change, that are separate from the care model, which not everybody can appreciate what's higher quality or lower quality care. But certainly, norms and economics will increasingly shape people's decisions. And I think those are the long term trend lines about where we get our care. It's not either or. It's like what portfolio of services and when, depending on who you are. And so that's just a function of time.

Tom Lee: And so people aren't radically choosing healthcare daily as part of their lives. So the pace of change isn't as quick as let's call it, beverage selection. So if you were to change habits on beverage selection, that happens quite quickly and dynamically. But the way people consume healthcare isn't changing as dynamically and that's fine, but we're focused on the structural changes over time that build a better care model, period. And most importantly, improve the affordability of care. That's really the net of the healthcare crisis is, how do you get affordability improved for the system, people that are paying for healthcare, but also the individuals that have to pay out of pocket to support that increasing gap between just the care and the affordability?

Robert Pearl: Final question, a decade from now, what's the American healthcare system going to look like?

Tom Lee: A decade is both short and long in healthcare terms. I'm quite hopeful. I'm thinking it could be one of the countries that are looked to as what's happening here might be a model to be examined elsewhere. I mean, I would like to think that in 10 years from now, we are exporting some of our ideas to other countries as people realize that quality and affordability can coexist, and it's not necessarily a trade off between the two. And what I call the innovator, disruptive entrepreneurial energy of the U.S. System, I think given its constraints, I think will produce some really interesting concepts and ideas that potentially could be exported.

Robert Pearl: Will it be fee for service or capitated?

Tom Lee: I think it'll still be hybridized, but a higher percent will be capitated. I don't know what it is realistically.

Robert Pearl: Will satisfaction of patients and doctors be higher or lower?

Tom Lee: Again, these are pretty broad generalizations. Like I said, 10 years is a short and long timeframe. Meaning there will be, let's call it pretty radical innovation in I think 10% of the sector, maybe 20% of the sector, but that doesn't mean the majority of the sector. So I think you're going to see a mixed bag of really strong pockets and really weak pockets on that promoter score, as well as on provider satisfaction. The provider satisfaction will likely be a function of which

environment people are working in, and frankly, which providers should be working in which environments. So I think that'll kind of be increasing rotational shift over the next 10 years is which providers are working where and how?

Robert Pearl: And will the gap between the haves and have nots be greater or less?

Tom Lee: There, I think it will be less. The haves and have nots that I described is more about who's leading and who's following, and less about premier care and underserved care. I think that gap will continue to close as more people focus time and attention on affordability and quality. So I'm hopeful that that gap doesn't necessarily increase. The gap I talk about is who's leaning in and who's dragging their heels on where the future of healthcare is going.

Jeremy Corr: Tom, how do you see an organization like Galileo being a game changer for rural healthcare?

Tom Lee: Yeah, so I did a lot of my medical training in rural environments. And even back then, it was quite apparent that the local family practice doc was overwhelmed. They don't have the resource, they don't have the density to support a bunch of providers and there are very few options. And so when you start to move consultation to the Cloud, your quality and access to expertise go up dramatically in rural environments. And the rural providers are then able to focus on the relationships and the high value items that matter, including house calls. So we view Galileo as an enabler of better care, better proportioned with the right allocations that improve provider sustainability while improving the quality of patient care. So one of our core thesis is how do you solve the rural care issue and crisis? And in my mind, I think what we're doing is giving broader division of labor and broader access to rural patients and improving the lives of rural providers.

Robert Pearl: Thank you Tom for being on today's podcast and for continuing to push the frontiers of what is possible in healthcare through innovation and technology.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. Please follow Fixing Healthcare on iTunes, Spotify or other podcast platforms. 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, Breaking the Rules with Dr. Robert Pearl and Jeremy Corr. Have a great day.