John Marchica:

Welcome to Health Care Rounds. I'm your host John Marchica, CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care and attaining joy in work. Please send your questions, comments, or ideas for Health Care Rounds to podcast@darwinresearch.com. If you like what you hear, please don't forget to rate and review us wherever you get your podcasts. Let's get started.

Kim Asciutto:

Today we welcome Dr. Daniel Durand. Dr. Durand serves as a Chief Innovation Officer and Chairman of Radiology for LifeBridge Health. Dr. Durand lead the LifeBridge Health ACO LLC and previously served as the first director of Accountable Care for Johns Hopkins Medicine. Prior to Hopkins, Dr. Durand was the Vice President and member of the executive leadership team at Evolent Health, a healthcare IT startup. He also worked as an associate with McKinsey & Company out of the firm's Washington, D.C. office. Dr. Durand earned his medical degree at the Johns Hopkins University School of Medicine and has over 20 years of experience in healthcare, science, and technology.

John Marchica:

So Dr. Durand to kick things off, you have a really interesting background, and a diverse background. So, I thought maybe you could just start off by orienting our audience with the path that's taken you to now be the Chief Innovation Officer for LifeBridge.

Daniel Durand:

Sure. It really depends on where you want to start that, but I'll just start it with my professional life. I was a junior faculty member at Johns Hopkins. To get to that point you have to do undergraduate, med school, and keep your head down, and just do the pre-scripted path in a way for quite a long period of time. And there were a lot of entrepreneurial pursuits that I had done to this side during medical school, in addition to residency, and also a lot of scientific research that I'd been involved in.

But I came out the end of that, and the beginning of my professional life faculty at Hopkins really feeling like I wanted to move a little bit more nimbly than you can in an organization that size. And I wanted to understand why US healthcare seemed to be somehow less than the sum of its parts. I mean, we have great research, we have great schools. I think we have great individuals and people that are very mission driven who choose medicine as a calling. But I felt like the system felt very dysfunctional. And I wanted to understand that better. And all of this was right around the time of the Affordable Care Act, a little bit after that.

So, I left academia. I think the biggest decision I made that puts me where I am today versus other less diverse or more standard jobs is I left a very typical academic track to go work for McKinsey. And at the time, it was I'll work here for a year and see what the rest of the world functions like. See why these changes are so difficult to make happen in real world even though seemingly so many people agree on some of them. Things like value based care, which at the time, from my perspective, there were very few people that didn't agree that fee for service was inherently broken, and that something different needed to be done.

I went to McKinsey and I sort of majored in that while I was there. I worked with Medicare on some of their reorganization. I worked with a variety of private companies that I can't really at liberty to share based on consulting arrangements. But they were hospital systems looking to either improve their throughput on an inpatient basis, or they were health systems looking to figure out how to pivot from volume to value. Those are the areas I worked in. And one thing led to another, and I joined a company as the founding members of one of their clinical consulting groups called Evolent Health. And Evolent was a company founded in I think 2011. I'm not one of the founders. I was part of the sort of second wave of professionals that went there. I was probably the second or third doctor that was a full time employee.

It was a bunch of ex-McKinsey, ex-UPMC, ex-Advisory Board people who really believed that the path to better health care was a journey towards value based care, but that it was going to be very, very difficult for the large health systems that still provide the majority of care or at least hospital care to people in this country. It was going to be very difficult for them to get there and for their senior teams to understand the sequence of steps, and it would be different for every market. And that there's a lot of opportunity, but a tremendous amount of complexity. So Evolent was built as sort of part consulting services to help people with what we call the population health blueprint, or later on it was called a value based care blueprint, and migrate them to get more and more of their business at risk over time, and then help them with the software, the people, the processes, the technology, all that stuff that it takes to start to assume that kind of risk on providing value versus just smoothly doing many transactions in a volume oriented system.

So that was about two plus years of my life with Evolent. I traveled all over the country, was in the C-suite with lots of different health systems. So it was a really interesting time where I got exposed to a huge diversity of perspectives and markets. And one of the things I became aware of from a value based care perspective was that there was a lot of tension out there. The tension not necessarily between people or entities, but tension between philosophies. And as you could have a conversation with a CEO and a CFO, both of whom firmly believe that better healthcare for everybody including their family members lay on the other side of this chasm between fee for service and value.

And furthermore, they could get aboard motivated about it, or the board might bring it to them, and they might even make significant progress. But there's a point at which you start to financially harm yourself in some of these arrangements. And you have to really, really believe that, on the other side of that chasm is something that works for the health system, and the five, 10, 15,000 employees that depend on those leaders for their jobs. What I noticed was that there was a lack of true alignment in many geographies, and a lot of these groups would eventually start retreating. Even if they believed in what was on the other side of the chasm. Eventually, the chasm seemed to risky. The cure started seeming worse than the disease, to put it a different way.

Around that time Evolent went public, which I think was an achievement, but it's also usually a time when the operations and philosophy of the business start to change. And Maryland as a state right around that time I went to capitation for the hospitals. And I was still living in Maryland, it's where my family and my children are based. And I thought that was a really unique time to come back to the state having been out there and seeing a lot of what does and doesn't work with very many clients in two different large organizations with McKinsey and Evolent. And the cool thing about Evolent was being there at that time, and maybe it's still like this that you get people that were from all the different major companies. So, people from Anthem or Optum, people from UPMC. We did a lot of our pitches to our initial clients in the UPMC steel tower because they were a major investor.

So, it was kind of this mecca of people interested in both the care delivery transformation as well as value based care. People from the payer side, the provider side, the pure IT side, the design thinking side. It was a really cool place to be for two years. And when Maryland decided to become capitated... Sorry, I'm flipping a text message here. When Maryland decided as a state to become capitated, I don't have a three hour lecture I can give here on the economics in Maryland. But folks at home, Maryland does Medicare differently than every other state. And it's a long standing thing that that basically stems from the fact that in 1978 most of the rest of the country, and eventually all the country went to DRGs for inpatient Medicare hospitalizations, and Maryland managed to exempt themselves from that. Probably initially, mainly due to hospital lobbying. But it's become a quite a bit more than that.

And so, Maryland does this interesting experimentation in order to stay below the cost growth of the rest of the country. And every few years, we're doing something different. In 2014, that something different was we are going to effectively capitating hospital payments. It is a really complex thing that is different than what capitation looks like elsewhere. But effectively, once you do that, if you buy into it as a health system your hospital costs just become costs, and your revenues are the number of attributed patients, which is sort of an equivalent. So you become... You start to think a lot more like a payer.

And so, that lack of alignment I had seen nationally. I had good reason to believe that we would have less of that issue in Maryland and be able to make more of these long term strategic investments that you need to make, and that to give the health system leadership teams here the stomach to get through those difficult parts that were reversing the work in a lot of the other geographies. And if you just read the news, I feel like you don't know that the work has been reversed in some of the other geographies because if you go back to 2011, if you go back in the news archives and the internet, the way back machine, you'll find all these announcements from payers and providers saying, "Hey, they're kind of declaring victory before they even start. We're going to do a value based arrangement. We're going to save the taxpayers $500 million." They never put out a press release when it fails, or when they lay off all the teams that are working on that.

So, it's interesting to go back and look for those kind of press releases in places like North Carolina, South Carolina, and really see what became of them. Because the industry doesn't always hold the mirror up to itself and acknowledge what's actually going on. But the cool thing is coming back to Maryland, I do feel like I... It's really not a me thing, but I've been the beneficiary of I think a very consistent set of strategies in this geography that are above the level of health systems. And it's made it really easy to be well aligned for clinical and finance and the boards and everybody else, the hospitals, the inventory networks. The alignment is not perfect because it's the real world. But the alignment is vastly better than I experienced in other geographies outside of systems like Kaiser or UPMC where there's been all this work done over many years, and they have a huge payer arm and a huge provider arm.

But even in those instances, there can be tremendous tension within the same organization between the payer and the provider side. So, in Maryland, a lot of that weight is taken off the shoulders of the local owners, and it rests on the regulatory edifice of what we call the HSCRC, which is a cost review commission. And it's not a perfect system. But again, it has allowed me to function initially at Hopkins, and for the last five years at LifeBridge in a way that if I think my innovations correctly, and tilt them towards value based care I am not fighting against or viewed as harming the traditional parts of the healthcare system because the reimbursement is already structured such that they need those innovations.

I guess the last is I came... I went to Hopkins from Evolent, and ran their ACO for a year, and then came for a broader scope to a smaller system at LifeBridge. And helped build their clinically integrated network. And about two years ago, really decided to pivot and for a time, and I'm still in this kind of phase, be very, very focused a little more on the tactics than the strategy in a way. Not that the job is a strategic, but really getting down to when you try to transform care delivery, how much of that needs to take place in the four walls of the hospital or even in the four walls of the office, the bricks and mortar versus the call center, versus telehealth, versus remote monitoring, versus chatbots. Really thinking and assessing all these different parts of technology that health systems will bolt onto themselves to become more than what they are. And to scale what they are, so that they...

At the beginning, one of my frustrations with our industry versus others as of 10 years ago was that I really felt that paradoxically we were less than the sum of our parts. And the reason we're less than the sum of our parts as a nation I feel like is because payers are very fragmented. When they innovate half the time their innovations are just blocking innovation by providers. So providers take 15 years. Well, researchers take 15 years using government money. They find a new cure, providers start using it. But then they use it too much, and the payers had to come up with an innovation to basically make less of that other innovation go on.

If you economically align folks, I believe that you'll see less of that arms race, and you will see more synergy and people working together. So, around these technologies, we've built an innovation center with care first. It's been a two year project. We are launching right now for our first incubation cohort. We have 115 applications for four spots, which is we're going to get four great spots, and four great companies, maybe five. We're going to bring them in, they're going to get pilots with both entities. They're going to get strategic investment from both entities. And so that as LifeBridge is innovating in this digital care space, rather than innovate, and then have the payer figure out how to anti-innovate and spend money, we're going to spend money together, figure out what we agree on given all the aligned economics and the aligning goals. We're not going to waste money. We're going to innovate together. So the system is more than a sentence parts, not less.

John Marchica:

Make sense. I want to get to some of those projects and talk a little bit about LifeBridge, but I wonder just going back to where you were back in '11, '12, and after that, and talking about how there was this tension between... And people use the analogy all the time, one foot in the boat, and one foot on the shore. That they wanted to... They see the benefit in value based care but then other forces are driving them backwards. So where do you think as you look outside the state of Maryland, how would you assess where we are today with respect to [crosstalk 00:15:06]-

Daniel Durand:

I mean, it's so regionally complex. I feel that nationally taking myself out of the... Taking my LifeBridge and my Maryland hats off. Here's Dan's opinion, which is one guy's opinion nationally. And I also preface this with, I'm too operationally focused and medically focused, honestly, to really be a policy expert. You can't... I don't pretend to be an expert at everything. So, I'm going to tick hardcore policy people off as I oversimplify here. From 2008 when Obama came in through, let's say, 2012 or '13, there was this wave of mixed enthusiasm for value based care. I think prior to 2008 there actually was a lot of alignment in both circles. You could argue that with the individual mandate in Massachusetts, and a lot of the publications in places like HBR that the right was pushing value based care at that point just as much as the left.

Once ACA came out, I do think it became a little more politicized. And as it started to be implemented, you could feel that. So implementation started in 2011 or so, or maybe even earlier with the pioneer. I honestly forget all these dates. And you saw a lot of... In parallel to that a lot of commercial plans doing ACOs. If you had one big ACO program that was maybe three or 400 health systems and various entities, let's say 2014 or so. And you had just as many totally fragmented programs different in every geography with all the payers. What started to emerge was a construct of quality gated shared savings that was almost always upside only. So really not true risk for the providers.

The idea was it would mature, like these capabilities around maximizing the quality. It would gradually teach people how to do certain things both within the office, but also strategically within the health system. And they would migrate. And you had all these analogies, and one is a foot in two canoes or whatever. At the same time, the country was changing. So, there was actually great economic prosperity, or at least higher employment. I mean, you could, again, argue about whether the wage growth was where it needed to be or not, but the economic indices whether it's the stock market, the Consumer Confidence Index, those all really got quite a bit better from 2014 to 2018 relative to 2008 to 2014, and beforehand.

What I perceived was... And because the employment market was so robust, and things were good all the anticipated competition. So people had anticipated part of the thesis for value based care was that economics will continue to deteriorate, that the population will continue to age, and that the entitlement crisis will loom. And between Medicare and private insurers needing to decrease the growth in the cost of care, it would necessitate the emergence of value oriented networks, more narrow networks, things we saw in parts of the country that were economically a little bit more honestly destitute, but having a harder time in the post industrial Midwest, that you'd see more aggressive narrow networks and providers were going to have to deal with this.

But in fact in the middle part of the last decade, consumers or employers starting to compete on the broadness of their plans as a benefit again, and there wasn't this huge emergence of narrow networks that everybody thought was going to happen. I mean, it may have happened in certain places, but in general it was very lackluster. And gradually, the enthusiasm for value based care became temporary. I've never heard people say that it's not the future, but I think it became much more tempered. And there was a lot of pivoting back and forth at the federal level.

One of the things I think that has really hurt diabase care is the MACRA legislation, which again, is middle of last decade, and there are lots of pieces to it. They really backed down on this, and the professional societies within medicine encouraged I think the government to back down. So what was MACRA? It was basically the idea that you got to show your quality, not just the amount of the turnstile, but you really got to show your quality as a doctor providing ambulatory care on the part B side. So for a while Medicare has had readmissions penalties and other stuff going on their patient side. And MACRA was the idea that your rates for Medicare will be partially determined by how well you can demonstrate within your specialty or within your specialty group that you're delivering on quality.

They spent tons of money and everybody spent tons of time. I mean, uncounted hours of my life with my health system and others trying to figure out not just how to convinced Medicare that cloud is good, but how to really change your culture around these things. But the problem is that in order to fund MACRA, in order to give more money to people who did well, the way the program works, and this makes sense is you take money away from people that didn't do well, and no one ever had the stomach to do that.

I'll just skip to the end for everybody. All right? Nobody ever had the stomach to do that. So it's just this thing that is now almost like... I think it hurts value based care because people say, "Oh, you're

talking about value again. Is this going to be like MACRA where I spend... I get 50 consultants to come in here and tell me how much more money I'm going to make for my health system to really pay back these huge investments you're asking me to make around analytics and everything else. And at the end of day, I'm not going to make any of that because you're not going to take away from people that didn't make those investments, or who couldn't perform."

I think the AMA is, frankly, kind of complicit in it. And it comes back to this thing, if you go to an auditorium of doctors, all these guys and girls that spent all their lives going through medicine, and they're generally a high achieving, somewhat competitive group. And you say, "Hey, guys, who here is an average... Who here is in the bottom 30% of doctors within their quality?" Nobody raises their hand, which pride is a good thing, but you can't ask people to hold themselves accountable for these kinds of things.

And yeah, I think MACRA was just a really big failed experiment, and I'm not sure that I haven't really heard about it called such on the pages of any journals just yet, but I'll just say privately a lot of people like myself that have been working in the quality and value based arrangements sphere don't really feel like that was very helpful because now that we've had this big national joke over this, it makes it harder to push people on investments and say, "You'll invest in quality, but you'll get your money back." Or not, if the government ultimately doesn't have the stomach to deliver and implement its own programs.

John Marchica:

So, is the answer to this conundrum, I was going to ask you if quality or if value based care is dead, and of course, it's not it, and it sounds but is the answer getting there through technology? Getting there through the kinds of things that you're working on now because philosophically the financial system or politically that the solutions that we try to come up with and implement just can't move the needle. But perhaps I had a lot of questions for you. I haven't asked if you have the hard stop in five minutes, but I have a lot of questions around technology. I was wondering is AI going to get us there? Is some of the projects that you're working on?

Daniel Durand:

I'm going to share to consultify your question and say, "Is it people, processes, or technology that matters? Let's just start with that kind of thing. It could certainly be other stuff, but going back to the theories that I'm familiar with, and I'm not an economist, so I'm taking other people's stuff that I've read and extrapolating here. If you go back 10 years or so, one of the big theories as to why education, healthcare, keep on getting more expensive, and I think this theory still holds is that other sectors of the economy have done a better job at substituting labor for capital... Sorry, substituting capital for labor, I'll put it that way. So in other words one worker with the right technology associated with them that needs a capital investment in some Op Ex scale, but you invest in something, and you put in an next to a worker, and then become a lot more productive. And if you do this over the full portion of an industry then that industry starts to look a lot more productive relative to other industries.

This goes on and on and on for things like let's say travel agencies or newspaper publishing. I mean, it's painful because people get laid off, but gradually these industries become more and more scalable, and more productive. But industries that require an in-person touch like education or beauty salons, or healthcare, just don't enjoy that. So over time, if you look at consumer price indices and things healthcare takes up a larger share of the wallet than it used to as does education. And it's thought that that fundamental lack of scalability lies at the core.

So, if you believe that, and I got to say, I believe that. Do I know enough about economics that explains everything? No. So there are a lot of people that can poke holes in that, but I think that that is mostly true. That's been a core belief of mine since I learned economics as an undergraduate at Wake Forest 20 years ago. Yeah, so part of my interest in technology is that a fundamental bedrock part of our problem in healthcare is that lack of scalability, and I hadn't seen it up close for about two decades. It's not just about the tech not being there, but there are layers of things that are barriers to that scalability.

At the most basic level, regulatory and liability are probably the single biggest part of that. And it's not necessarily getting any simpler because then HIPAA is made in the mid 90s. And that starts to interact with other types of liability and cyber attack type risks that emerge. And so, in some ways, it's probably getting worse on the regulatory liability side rather than better. And it might be necessary evil, but it's a big disconnect between us and other industries that have less of that going on, and where the stakes are a little bit, frankly, lower.

But a big part of it is cultural. And that's the part I'm trying to work on right now, which is because that first layer of legal liability has built a moat around health systems for so long there is the expectation that we won't even engage in a lot of the productivity work that other industries have been frankly obsessed with, and that needs to change. And I think the biggest thing that's starting to move the needle on that isn't people like me that want to move the needle because I think there's been a lot of people like me over time. I don't think I'm the first person to have these ideas. But I do think that there's such an emerging chasm between the consumer experience and the rest of their lives versus the consumer experience in healthcare.

The government's been really good at making at holding providers really accountable for the experience. So, with H Caps and all that, and people being more free agents in healthcare and being able to choose one provider versus another and the ratings being online. I think that's really healthy stuff, and it is creating a real need. I think that more than anything is what's creating the need for consumers... Sorry, for health systems to master these productivity and IT things because the consumer, they no longer want to... I'll give you an example. I'll give you an eg. on this, right?

Access is a big deal. Access is a big deal. It's one of these Venn diagram overlap areas between fee for service and value. No matter what you're doing whether you think your geography is just concierge medicine, or whether you think your geography is pure Medicaid, full risk agreements, you need to figure access out right along with a few other things. And so, access becomes a big deal. So how do we experience access? How do we measure it? How do we offer? Well, we used to build call centers or just extra bricks and mortar. You want people be able to find care? Hire more doctors, create bigger waiting rooms, have more call centers.

If a patient in 2021 wants to become a patient in your health system. And they are forced to go through those traditional things, they are going to choose another health system. And they're not even going to do it by having to drive their post COVID, they're literally just going to have to download an app on their phone, or go to... If you're near city, go to the NYP OnDemand site. Or if they already have insurance through an innovative insurance company, they're going to go to that app that they downloaded four months ago, and get their symptoms triaged. This is more and more the case. So, because consumers are really forcing an issue. It's a pretty beautiful, I would say pretty American thing. I still believe in using that word that way.

People's expectations are what is really forcing health systems and people like me within health systems to really say, "This culture that we've had doesn't work." Where every department wants to have its own unique little pathway to getting an appointment there that works for that department. You can say, "Hey, that works for that department. It's always worked for that department. It works for

those individuals work there, we want our workforce to be happy." Okay, but the consumer wants it all look pretty much the same way, and they want an easy, and they want it to feel more like Uber than going to a doctor's office 20 years ago, and that's just reality. And so, convincing folks that there's this Bernie platform is a lot less difficult when you see it happening in real time when patients are complaining about their experience, when you start to hear feedback from consumer surveys that people are choosing other providers because you're not providing X, Y, or Z. Now, that becomes a big deal.

So, our access strategy is I think one of the most transformative things we've worked on in the past two years. And we're trying to use the fact that we're smaller than a Hopkins or MedStar, or a Maryland, and we're relatively good financial shape. I mean, I think everybody is... Who knows about the future, but I think we've made good decisions, and then haven't overspent on silly things. But I think we're looking at... I mean, we are looking at access, and we're doubling or tripling down there particularly after this last year because we could take ourselves as a small health system and become massively accessible with the right strategy.

A big part of that strategy is what scales? What kind of particularism and exceptionalism at the local departmental level or the office level are you willing to let go? And how do you balance that sort of a little more corporate culture from other industries with the natural culture of medicine and physicians. That's really tricky, and that's why in any other industry you have someone that's much more... Has just the pedigree of doing this kind of thing that's more like a electrical engineer, software type. In our industry, you have folks like me doing it because you really have to understand and translate all this to what the doctors are doing every day, what the nurses are doing every day, and why they... How to get them to yes on some of these things.

For example, these common pathways, like you want it to be easy for the patient or consumer to access your health system. You don't want to get to the level where you're letting an analyst that is really good at building schedules, and AI algorithms, and ingesting insurance information to make a seamless experience to the consumer. If they just run everything then every appointment block is going to look the same. They don't know enough about medicine to know, well, the orthopedic surgeon needs these 15 different appointment types. And this particular orthopedic surgeon really only wants to see three of those. And it's not just about them being difficult, that's just what they're really good at treating, and that's where the quality is. So, it gets very... You have to really micro dissect this as you get closer to the point of care, and that's where the medical background comes in.

John Marchica:

Interesting. So, it's almost like... I mean, I'm oversimplifying this, but the degree to which technology has affected our lives has put an expectation or consumers now have an expectation of a certain kind of experience no matter what they're buying, no matter what goods and services that they're they're buying because 25, 30 years ago, you had a rotary dial phone, or maybe you had a touch down phone, and you'd call up, and you'd make an appointment, and it was all part of the expectations were much lower. Now, when you've got your iPhone, you're accustomed to using apps, you're accustomed to almost instantaneous service. But to your point, it's not as easy as just setting up my chart. To be able to get this to work right you have to get the clinicians involved to ensure that orthopedic surgeon that only wants to see these three types of people or three types of procedures because that's what he or she is good at, that requires an entirely different level of commitment, really. How do you get that? Right? That's tough.

Daniel Durand:

And if you get it wrong you can really alienate... Alienating a few customers as much as patients certainly come first. But if you alienate a surgeon by over indexing on what you think patients want and you lose the surgeon, that doesn't help patients writ large. That hurts your health system, and it hurts access. So you have to be... Our general approach to these things is to work on them. We want to be nimble and want to be fast, but we definitely want something to be fully baked. We don't put stuff out there in beta. We just don't do that. We really try to make it pretty fully baked because we don't want patients to have bad experiences, and we don't want to lose doctors over they came to the clinic one day, and it was all the wrong kinds of visits or there wasn't good gathering of information relative to what they're... They might have had more of a manual process in the past that is highly inefficient, that is infuriating for patients, right? Like all these extra forms you got to fill out by hand and stuff.

So, as we take them to paperless and try to make their offices flow better, if the first day of that is really miserable, and the second day is much better at some point you can lose control of this. And so, we have developed a core group of people that gets these things done. And the pace is pretty conservative relative to what you might see in other industries. Like in another industry, maybe Chick-fil-A is going to try a new this or that with one of their lines. They're highly organized, but they can do kind of AB testing. Nobody's is... It's food people are putting in their body, but if you're just talking about process changes, you can try it out. And the worst thing that might happen is the workers at one Chick-fil-A might be annoyed that day. Maybe you have slightly a turnover that month at one of your offices, but your overall brand is intact because you're huge.

With healthcare, it's just if you tweak stuff like that a diagnosis could be missed. You could lose a surgeon who might be half of your assets in that area because health systems are smaller, and there's lots of more pluralistic parts then an assembly line let's say like in another industry. And I'm using Chick-fil-A because I think they're about one of the best businesses out there. I mean, pull politics aside, they know their stuff when they... There's a mass vaccination clinic that was having a really difficult time in South Carolina. And they traffic backed up for three hours, and they called up Chick-fil-A to fix it, which I thought was a smart move.

We draw these kind of parallels. But if you look at other industries, and their threshold for experimentation of operations and ways that they can do AB testing. I mean, Google can do it massively quick. Anytime someone searches, they can just tweak it and see how that works. They're not going to get sued over a bad search, right?

John Marchica:

Of course.

Daniel Durand:

But healthcare it's harder. You have to be much closer to your final product when you deploy it. And you can't just naturally evolve with AB testing for most things. You can do it in some areas. There's no question you can do it in some areas, particularly toward the front of the funnel when it comes to marketing and search, and a little bit when it comes to triage and things like that as well. But at some point, you wind up as you get closer to the encounter in this space that has to be much more mistake free than most industries. And so, it's a challenge. Scalability is a challenge because the content is different between specialties, and nimbleness is a fundamental trade off between how nimble you can be in your operational experimentation, and in just the reality of healthcare and the regulations and liability.

John Marchica:

I had a question around HIPAA. We talked about this a couple weeks ago, and I was thinking about, okay, what's my recent experience with healthcare? So, I had bone spurs on my toes removed, that was one. I had the PRP on my elbow, and my knees, and my wrist. I had primary care, two primary care visits. There's one that I'm that I'm forgetting about. And of course, all of those interactions with the pharmacy. None of these events did anybody in the continuum understand or know about my healthcare from any of the other areas. So every time I'm filling out forms. Every time I'm entering in new information. Every time I'm getting my insurance information. Where are we in this journey to getting to true interoperability? And is HIPAA one of the barriers to getting to that place, or is it more of a technology problem?

Daniel Durand:

So, at some point, you should have if you haven't already a HIPAA expert on your show so they can untangle whatever I'm about to say with my... Again, I'm not a lawyer. But yeah, HIPAA is a big part of it. HIPAA was really written in, I think, 1996. It's tough for IT laws to remain relevant within decades. So when you put it 25 years out there's no surprise that this huge law is very bulky and not, I think, serving people in great ways at this point. There are ways that it still protects people in important ways. But by and large, no one's ever done a study that I'm aware of that shows how many people might have died because of HIPAA.

People react when I say that, but I don't know why they should. It's an action we took as a society or the people took on our behalf at the federal level. It definitely makes certain types of information sharing harder. And it'd be hard for me to believe that there has been significant human consequences to the ways that it doesn't work, and someone ought to look at. Not so much so startups can get rich, but so that we can improve and make the system more intelligent.

One of the ways that because HIPAA is so dysfunctional in many ways, and because our government, frankly, is so dysfunctional. There's a guy named Aneesh Chopra, who I believe is a Democrat, but he's fairly centrist, and he's the CEO of a company called Care Journey, I believe. But he's been working for many years along with others to build a movement around consumers that want to experience but you're referencing, you can waive your HIPAA, if you want to waive the protections. I don't know if you can wave them partially or either like veto power in each block, or if you have to do all of them together. But if you want to waive that a lot more becomes possible with your data. And if there was some sort of codified central repository for people doing that you can imagine, at least an environment would exist where people could sort of say, "I don't care as much about my privacy. Make it all work for me."

We've had people come to us who have more... Not so much in what I'm gathering based on the procedures and services you've listed. You sound like what I would describe as a fairly healthy guy with a few specific things that needed to get addressed. But not someone who has a massive amount of comorbid conditions going on. But as you get older, eventually that happens to everybody. And when we speak to Medicare beneficiaries directly who are in that period of their life where they have more complexity, many of them will verbalize the sentiment as far as follows, not all of them, but many will say, "Listen, I care much more about my financial information security. I don't want anyone getting my Social Security number. I got to figure out how to put food on the table and my fixed income life. And that, in that area, I'm super tight about my credit card numbers and all that type of thing. But I don't have any conditions I'm embarrassed about. And frankly, I don't really care if guys have my medical information as long as they know how to help."

That is the attitude of many seniors in this country, many of them. Not all of them, there are people with mental health conditions. There are people with HIV, and other things that are stigmatized, and it is their right to decide whether or not they want to share it. But there are a significant number of people out there who truly believe that keeping the information bottled up is much more dangerous to them than anything that might happen as a result of others knowing information.

John Marchica:

I would agree.

Daniel Durand:

And that's a growing number of people. And so, HIPAA, more of those people are educated as to what HIPAA makes not possible for them. You may see more of them decide to opt out of it. So, yeah, I think that HIPAA needs to change, and it'd be great if we could just pick what works about HIPAA and clear out what doesn't. But it's a very legislatively complex task in a country where, yeah, the most basic stuff seems to be a challenge at the federal level in terms of passing laws.

John Marchica:

Yeah. So, last question before we wrap up, I think it's an important one. We talked about data. What do you see in terms of patient data assets? What's the low hanging fruit? Like for your health system, or for many health systems, something that isn't getting done, or something where you feel that you can bridge the gap between your system and payers and maybe even pharma companies and clinical trials. Is there a common low hanging fruit that you think that people should be focused on and is attainable today?

Daniel Durand:

So, one of my core beliefs, which is going to explain my answer to this question is I am just of the opinion that it's been many years in this country where we've been, and most of the industrialized world where we're in a position where if we really want to extend life expectancy, it's less about what we need to discover. I mean, you can always discover a new cure for disease. But it's more about how, in my opinion, and many others, figuring out how to more consistently deliver what we already know works to people the right way. And if we did that we would see a bigger life expectancy than if we get a new cure for a given disease to get disease. Because even if we get that new cure for that new disease, if we don't deliver it, we're only to get part of life expectancy bump anyway. So, how does that...

I'm going to focus more on the payer provider part of this because that's really delivery. The Life Sciences clinical trials part of it. Yeah, there's stuff that can be done there, but I think that's at this point the 20 and not the 80. Now, you could say with COVID it's shown how we still need discovery. And I'm not saying we don't, but I still believe that most of what we need to do to improve outcomes is in that payer provider continuum. Okay. And whether it's government payer, or private payer, or self pay, I'm just going to say they're all the same for the purposes of this.

Three trillion plus dollars get spent on healthcare. I think we're going to start to talk about four trillion soon. I think we're right at that... I think we're going to start rounding up. Whether it's three trillion, or four trillion, about a third of it is administrative. And part of those administrative salaries are I think people like me. People that are leaders in health systems, that are leaders at the department level. There's administrative work that is not frontline patient facing work that needs to be done. But there's also a lot of this arms race mentality between payers and providers. And so, a significant amount of that

one to 1.5 trillion that's administration is just people spending money twice to have a non-solution to a problem. One of the ways that [crosstalk 00:44:28]-

John Marchica:

Can you tease that out a little? Just people spending money twice.

Daniel Durand:

Sure. So, if you look at the history of inpatient concurrent review is a good example. All right, so inpatient concurrent review is when you get admitted to a hospital, the second you get admitted behind the scenes the hospital and the health system are trying to prove and code for the fact that you're there and you have a condition and you need our help. And that your insurance company needs to acknowledge that and start queuing up for payment. And at the other side of this, the insurance company is acknowledging that you're there, letting us know what your benefits are, but then in many cases as the days go on sort of saying, "Hey, you guys need to manage this patient better, or prove to us that they need to be there." And on the outpatient side it's like, "Before you ever show up for an MRI there's this adjudication of medical necessity."

Now, some of that is driven by algorithms and fairly automated, which is a good thing because you don't want unnecessary care delivered. And algorithms are a great way to take the evidentiary basis that exists, and in real time make sure that that this service is indicated. But there's also a lot of people that are involved in working these jobs and administrating the algorithms. And over time, the number of people has gone up on both sides. Because as much as the provider might not want to spend money on it, on the payer side if they have a target they need to hit one year they may say, "Hey, we need to save another $5 million. Let's look a little closer to imaging and put another two or three people in to review it because every person we put in to review tends to eliminate five or six studies."

And so, you have the appearance that you're lowering the cost of care, but over the time you're just adding two bodies to both sides. So whether it's concurrent review, or [crosstalk 00:46:13] management. You also see it in areas where people are trying to help. So you might have a care manager that's going to help someone navigate the health system within the health doctor's office, but you got another one on the payer side. And then that just starts to confuse the patient. So again, the whole ends up lower than the sum of the parts. So, in all these areas, the more that you share data both on what you're doing and how you do it. You can agree on... For example, let's take utilization management. I can take one little piece of this.

You could perhaps imagine a future, it's not happening anywhere today that I'm aware of. But let's say in the future, the medical director of an insurance company, and the medical director of let's say, an outpatient imaging chain. They get together, and they actually get really on the same page in theory on what's indicated and what's not for a scope of services. Like let's say MRI for the joints, all right? And then they usually develop an algorithm that's got machine learning in it, and they test it. They say, "Listen, this was our combined opinion that we agree on 300 cases, and then the algorithm performs almost perfectly." So now the algorithm is attaining the result that two or three employees working against each other used to obtain. And if they can trust the algorithm enough, maybe they can co-invest in it, and then there will still be staff administering this. There will still be jobs, but there might only be half as many, and there won't be as much antagonists.

That could play itself out. And that sort of you're seeing the beginnings of that kind of thing in a variety of areas with EHR integrated computerized decision support, which is now required for imaging for Medicare, but it's not AI yet. But eventually you can see that a common data infrastructure and a

common set of tools, if we can get there, around medical necessity could have tremendous savings, and also probably improve the quality of what's done. And so, that thing played out on care management would look like, "Well, we're going to sit down and agree within a given geography, what are your care managers doing? What are ours doing? Maybe they all should be on your side, maybe they should all be on our side." But we shouldn't be paying the same people to do the same thing.

So, it's kind of a standards approach, and there aren't national standards. The standards tend to be local. And if you can agree upon standards and tools to administrate them, then you will effectively in many instances substitute capital for labor. You've done a capital intensive process, you set up a product or technology tool that is agreeable to both sides. And now it's doing something that might have taken a lot more people to do, and would've taken a lot more time to do in the past. So, through those types of projects you could increase productivity and efficiency, decrease the administrative load of healthcare.

Also, probably improve the time to decisions, which will improve the access and the perception of these variants on the patient side. So these are just some examples of how all the kind of stuff works together. I do what I do right now because I've seen a lot of opportunities for growth within healthcare where the payer and the provider collaborate. They just seem a lot closer to reality than some of the similarly theorized things on the life sciences side. So, we could talk about that as well. But I think there's tremendous need in a fairly immediate possibility three to five years if payers and providers share standard, shared data, make similar investments in innovative platforms.

John Marchica:

So, this sounds like what you're working on with Care First.

Daniel Durand:

Yeah.

John Marchica:

I mean, philosophically. Yeah, yeah.

Daniel Durand:

Yeah.

John Marchica:

Well, Dr. Durand, this is been great. I really enjoyed talking to you as I always do. I hope one day I can have you back and ask the other long list of questions that I had, but this is terrific. I really enjoyed the direction that we took, too.

Daniel Durand:

Cool, anytime. Yeah, I tend to give long answers. So, it might take two interviews to get through all the questions, but I appreciate it. It's been a lot of fun, John.

John Marchica:

Much appreciated. Please say hi to Neil for me.

Daniel Durand:

I will. Absolutely.

Kim Asciutto:

From all of us at Darwin Research Group thanks for listening. Health Care Rounds is produced and engineered by me, Kim Asciutto. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift toward value based care. Find us at darwinresearch.com. See you next round.