Talking Pop Health
Transcript: Eric Tower's interview with Deb Geihsler, Principal of Activate Healthcare
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Eric Tower: Welcome to the Thompson Coburn Podcast Series Talking Pop Health. I'm Eric Tower, a transactional health care attorney at Thompson Coburn. Our first speaker in the series was Lee Sacks, who's widely considered one of the pioneers in the areas of clinical integration and population health care. In our talks with him, we discussed the origins of clinical integration and population health care, some lessons he's learned and we looked into our crystal ball to see what the future may hold for population health care. Our next guest is Deb Geihsler, principal at Active Healthcare. Whereas Dr. Sacks examined population health care through the lens of a leader in a large health system, Deb's focus is on employer-based health clinics as a solution to providing high-quality outcomes at the lowest possible cost. Hi Deb, welcome to the podcast.

Deb Geissler: Thank you.

Eric Tower: Just to tee things off, could you give us a little bit about your background?

Deb Geissler: Sure. I've worked in health care for 35 years. I actually started with Trinity Health System in Ann Harbor, had a little bit of a background with starting new companies through the systems, and then was recruited to be CEO of Advocate Medical Group. Then I went on to be the CEO of Harvard Vanguard Medical Group and Atrius Health System in Boston. Through my experience, I learned that there are differences in the way geographies manage their health systems and how clients care is received. I spent some time in Wisconsin and in Minnesota – the thing that I actually liked about those experiences are that a lot of doctors driving the care versus health systems. You look at the Mayo Clinic, you have large providers groups that move to Chicago and you realize it's really system-driven. The providers are just an access point to the system so you're not necessarily driving health care. I was finding that it's disappointing because we are blessed in this market area to have fabulous providers, great ideas, great quality but the real focus tended to be more about what's good for the system. That's when I started to get very interested in looking at how do we work with our providers more effectively and how do we make them more accessible to get into the right care with the right people.

Eric Tower: So can you tell us about what Activates care model is?

Deb Geissler: I was part of a study in Boston with some other CEOs where we tried to look at how to redevelop a better system for patients. It was also at the same time when there was a push around consumerism and the patient making good choices. I used to say, "I've been in health care for a long

time and I can't make a good choice." It's really hard to tell -- how do you make a good health care decision? How do you identify what quality is, even if you know a lot about health care? I decided to take a look at how we could make health care better – I wanted to see it from the point of view of the patients. When we see them, are we actually taking care of their root clause issue or are we just patching them up and waiting until we see them the next time? If we actually spent more time with our patient, could we reduce some of the repeat follow-up and improve their quality of care? I did a study and found that (it was embarrassing to me, frankly), because if we would've spent more time with the patient in the beginning to find out why do you have this health care issue versus this is the issue that you have, we would've really been able to improve them, work with this lifestyle and reduce their visits downstream if we take care of them more holistically versus just one piece at a time.

There's also a lot of fragmentation going on. I remember a patient came to my office and said to me, "I use your cardiologist. I use all of your specialists, but I can't find anybody to return my call because nobody wants to own which part of me that I have a question about." So I was sort like, "Okay, well we need to get you to a primary care provider to start looking at your total health because you're right, nobody's going to return your call." So the key to me was putting primary care back in the center. I was giving a talk in New York at Columbia University about health care and how we can improve it and I was introduced to my business partner, who was CEO of Steak N Shake. He was looking at it from the point of view of "I've got 20,000 employees that I have to provide insurance for." As I look at the health care system, the delivery model, I don't see anybody really trying to improve the health of my patients. I see them managing their sick care but not necessarily telling me how to become healthy and how to reduce the cost. So we got together and created Activate Healthcare. You know my story about how I thought we could improve health and his story about nobody's managing the costs.

So when we decided to get together, I had several rules that I wanted to make sure that we followed if we were going to create an organization and the first one was: we need to hire the providers fulltime. We need to care for providers. We need to have them not worry about RVUs [relative value unit] but instead worry about the patient. We also wanted them to know that we salary them and that we provide bonuses for the right things: patient satisfaction, quality outcomes and unique participation. The other thing I wanted to make sure was to reduce the barriers for patients, in that there's no cost to the patient to get the care. They're able to come in and spend as much time as they can with the provider. It's not a five or ten-minute visit. It's as much time as the patient needs to be able to understand their health and we're going to make sure that we don't just treat the symptom but we understand their lifestyle issues as well as their medication issues and their medical history. We had to combine both because it's really the patient that it could improve their health, not the provider. They have to understand compliance. They have to understand how their behavior contributes to their overall health or detracts from it. We really need to guide them and have them make their own choices about how they manage their health.

Eric Tower: You really turned the reimbursement methodology – you've eliminated the common ways. How do you determine that the doctors are being efficient and successful?

Deb Geissler: We are very selective when we hire providers. We always say that we're looking for a provider coming to the model, not going away from the model. You'll hear a lot about primary care physicians who feel like they're burned out because they're tired of the RVU system. They have to see more and more patients to maintain their compensation. They're charting on their EMRs [electronic medical record] at night. None of those are good quality care. None of that contributes to quality care. So what we wanted to do was make sure that we take care of their quality of life. They work 40 hours in the clinic. They need to chart as they go so that when they go home, they shut off. They don't have any calls. We also wanted them to say you can practice medicine the way you want to practice medicine and that is to get to know the patient. Get to understand them and manage the patient more holistically. So many of our providers were saying, "gee, I'd love to spend more time with our patient but number one, I don't have the time. I can't squeeze them in anymore." It costs the patient every time they come in and they're not necessarily going to come in so that they can spend more time with their physician. We find that providers actually love the idea of saying, "I get to know my patient. I get to manage them holistically." We've removed the barriers of them coming back and forth. They can sit down with their patients and learn about them understand the root cause of what's driving their health care issues. Then, they can educate them and teach them.

Eric Tower: A lot of people have argued that the solution to a lot of the issues is to make patients responsible for the cost of their own care through high deductible health care plans. Your model is obviously very different. What you have noticed in that regard?

Deb Geissler: What I've noticed is that when we started transferring the risks to the patient, what we started seeing that patients were putting things off. Even though physicals would be at no cost, there still was a lot of concern that they would need more specialty care and that would be out of pocket costs. There's some intimidation and fear about that. In our model, we go to work with employers. We want to engage the entire population. We want to have it at no cost. We want to be able to discuss generic drugs at no cost to the patient. We want to provide labs at no cost to the patient. The provider is interviewed by the company so that the CEO and the provider feel like they are a match. And for the patient, it's the experience that counts. So they actually get somebody who's going to sit down and listen to them and care about them. Somebody who's going to manage their total care. Not just the physical or corrective outreach but actually listening to "how are you feeling", "when do you feel good?", "what other questions do you have?" Because when you think about the patient when they finally make an appointment with a primary care doctor, usually they have like five or ten questions they want to ask and then they sit in the waiting room and they narrow that down to three or four questions and then they sit in the examining room and they narrow that down to one question. At that point,

they want to just get out of there because they've been waiting all day. So with us, the patient actually gets seen on time, they get to see their provider who will listen to their whole story.

As we always say, it's not the 10-second rule where the provider listens and tells you what's going on. It's the patient telling the story first, then we decide how we're going to manage the patient. We shape the care plan around the patient. How do we fit our plan with their lifestyle, how do we work with them, what are their concerns and issues. These are all things we consider. The patients love that experience because they're not intimidated. No question's a bad question. We're not going to preach to them about stopping eating, smoking, and exercising. We listen to their story and craft a plan that will improve their quality of life -- and they love it.

Eric Tower: Where do you get your customers? What type of entities are interested in engaging with Activate?

Deb Geissler: Most of the time our entities that are coming to the table are organizations that understand the high cost of medical care. When do you think about from a customer's point of view, it's still sort of common these days to have 5% to 30% of your population drive 80% of your costs. So they just don't know how to control those costs, how to avoid them, how to improve them. They don't know what's in that dollar amount. Somebody comes every year and says, "here's what your insurance rate is." When we talk to them, we're actually trying to engage the total population which is 40 to 60% of any given employer population that's not accessing health care. They're waiting until they get to that catastrophic event to get involved in health care. So our customers are people who understand that we've got to control health care and we've got to improve the quality of our employee-base.

Usually, it's the privately held companies because they understand how their benefit costs and health care costs work and how they know where every dollar and dime is and so they understand that and they're very paternalistic for the most part about their employee base. We have a lot of city/county school districts and government entities because they need to sometimes work on their benefit plan and plan structuring and manage their health care costs at the same time that offers a better benefit for people to be able to understand their going to get better care ultimately because they have a provider that's going to sit and listen to them and manage their total care. We have a lot of our Taft-Hartley groups who really are responsible for their populations and deliver their care and they understand the cost of benefits and how to provide better care for their population.

Eric Tower: What do you think about some of the large employers that you have been using? The Center of Excellence, for example.

Deb Geissler: They're looking at the episode and they're looking at managing that quality cost of that episode. They're not looking at the total care of that patient. So when we started Activate we wanted to say, "anybody can open up access and increase it." You can negotiate prices all day long but are you really managing the total care of that patient? How did they get there in the first

place? Why do they need that surgery? Are they going to be compliant? Do they understand their health? A lot of times we talk to patients and they don't understand how they became diabetic. What does diabetes mean? How does that impact my life? We're able to sit down with the patient and say, "tell me your life story and let's manage your health care more collectively." These episodic things are not going to bend the care, they're just taking care of the issue at the time. They're actually just taking of that episode.

Eric Tower: If you're not paying – you're paying your doctors a flat fee – how do you get paid?

Deb Geissler: We'll go in to talk to the organization and we'll see how many employees they have. We'll see if they want their family members to be covered. Typically what happens is the employer will have all of their employees eligible to use the clinic and they'll usually have their family members who are on their insurance plans to be able to use the clinic. Then we look at how many numbers and members of population there is to manage and we build a staffing plan for them. Our panels for our providers are usually anywhere between 900 and 1,200 bellybuttons – that's individuals – that they would manage and then we charge them per member, per-month fee.

Eric Tower: So you mentioned the family members – what if someone has a 20-mile commute? Accessing your clinics can't be terribly easy under those circumstances.

Deb Geissler: 10 years ago when we started this we actually had an organization that was 30 miles away from our clinic and they wanted to join. We allow other organizations to join; we worked the staffing around us. We may start with one employer but after two or three years, we may have 10 employers in that clinic and we just keep adding staff to man the growing population. We had an organization that was 30 miles away that wanted to join the clinic. I'm like, "why would you want to join us 30 miles away?" What they said was that they can send their employees down to the street corner and they'd be gone all afternoon. Or they could send them 30 minutes to our clinic, they would be seen on time, they would get all of their issues taken care of and they'd walk out with a prescription and their labs done all in one organization and they could be back to their offices faster than they could be if they went down to the street corner; and they'd get all of their care more efficiently and more effectively.

The other thing that happens, too, is because we're not billing and we're not in the RVU system, if we do a comprehensive physical and evaluation on somebody, we don't always have to see them to take care of their issues because we already know what's going on with them. We can do a house visit with them. We can do a phone visit with them. It's really about managing that patient and how best to manage them. We've had people drive an hour and a half to go to the clinic. They know they're going to be seen on time. They spend as much time – and again, because we're not worried about the RVUs, you could come for a physical but we're going to take care of the dermatology problem, the cardiology problem, a rash, or

anything else that's going on at the same time. We don't care because we're taking care of the total patient. We're not worried about the type of visit. How much time we have. What's the condition? Are we billing for different variations of things? We're just simply taking care of that patient. On average, what I figure is, about 30% of our visits are probably multiple type visits rolled into one just because we can do that.

Eric Tower: If you're working with multiple employers in a geography and you have multiple clinics, do people have to come to the clinic at their workplace? If I'm out running errands or something and all of a sudden something happens, can I swing by if I'm getting sick?

Deb Geissler: Most of our employers like the idea of sharing, not only sharing, opening their clinics to have their populations come in but sharing to say, "If your family lives in a community where there is another Activate clinic that's close, they could go to that clinic. Or they could come to the employer-based clinic." They actually have access to any of the Activate clinics in that region. It makes it nice and convenient. The other thing that we do a little bit different is we understand our employer/organization population and so the hours are really around the populations. For example, school districts like to be seen earlier before they get to their classrooms so our clinics may be open at 6 a.m. We know that with some of our clients, they really come after work so that's really busy between 3 and 7 p.m. Our hours are variables across each of our clients space on the population we're serving. The one thing we found is that most people don't like to go on Friday afternoons and Saturdays because they don't need to. They have so much access to come in the same day or next day.

Eric Tower: What's to stop me from opening Eric's Medical Clinic and having a doc work there and plop someone down in an office and just doing this? How is this different?

Deb Geissler: I would say the first thing is, it's good to have primary care and make it available but you really have to be able to have proactive outreach to get all the right people in ahead of time – not just wait until there's a condition that has come up to drive them to it. You have to have a provider who's going to get to the root cause of what's going on with your total situation. I can give you an example, we have an organization that's in a rural state and they bring in a lot – they can't find enough workers so they bring a lot of people into the country from different locations. We had a patient that showed up that had high triglycerides, low sodium, high A1C, numbers are all off the chart, our provider was going, "wow, if I was practicing in a typical health system, I would be sending the patient directly to the ER for fluids and put on metformin and take care of all of these issues." You're not in really good shape at all. But he said, "I had the opportunity to sit down and have the patient tell me their story." I had the opportunity to sit down and have you tell me my story and the patient was saying that they moved to this country alone as a 40-year-old male who has been living on nothing but white rice for 5 years. So our provider decided to take a chance here and let's work on his diet instead of sending him to the ER. We're going to work on it and we're going to take care of it. And his numbers were down within

three weeks. Now, if the patient had gone to the ER, absolutely they would've gotten quality care but they would've gotten quality care with the symptoms that were showing up not with the problems that were going on with the patient.

Eric Tower: How do you compare the care that Activate provides with some of the systems that say they're involved in population health care?

Deb Geissler: We actually have a contained population so our providers are dedicated to that the population. We manage the cohorts' progress or nonprogress. So can ask year over year, are we actually improving your care? Are we taking care your family or seeing the patients? The first clinic that we opened 10 years ago, we're still seeing all of those patients. We know those patients really well. We know their lifestyles. We know their work style. We know their health conditions. We have managed their referrals. We managed all of that. We really understand the intensity. I always say if I was still over at Health Systems when the patient leaves the door, they're not part of my problem.

When a patient leaves our door, we worry about everything they do. Are they getting enough sleep? Are they taking their medications on time? We literally had our providers go to the floor of a Manufacturing Company to make sure the patients are taking their medications at the right time or taking care of whatever their issue was. We really have that freedom not to just see the patient how we want to but go visit them. We can get out on the floors and see them. We can go to their house and we can see whatever it is needed to do to take care of them. So the difference is it's much more intensive about worrying about the total care of the patient. And it's not just about pop health and looking at the data and saying, "oh, we've got high-risk patients over here." We tend to look at the data and say we're managing the high-risk population.

These people do here who aren't engaged yet and a lot of systems treat the people they see but don't know about the hidden population that's laying out there to be seen, these people need attention as well. We want to prevent them from getting up here into the high-risk population. So we encourage our total population of any one given organization and their families to come in and get established care. Or come in and get a physical. Or come in and just let us have a conversation with you so we can understand from the very beginning if there are risk factors that could effectively impact their care. And let's make some choices now if you can or want to. We don't try to preach to the patient, we give them the choice. If we want to we can do that. But catching people early, getting them engaged, we can actually see how we're managing and avoiding them becoming a diabetic. We see so many people here who are pre-diabetic that don't understand what it means to become diabetic. And then we can measure our real care at that same population, that same cohort, year over year over year.

Eric Tower: And presumably, you've done that. What kind of results have you achieved?

Deb Geissler: I don't have the data in front of me, we do it by organization. We actually start with the patients who come in to see us versus some patients who don't. We keep track of their conditions so that we can determine if have they improved or maintained so that when we give our annual report every year to the clients we can just to say, "here's the population that we're managing, here's who's improved and here hasn't." But I would say overall, we probably see probably 2/3rds of the population that we're managing, get to see improvements.

Eric Tower: How does that translate into the costs for the employer? You're an add-on for any self-insured fund or whatever way they choose to elect to get coverage. How does this help them?

Deb Geissler: We have over 150 employers and on average they get $1.50 in return for every dollar. Not only that but the first organization we brought in, we reduced their health care expenses by 28%. Their trend going forward is usually is zero to three and a half percent. It's not the five to eight percent. Everybody else is getting an increase in their insurance plans. Here's the other nice thing too: say you're an employer, you have an outside clinic and we try to get unique participation. That means, we're penetrating the whole population because if we just see the patients that decide to come, we're going to end up managing that same 20 or 30% population. But if we try to engage the whole population we try to get 65% of participation for those disbursed populations and 85% for those that are in the same category in the first year.

So now if you're an employer and you're always focused on the 5 to 20% in the drug and 30% cost, now you have 85% of your employees engaged. Now you have a provider team that's committed only to you and you can sit determine what are the biggest problems with my employee population? How do I design my benefit plan? I've got savings now. I've saved dollars. Now I'm managing, now I have a team that managing my population, how do I design my benefit plan? How do I encourage? Are there some programs I should take on? A lot of times the CEOs will say, "you know what, let's do a year along program on how to manage tobacco use." Or, "we know nutrition bad or maybe we have a trucking company where it's hard for them do we show them how nutrition works?" Or, "we know exercise is bad for people who – truckers again, that might be a problem, they don't get exercise." So we actually sent some videos to help the work with that. The other thing is our providers know the organizations and they can be advice to the CEO so they can go in and say – we had one of our organizations where our provider was seeing a lot of shoulder injuries so he went out and walked the floor and he saw what was going on. He took the CEO out and said, "see these trailer hitches to these trucks? you replace those you're going to reduce 50% of your shoulder issues." We're actually able to give advice on things like that. We really know our population. We know our population from work. We know our population from patient. If I'm an employer and I've got people on my team and I now know what's going on with my health care spend and I'm saving money, why wouldn't I do that?

Eric Tower: So I had a question for Lee Sacks, my first guest on the podcast. He started talking about the extent to which there are food deserts and we really need to start a lot of social issues --

Deb Geissler: -- you're talking determinants.

Eric Tower: Yeah, yeah. It sounds like you're right there with him in that regard but maybe even further, insofar as you've got people embedded into the organizations.

Deb Geissler: Part of our training process is to have our providers spend at least a day or a day and a half with the CEO talking to them about mission values in the organization. So we have a good repor with them. But a lot of times they'll go through new employee orientation and they'll go out and work on the line. One of our doctors was with a beverage distributor. He went out and distributed beer with the truck drivers so he could see what they were doing. We have the bus company and one of our physician went out on the routes to see what it's like to be a bus driver all day. So they understand now. A lot of our providers come back and go, "this is incredible because I if I had just been seeing them I wouldn't have gotten the whole picture of what's happening with them during the day and the work that they're doing and how it impacts their lives and their health." So it's really great for them to have that total picture.

Eric Tower: You were talking earlier about geographic differences in health care. Do you see Activate as scaling throughout the country or in a particular region? What are the plans?

Deb Geissler: There isn't any population that we can't fit into the model. We have organizations that are small as 25 employees and we have organizations that are as large as 100,000. It's really about how we scale the staffing and the training to make sure we have appropriate access for everybody who's eligible. We're from California to Maryland. The only changes aside from geography is the way people receive their care. So we might see in some geographies there's more specialty care than there is primary care. We may see in some areas there is more urgent care than there is primary care. We kind of are able to see just how people are receiving their care.

Eric Tower: Sounds like a lot of this is very customized. Do you apply protocols across your entire enterprise? A truck driver's going to have a very different of needs than a school teacher.

Deb Geissler: When we set out to start an organization, we know a lot of the segments so we may look at some manual labor type organization and say we might want to have somebody that's trained in the fellowship of musculoskeletal tissue, or a sports medicine fellowship. We start to divide, design the service type things that are needed. A lot of the manufacturing may end up doing a lot of drug testing or hearing testing or things like that because it's part of their service. We really kind of create the team that's got some knowledge about how to work that population. It's customized to the organization but it's also the delivery of care is pretty darn consistent so we

really do a lot of measurement quality revenue, grand rounds, shared chart reviews to make sure that we're delivering high-quality care. But as I always say, "the experience is the same, the services will vary by the organizations."

Eric Tower: What do you see as the future for Activate health? What do you want it to become?

Deb Geissler: Because we're not doing RVUs, we can put providers in places where they would never be able to make a living. We had a NASA medical director move from the State of Washington to Southern Indiana because he wanted to be a farmer. He could not have lived in that small community and had a good living and treated patients the way he wanted to. We can do rural. We can do big cities. We can do medium size because if providers like the model, they love it. They love taking care of the patients and seeing the results and seeing people get healthier. They like having a quality of life and they like to have that freedom that they can live anywhere they want to. So that's one part. The second part is employers love having somebody actually understanding and taking care of that population at single cost savings and that happens for any size of the groups. Patient love the idea that they have somebody who's managing their total health care. Not just here goes the specialist. It's no, we're going to co-treat with that specialist so we can manage all of your care. They love it because they're seeing the quality of health care and understanding it. Our pipeline is huge and keeps growing. I think it's going to continue to just get better because nobody wants to give up that freedom enough to give up that medical home sort of speak for their patients.

Eric Tower: Are there any specific lessons that you draw on from your time creating and then expanding Activate that might help people work better in pop health?

Deb Geissler: What I see a lot of times is physicians who are trying to find the solution without engaging the patient. A lot of times you'll find people are sitting around saying they know how to take care of the population. They'll add technology. They'll add kiosks. They'll add all kinds of things and services. When in reality you need to engage the patient. It's really about the patient. It's really about the service for the patient. The understanding of the patient and that becomes clear to me that you can't fit the patient unless the patient wants to be fixed and they understand why. Too many groups out there really want to just fix the patient. You've got to engage the patient.

The thing that I've noticed that is different is the amount of people who just aren't engaged in health care right now. It's huge and they don't have a lot of opportunity to get engaged. And they don't understand how to use health care very well. A lot of times they'll wait for that catastrophic event to get into health care. Sometimes on the health care side or the system side, we keep looking and studying the population we're seeing but we've forgotten those people so there's a lot of services that we can do to really engage more people. We need to put the patient back in the center. We need to hear their story. We need to respect the patient. When we first started we thought we would have the position through the medical

management and a nurse practitioner or PA did the health coaching that was wrong. That didn't work very well because the patient had to tell her story twice. What I mean is to respect the patient, listen to them but make them tell their story 10 times to 10 other people. Guide them, understand them, have a true provider managing their care. And then we have all of our providers learn coaching versus just telling them to go on their way and here's your problem. So we really tried to marry medical management from lifestyle management because it has to go hand and hand. In reality, when it gets down to it, the patient really likes being listened to and respected and it's the basics that really count.

Eric Tower: When I hear you talk, it almost seems as if you're talking about lifestyle coaching more so than medical interventions in the traditional sense.

Deb Geissler: I appreciate your saying that. One thing that we always try to do is we always knew that wellness didn't work right?

Eric Tower: Trust me I saw plenty of that.

Deb Geissler: So wellness does not work. Why? Because the patients were resistant just like they didn't like HMOs. Because it felt like you're trying to do something to me. You're trying to control me. What we try to do is we try to say let's teach you about your health and then we're going to help guide you to the right choices about your health. So it's coaching in that way, but it is coaching with medical management.

Eric Tower: Might some employees think that this is sort of a big brother there to control and you know force you to do certain things?

Deb Geissler: Early on when we first started 10 years ago there were people who were very skeptical in thinking that their employer just wants to find out about them and they're going to use that against them. We do a lot of communication with people about why are we doing this because we want you to have immediate access to good primary care, we want a population or a group or a team who is going to take care of health and we're going to manage your total care, your referrals, your coaching, your proactive physicals and your acute care. You're going to automatically reduce costs. And dispense generic drugs at no cost to the patient. So there was a lot of skepticism at that point when we first started. Over the years there's been more and more cost-shifting going on across the country and just hard for people to manage their health care dollars because they've got huge deductibles. They're going to have to pay a lot. You take a family of four who's got kids that need school physicals and somebody who may have some kind of condition that needs medication and then you've got somebody who has to have frequent visits. They're just going to come because it's more cost-effective and they learn to trust their provider. So it's changing all the time.

Eric Tower: A lot of companies have these online wellness programs and other interventions. Having been part of those I know those are sometimes received a little skeptically. How are things different with Activate?

Deb Geissler: They shouldn't view them skeptically. In my estimation, they don't add a lot of value because you don't know the person. You're missing part of it. I also feel like when we're just doing HRAs or biometrics. We'll do the biometrics and people think they really contributed something. Well, you're getting half of the story. You're getting some of the numbers but you're not getting why they have the numbers. You need the total picture. So I don't think it works. I think you have to know the whole patient. You have to know the whole person behind it; you have to know their conditions, how they manage their health, how they think, what's their values, what's important to them. People like to learn about themselves but they don't like to be told what to do and they don't like to be forced into trying to follow a category or fit into a pattern. So we don't do that. We try to respect each and every individual who walks in. Try to work with them about how they want to improve their care. Some people come in and say I'm not improving my care. A lot of patients come in and say they're big-boned and can't lose weight. Or their family has always smoked. The first thing do is to let them know that those are their choices. We can talk about what that might do for their risk factors. A lot of times those are the first people that come back – they lose weight and they gave up smoking because nobody's ever just sat down and said, "let's talk about what your choices are."

Eric Tower: It's not one of those situations where you tell them that their body mass index is high and if they don't lose X pounds, they won't get this bonus payment.

Deb Geissler: Right. It's really about, again, the only person that change and improve is the patient. They understand that. It is letting the patient do the talking and it's letting them help decide I want to do this or I'm not going to do this. It's about education and understanding.

Eric Tower: So you would say the freewill lives at Activate Health?

Deb Geissler: I would say that. Yes. I believe that's true. I've had some providers that go, "the best practice is X," I go, the best practice is to first engage your patient and be here for them. A couple of things I see happening around the country is that people have numerous choices of where they can go. There's a lot of urgent cases everywhere. There are people who will actually give people what they want. One of our first patients in the first clinic that we had came in and said that they were going on vacation but they thought they were catching something and needed antibiotics. We're like, no. It doesn't require an antibiotic. But a lot of times patients have gotten into the mode of directing their own care. They'll say, "I think I need to go to the doctor because I need an x-ray on this and I need an antibiotic for this." They start directing their care and people are so busy a lot of times you get away with it. In our case, we actually have a lot of conversations with the patient and go, let's just first learn about you and what's going on and let's understand if you really need an antibiotic or not and what are the challenges of having too many antibiotics. Let's educate you on that. So it's really a learning process – or what we call the Activate Way. We train our providers to listen first, teach what we're hearing – educate – and then coach on the patient what choices we want to make. And yes, there's the

latest and greatest trend is also to talk about social determinants. What I say about that is this: when you can give the person the gift of health, when you can empower them to understand that they have control over their health, we see confidence build in other areas. We can't fix their family life or their paycheck but we can start to have them understand they are respected by a professional who is interested in what's happening with them. We want to get them the best care. We want to guide them. We want to support them and sometimes that turns on a whole lot of other things for that patient. They'll feel power to do things.

Eric Tower: Is this a throwback to the practice of medicine? This, frankly, predates my lifetime.

Deb Geissler: Not mine. I'm older than you. I remember when community hospitals used to be just community hospitals. But, yeah, it is. It's sort of back to your old general practitioner who managed everything. It's just that we've got a lot more resources that we can use more effectively. We have more knowledge and we can see things farther and faster. I think our patients really like the idea that somebody listens to who they are; why they're different from you or from me or from anybody else. What's unique about them. Originally, I questioned if these providers are going to like being in an organization where they're going to see the same people for the next 20 years. It was a worry to me when we started this; I thought that would be interesting. Because, you know, our first provider, he had 2,100 patients. After the first years is he going to say well, I've seen enough of these people.

In reality what happened was he got to know each and every one of those people, individually, they're all unique. So it's not like he was seeing the same thing all the time. He was seeing 2,100 unique, real people with real issues and real things going on. Versus if you're in a health system practice, a lot of times what you're doing is you're saying flu, cold, allergy, flu, cold, allergy but you miss the person sometimes in there. They love what they're doing because they're actually putting all of the pieces together and saying if they came in for strep throat but guess what, we found out that they have all these other things going on. And we've had some incredible cases in that capacity. It's a good story. People love it. I said in my lifetime it's the first time I've seen happy patients, happy payors, happy providers all at the same --

Eric Tower: -- usually all three of those are miserable.

Deb Geissler: I know. It's pretty fun actually. The providers like the freedom. I think – people are like, "oh, you're salarying them – are they going to do the right thing? Well, I'm treating them like adults. They're empowered, brilliant people that understand the process and they can manage that population. So what we say to our provider teams is that this is your population to manage. We've worked in a company where the nurse practitioner discovered that one guy was diabetic. – he had no idea he was diabetic. And he started to see blood. His vein started to stick out and he saw infections coming out of his foot. He literally went to his place of work every

day to make sure he was cleaning his wound, taking care of it and making sure he was doing the right medication until he got on the right track. They love it because they can do that. Because they have that freedom to be able to do that. They can take care of their patients however they want to and we say to them, you know, personally, if they want to do telemedicine, they're still doing it. But the same team; it's not fragment. If we want to do phone calls we can do that because we now know them really well and we can do that. And the providers have the opportunity to work with the employer and go, we're changing our formulary. This population needs a whole lot of these kind of medications. What's not to like for the payor? What's not to like for the patient?

Eric Tower: Do you want to do house calls?

Deb Geissler: So here's the story, yes, so we had a patient that we were taking care of. Couldn't get transportation. Couldn't get to the facility they're at – was not close to our clinic. Our provider said we'll go over there and take care of them at their house.

Eric Tower: Unheard of.

Deb Geissler: It's pretty much fun.

Eric Tower: Excellent.