[00:00:01] Andy Mueller, M.D.: CO pays are a hangover of the fee for service system. There are no CO pays with Trellis, so we've done everything we can to eliminate barriers.

In addition to that, there's no prior authorization for any of the services provided by Trellis, which, in addition to traditional primary care, include behavioural health, the services of PharmD, and physical therapy.

[00:00:21] Narrator: Welcome to A and M Healthcare Industry Group's What's Your Moonshot podcast series, where leaders seek to solve big problems and transform healthcare.

Join us for conversations to hear how their vision and bold moonshots are becoming reality.

[00:00:39] Aaron Bujnowski, DSc, FACHE: Welcome to A and M's What's Your Moonshot Podcast series. My name is Aaron Banowski. I'm a managing director in A and M's healthcare industry Group. I'm joined by my co host, David Shulkin, who's a senior advisor with us and the ninth secretary of the US Department of Veterans Affairs. And today, we're pleased to have Andy Mueller join us today who's the CEO of Maine Health. He's back with us again for a second time. Welcome back.

[00:01:02] Andy Mueller, M.D.: Hey. Thank you. And before we dive in, David, just want to thank you as a veteran for your services, our Secretary of Veteran affairs, and all the work you did for all of us. We're grateful.

[00:01:11] David Shulkin, M.D.: Tell us about your service.

[00:01:12] Andy Mueller, M.D.: So I was very fortunate in that the Air Force agreed to pay for medical school for me. It enabled me to go become a physician and got to do my residency at Andrews Air Force Base and family Medicine and then served at Charleston Air Force Base as a flight surgeon some of that time during Enduring Freedom, where I got to see the world and do some interesting and exciting things.

[00:01:32] David Shulkin, M.D.: Wow. Well, thank you for your service. It's amazing.

[00:01:35] Aaron Bujnowski, DSc, FACHE: Thank you. By the way, my father was in the Air Force. I was born at the Air Force Academy.

[00:01:39] Andy Mueller, M.D.: That's great.

[00:01:39] Aaron Bujnowski, DSc, FACHE: So this is an Air Force family. Yeah.

[00:01:40] David Shulkin, M.D.: And I was born at an army base.

[00:01:42] Aaron Bujnowski, DSc, FACHE: There we go.

[00:01:43] David Shulkin, M.D.: So everyone has a connection. Thank you.

[00:01:45] Aaron Bujnowski, DSc, FACHE: Great. Well, Andy, welcome back to the show. I think the last time you were here, we talked about a really innovative approach you had to

primary care, Trellis Health. Do you want to give us a little reminder of what that is and what you've been trying to accomplish with that?

[00:01:56] Andy Mueller, M.D.: Yeah. So Trellis was really born out of a moment of frustration, em recognizing how much work we had to do to try to make primary care better. I'm a family physician myself and certainly empathize with the plight of primary care today.

And while we decided to commit to making all those incremental changes to improve it. Just thought for a moment, gosh, it would almost be easier to blow up primary care and start over from scratch.

To which we thought, why not do that? And so we decided to give that a whirl. So we spun off a separate company to insulate it from our bureaucratic antibodies and decided to launch it with really two hard rules. The first was absolutely, positively no fee for service payments ever. The second was it needed a standalone break even or better P and L in two years. And we didn't want to use primary care to leverage against downstream referrals or Medicare Advantage premium risk. We just felt like it should be able to create value, economic value, on its own.

So in 11 months, from the time we recruited Tam St. Clair, just an amazing serial entrepreneur from Silicon Valley, who's led this effort to 11 months to go from the idea to seeing the first patient in this new novel way of delivering care.

We've been at it for about 18 months and we've had incredible success to date. We've got about 2,000 members now. We were the first customer paying a PMPM to Trellis for the care. We've now got about 10 other businesses that are now sending employees to Trellis.

And in that period of time, we've seen about a 25% reduction in avoidable ED visits, 50% reduction in admissions. And to be clear, since we're sending employees who wanted to go there for it, we've got a beautiful prospective control trial because we can see the difference between what we're spending on the patients who go to Trellis and those who don't. So the numbers I'm giving you are age adjusted and acuity adjusted. For a true apples to apples comparison.

47% fewer specialty referrals out of Trellis quality metrics equal to our medical group, which are really strong.

91 net promoter score and about a 30% overall reduction in the cost of care.

Looking at the two, and that is in no way, shape or form an indictment of our existing primary care practices and the primary care system in Maine. We've got amazing primary care physicians, apps and teams, but we feel like the system artificially constrains them and doesn't allow them to really practice at their best. And we think Trellis creates opportunities to do that better.

[00:04:27] David Shulkin, M.D.: Well, let's take this from the patient experience. How does this feel different than when you or I, as primary care physicians were seeing our patients and what has the patient reaction been?

[00:04:39] Andy Mueller, M.D.: So the patient reaction has been pretty overwhelming. And we've had again a 91 net promoter score again in healthcare. So it tells you how much they've appreciated it. In addition to that, we're seeing we've actually had a couple of patients who've

switched jobs, who lost the benefit of Trellis and who decided to pay out of pocket to continue to be part of the program because we found it so valuable. So one of the things we decided was that CO pays are a hangover of the fee for service system. So there are no CO pays with Trellis. So we've done everything we can to eliminate barriers.

In addition to that, there's no prior authorization for any of the services provided by Trellis, which in addition to traditional primary care, include behavioral health, the services of PharmD, and physical therapy. So for example, if you have a known physical therapy injury, you're a runner, you have chronic hamstring pain, you don't need a prior authorization, you just go directly to the physical therapist. Right. There's no limit on the number of visits and it's a very direct relationship.

Every Trellis member gets a welcome visit to get to know you and start talking about your healthcare goals. After that, more than 2/3 of the care is delivered virtually and outside the walls of the practice.

And care is delivered by the care team member at every level to try to own as much of the patient's problem as they can. So we've tried to intentionally displace the physician, the primary care physician, from being the court of highest authority to becoming the court of last resort, which really frees them up to think about how they manage the whole population, the whole panel of patients.

In addition to that, medical assistants are also certified health coaches so they can provide credible advice and guidance on lifestyle modification and other healthy behaviors to try to improve outcomes.

What's interesting is when you talk to the team, if you talk about individual patients to them, you'll never know who the real owner of that relationship is. Sometimes it's an MA, sometimes it's the PharmD, sometimes, sometimes it's the physician, sometimes it's the physical therapist or the licensed social worker, just depending on the individual needs. So the feedback we get from patients is this feels tailored to me and I think some of the greatest success stories we've had are about patients who are skeptical, put off or frustrated with the existing healthcare experience, who've now feel like they've been able to reconnect in a way that works for them. Again, not an indictment of the other care teams who are working their best is just in a system that doesn't give them the freedom and the flexibility to provide this level of care.

[00:07:08] David Shulkin, M.D.: Now, about 10 or 15 years ago, and I know you'll be familiar with this, that sort of frustration of not having the access to primary care and people who really understood their problems led to the birth of concierge medicine.

So how is your model different than concierge?

[00:07:25] Andy Mueller, M.D.: Get asked that a lot. And I think in some ways concierge or direct primary care is trying to save solve the same problem. Often, not always, but often concierge or direct primary care is a physician, maybe an assistant, sort of against the world solving their patients one patient at a time. Ours is still advanced primary care. So the care team consists of a physician, two or three apps, two licensed social workers, a PharmD registered nurse, physical therapist, four medical assistants who are licensed to health coaches.

So it really is care delivered through a team. It's not disintegrated from the healthcare system. It's integrated with the healthcare system in terms of specialty access and those types of things.

And so we see that as a big difference and differentiator between the type of care you get at Trellis than you may be it may have available to you in a director concierge type relationship.

[00:08:15] Aaron Bujnowski, DSc, FACHE: Now with the kind of cost reductions you're talking about, that could actually strike fear into the hearts of a CFO. So wait a minute. How have you thought about integrating this with your total strategy? Because I think this is part of a larger strategy.

[00:08:26] Andy Mueller, M.D.: It definitely is. Our situation in Maine is different than it may be if you're in a super competitive metropolitan market. We're here in Chicago today and for sure it would be harder to do what we're trying to do there. But when we look at our community and the needs of our community, we've got to impact the per capita total cost of care. We have to bring it down. Our community is screaming at us. They can't afford us for the amount of care we deliver at the cost of that care. And so we've got to be engaged in that conversation. We also don't have a sustainable business model in the current environment.

The incremental cost growth is going to outpace incremental revenue growth by a wide margin.

So we have to get good, reducing avoidable care, particularly in the emergency room, particularly in our hospitals. And this is actually giving us confidence we can do that if we re empower primary care.

So to that end we have. One of the beautiful things about Trellis is when we launched it, we decided very intentionally that it had to be A learning laboratory for us to help the rest of our healthcare system adjust if we found things that were valuable to bring back. And we have.

So we launched something called Project Horizon, which is where we took one of our existing practices and told the care team, close your eyes and pretend really hard that you're paid in a per member per month way too, even though we're technically not, and collecting fee for service revenue on the background, but just manage your patients that way.

And what we're discovering is, not surprisingly, patient experience has gone up significantly, care team engagement has gone up significantly. And the outcomes, while not as dramatic as Trellis, are pretty close and still fairly significant.

And unlike Trellis, they're continuing to see the entire continuum of the payer classes. So those with no insurance, Medicaid, commercial and Medicare, Medicare Advantage.

So they're doing a remarkable job doing this. So much so we're now starting our second practice in this direction. And our care team, yesterday our primary care leadership presented a new practice that they want to open. And they're opening with what is really a Trellis like model in terms of the distribution of teams. So we really think that we've got opportunity to grow this type of care within our health system to drive those outcomes, which we think are going to be really important for us as a business to survive, but more important to our community in terms of creating greater value for the care that we deliver.

[00:10:49] David Shulkin, M.D.: You've rearranged or you've remodeled what primary care does in sort of a more holistic way. You've also changed the reimbursement model. How does this change your relationship with the payers in Maine and how are they reacting to it? Or is this a model that actually is outside of the traditional payer relationship?

[00:11:11] Andy Mueller, M.D.: So it's outside the traditional payer relationship for now. And that's sort of how we begin began this by selling it directly to employers like Maine Health and others in our community. But we're beginning to think that this would make more sense integrated into a benefit plan. Fortunately, one large commercial payer in the marketplace has already come to us because they've seen the data and the impact and have said, hey, we've got a greater than 10,000 member level funded plan in your state. We want Trellis to be a part of that because we actually think we can drive down the savings pretty significantly. So I think it's going to change the relationship. But I think the big unlock with Trellis and I think what we're finding to some degree with our Project Horizon practice is that the key is breaking away from the CPT and EM coding that our primary care teams and other outpatient cognitive physicians are structured into, because in that environment, you're effectively delegating the resource allocation decision to the payers. And it doesn't make sense because in order for that to work, you basically need a one size fits all.

And anybody who's provided primary care or delivered care in any way for that matter, knows that no two human beings are the same. And so by not having to be confined to that really rigid, burdensome structure means that if you can safely and appropriately call in a prescription over the phone or send it electronically, you can do that. Or if an E visit would work, you can do that. Or if an E visit would work. But you know that patient needs some additional hand holding or attention.

Bring them into the office and you're not doing it worried about am I going to get paid or not? You're doing it because it's simply the right thing to do. And I think one of the liberating things for us is to be able to tell the Trellis team, the Project Horizon teams, don't worry about RBU targets, just take great care of your patients. Just do the right thing. And I think we're seeing the rest is following.

[00:13:13] Aaron Bujnowski, DSc, FACHE: Maybe it's appropriate. We're talking about moonshots where we just had Artemis 2 come back. So for you, Artemis, I was trellis, and Artemis 2 is E M codes.

[00:13:21] Andy Mueller, M.D.: Yeah, there's a little bit of irony there because originally we called Trellis Project Apollo, sort of referring to a moonshot. I mean, that was sort of the rationale behind that originally. So I think that's exactly right.

[00:13:30] Aaron Bujnowski, DSc, FACHE: So what could prevent health systems from doing the kind of disruption? Because this is a very disruptive way to look at your business. What can prevent them from doing this in the way that you've described it?

[00:13:38] Andy Mueller, M.D.: We had a number of fights at the dinner table as we were launching this. We still have fights at the dinner table over Trellis.

And I think one of them was the first fight was do we spin this off as a separate company or do we do this internally? And I think it was important for us to spin it off because I think had we not not only would we have had trouble identifying and bringing in talent like tam, I do think our

bureaucratic antibodies would have really maybe have not killed it, but they certainly would have slowed the growth dramatically. And just why wouldn't it? Because this is going to be a relatively small priority against all the other priorities and day to day challenges that we're facing. So I think creating an environment where this can incubate safely is really, really important. We had some other big fights including whether or not to which paramecs, which paramecs class to sell. And we had debate about maybe we should start with Medicare Advantage, maybe we should start with commercial, maybe we should do something with the state on Medicaid. And ultimately, after doing a lot of thoughtful research, the team concluded commercial would give us the greatest flexibility to move fastest to try to prove the model with an intent to try to expand it to those other peer classes. And we're beginning those conversations now. We're not for profit healthcare system. We need to take care of the whole community and we need to do that. We had another big one around technology. We're an EPIC system.

Should we be on epic? Should we not be on epic? I'll tell you, we started on EPIC and found that it just doesn't work for this type of care. And so we had to switch to a different electronic health record. So those are all the challenges that I think health systems have to overcome. But I think the first one is a belief that your business strategy is incumbent on reducing avoidable care. And if you can't cross that threshold then I think this would be hard for many to embrace.

[00:15:21] David Shulkin, M.D.: Does this intersect with an ACO strategy? I'm trying to see how you align the interest of reducing the total cost of care with what you're really accomplishing. And in the direct primary care model, how are you benefiting from these reductions? It's the right thing to do. The community needs it. You're a not for profit, so I commend you on that. But the sustainability may depend upon ultimately having alignment with the outcomes that you're driving.

[00:15:54] Andy Mueller, M.D.: Well, I think it's going to require outcome or alignment with the outcomes, but it's also that's going to be dependent on different payer strategy in relationship with the payers. We're really interested in the lead model and seeing what that may do. And while we've had some conversations with Abe Sutton and the CMMI team, I don't know that they're quite willing to say you don't have to code any EM codes. I do think they're saying, hey, look, in the overall scheme of theorems that's not going to matter as much. And maybe you can effectively de emphasize that with the teams. And I think there's some, probably some truth to that. So we're going to have to get to that point. Now our situation is Also a little different. We right now have more volume than we have capacity for.

And Maine is struggling as a healthcare ecosystem. And there have been reductions in services at many of the other systems in the state, which we don't view as a good thing.

We don't view any of the other health systems, Maine as competitors. We view them as necessary partners.

Our vision statement is working together so our communities are the healthiest in America and we're not going to be successful if they're not successful. But that means that that volume is now coming to Maine Health as the safety net.

And so we feel really compelled to do this. And then back to what I said earlier.

We can't afford to hospitalize all the patients we're hospitalizing. We've got to figure out how we can deliver better care to keep them out of the hospital because the cost structure is just so high. And we still have plenty of need for our hospital beds, still plenty of high acuity patients that aren't able to get the access all the time that they need it. So for all of those reasons, we feel there's enough alignment that we need to move in this direction. As you all know, everybody talks about all the uncertainty in the future of healthcare, but this all seems pretty certain to us. We've got to reduce the cost structure. We've got to provide better care for our patients. We've got to create greater value for those paying for the care.

And so we see this ultimately align. These skills and capabilities are going to be required for us to be.

[00:17:42] Aaron Bujnowski, DSc, FACHE: And not only that, the alignment is for all players involved, because what I'm hearing from you is that patients are highly satisfied, the physicians and caregivers are highly satisfied. And as a health system, you're going to have actually more access and actually greater profitability at the end of the day.

[00:17:57] Andy Mueller, M.D.: We think so. We've still got work to do to prove that, but we really think that's going to be important down the road for sure.

[00:18:03] Aaron Bujnowski, DSc, FACHE: What outstanding. Anything else, David?

[00:18:05] David Shulkin, M.D.: Just trying to think through the implications of this and whether this ultimately gives patients more control of their health care dollars and their decisions. And you've heard the president sort of float this concept of, well, let's have the patients decide where they spend their healthcare dollars, not necessarily the payers. And I wonder whether direct primary care is a beginning of that type of trend.

[00:18:33] Andy Mueller, M.D.: Yeah, I think so. And again, I want to make sure you think there's a difference between direct primary care and trellis. But I think that at its fundamental core, David, you practice Primary care medicine. Why would you pay a primary care physician, app or team in an acute transactional, episodic manner for maintaining a longitudinal relationship?

Amazon figured that out with Prime. Right. Why are you going to pay me to download a movie or ship a product when really we should have a longitudinal relationship through a subscription based payment model? It just makes too much sense. And so I think at some level we've got to recognize that for primary care, break the mold and begin paying them that way. And we had a conversation earlier around, well, you're not really taking risk with Trellis. I would argue in some ways we're taking full risk with Trellis because if we aren't showing the savings, it was going to pay the subscription. If you weren't getting value from Amazon prime, you wouldn't pay the subscription every month. And so we think that this is an incredible way to put ourselves at risk for the performance of Trellis. And in addition to that, we're holding it accountable not only for the patient experience, but the quality and safety outcomes to ensure we're delivering high quality care at the same time.

[00:19:45] David Shulkin, M.D.: Great.

[00:19:46] David Shulkin, M.D.: Well, thank you for sharing it.

This is a big idea and we're definitely following what you're doing and I hope others are going to innovate the way that you are.

And with all the changes going on right now, new models of primary care really are needed and it's going to be an important part of the story as this rolls out. Yeah. So thank you.

[00:20:07] Andy Mueller, M.D.: Yeah.

[00:20:08] Aaron Bujnowski, DSc, FACHE: Thank you very much.

[00:20:09] Andy Mueller, M.D.: Pleasure being here today. Thank you both.

[00:20:10] Aaron Bujnowski, DSc, FACHE: Thank You.

[00:20:19] Narrator: Alvarez and Marsal Leadership Action results.

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