[00:00:01] Edmund Pribitkin, M.D.: Virtual care has become really part and parcel of the way that we serve our communities. It's a way that we engage with patients that they truly appreciate. That's really been the change since COVID because before there was a little bit of hesitancy on the part of the doctors and also hesitancy on the part of the patients, but now it's basically like everyday care.

[00:00:28] Narrator: Welcome to AM Healthcare Industry Group's what's yous 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.

[00:00:45] Seth Ciabotti: Hello and welcome to what's yous Moonshot Podcast series. I'm Seth Ciabotti, Managing Director of A&M's Health Industry Group, joined by co host Dr. David Shulkin, the 9th Secretary of the US Department of Veteran Affairs. We're delighted to have our speaker, Dr. Edmund Pribikin.

Dr. Pribitkin serves as the President of Jefferson Medical Group and Executive Vice President and Chief Physician Executive of Jefferson Health at one of Philadelphia's largest health systems. Jefferson health consists of 32 hospitals and nearly 6,000 beds. More than 20,000 physicians, practitioners and nurses in 50 plus outpatient locations and a managed care health organization. In his role, Dr. Pribitkin develops and implements strategies for growth.

He's a full professor of otolaryngology and head and neck surgery, also boarded in facial plastic and reconstructive surgery, specializing in thyroid, parathyroid and rhinoplasty surgery. And he has more than 100 peer reviewed publications. Dr. Pribitkin, thank you for joining us today.

[00:01:44] Edmund Pribitkin, M.D.: Absolutely, my pleasure.

[00:01:46] Seth Ciabotti: So, we're going to start right off with what's your moonshot? And how are you doing with your moonshot? And so how has virtual care evolved since the pandemic?

[00:01:55] Edmund Pribitkin, M.D.: Well, 3 million visits later at Jefferson, at least, virtual care has been part of our DNA. It really shouldn't necessarily be called virtual care, because care is care, and the truth is that you can deliver it with many different modalities. But virtual care has become really part and parcel of the way that we serve our communities. It's a way that we engage with patients that they truly appreciate. That's really been the change since COVID because before there was a little bit of hesitancy on the part of the doctors, and also hesitancy on the part of the patients. But now it's basically like everyday care.

[00:02:36] Seth Ciabotti: Oh, great. So great segue. So how do you feel virtual care will be in the next three to five years? Where do you Think it's going to go well.

[00:02:44] Edmund Pribitkin, M.D.: I really think that you're going to see more and more virtual care because you're going to be able to deliver care in ways that the consumer really wants. And one of the big things that has happened over the years is that you have an asymmetry of care in medicine. So, you have this asymmetry which is bidirectional. Actually, doctors know more about medicine than patients, but patients know more about themselves than doctors. Well, over the past decade, what we've seen, and with AI is that patients know more and more about medicine, sometimes even getting to the point they know as much as their doctors. But what is really interesting that is happening is now doctors are starting to know more and more about patients

because they have access to their Apple watches, their Aura devices. All of their lives actually are being recorded and shared with doctors in ways that they were never shared before. Remote patient monitoring is not so much a gimmick anymore, but it's actually a device driven, technology driven ability now for the doctor to know the patient better. And so, I think that you'll see more and more of this come into play. The real key to virtual medicine, honestly, is being able to take something where you have the resources in one area, but you're scaling it to a much larger area. So, it's really about equity and growth and providing care.

[00:04:21] Seth Ciabotti: Great. Going a little bit farther with the technology piece you mentioned remote patient monitoring. What about AI?

The layering on of AI and maybe more than the layering on of AI. But where does virtual care go with AI? Where do you think it could go?

[00:04:37] Edmund Pribitkin, M.D.: I think it's very exciting.

What we do as physicians is we take data, information shared with us by the patient, and we use that to extrapolate diagnoses and workflows.

So, imagine that you're not feeling too good and your Aura ring is finding that your oxygen levels are dropping, your respiratory rate on your smartwatch has gone up, and you've got a little bit of pressure in your chest. How cool would that be if the AI in your smartwatch elsewhere would say, looking at your EKG that we see, looks like you may be having a heart attack.

You know, get to the hospital, call 911. It wouldn't be so cool if it called 911 for you. You know, why do people die of heart attacks? People die of heart attacks because they don't know that they're having a heart attack.

My father died of a heart attack. My mother called me and he was already gone. He had Called his doctor and his doctor had said, I think it's your peptic ulcer disease.

Imagine if the AI in your devices can really say, no, you better get to the hospital, lives will be saved. So these really exciting.

[00:06:08] Seth Ciabotti: AI is the connector of these devices?

[00:06:10] Edmund Pribitkin, M.D.: I think so.

[00:06:11] Seth Ciabotti: Be able to help connect and then even connect to outside?

[00:06:15] Edmund Pribitkin, M.D.: Yeah, I really think so. I think, you know, what we need to do is to enable our AI to develop this ecosystem. And I'm not saying to replace the physician or replace the nurse or the EMS folks. What I'm really saying is enable it to happen faster. Enable us to build a safety net around people so that, you know, the tragedies don't occur. Not that you're going to be able to manage everything, but the AI is going to help you to get the care faster to the people that need it. You know, and that's just one component, right? AI is just one component of the way we do care. At Jefferson, we've had a number of very successful launches that deal with not, not the emergent care, but the anxiety that is around care. So, about a third of Google searches over the weekend and at night relate to health care.

People are very nervous about what they're going to do with their health. And, you know, we started a same day, next day program which is all virtual care, so that if someone is worried they may have gotten a cancer diagnosis, they may be worried they have cancer, they can schedule an appointment same day or next day with any one of our advanced practice providers that are trained in all of the National Cancer Institute guidelines, workflows for cancer. And so within essentially hours, they can talk to someone to relieve their anxiety, write for all the tests that they need, and see an oncologist or a surgeon or whatever. So, we've done over 100,000 same day, next day cancer visits. And the response has been uniformly positive. Because imagine sitting at home with a cancer diagnosis. What's even more interesting is, you know, where most of these cancer diagnoses come from?

The ER and urgent care people go in, they get a chest X ray, they get some kind of study, and the next thing you know, and you came in for pain in your stomach, and you've been diagnosed with a cancer. I mean, you used to have to wait to see a doctor. Now, same day, next day, boom, you're now in the loop, your anxiety is relieved. We've done a great service to the patient and it's all virtual, you know, so these are the kinds of things where you're using virtual to really Solve problems.

[00:08:47] Seth Ciabotti: So here you say cancer. Virtual care emerges from urgent care. Are there any other specialties that are. Are weaved into your virtual care program?

[00:08:56] Edmund Pribitkin, M.D.: Yeah, I mean, the. One of the things is to look at simple workflows that can benefit from virtual care.

So, we designed the Honickman building, which is a building to bring all of our medical specialties together in Philadelphia. One of the things we did was we said, how does this building serve the most vulnerable among us? What, what is the challenge that a person who can't hear very well, a person who can't ambulate very well, a person perhaps on the spectrum, what are their challenges?

How can we address those? Is there anything we can do virtually that might be able to help?

And so we came up with virtual checkout.

Virtual checkout is a system by which the people come in, they see the doctor in the room, and then at the conclusion of their visit, instead of going to the front desk and waiting in line and maybe not hearing with the background noise, or maybe having to stand there when it's hard for you to do so, or maybe being on the spectrum and not being able to really deal with the front desk and the situation which many people encounter, you're checked out in the room. How does that work? The doctor hits a button that says virtual checkout.

Our statistics. Within 18 seconds, one of our enterprise central schedulers comes on the screen, schedules all of your appointments that the doctor has requested, confirms that your prescriptions have been delivered to your pharmacy or in the building, and then within 2 minutes and 40 seconds, you are on your way out the door. Never stop at the front desk.

Think about how wonderful that is for the person that has challenges.

And you know what?

We can do it in 235 languages because we have a system that allows you to communicate with the checkout person in any one of those languages.

[00:11:05] Seth Ciabotti: That's a moonshot. I have not heard of that.

[00:11:07] Edmund Pribitkin, M.D.: Yeah, really, it's changed the way we've done.

[00:11:09] Seth Ciabotti: That's fantastic, dude.

[00:11:11] Edmund Pribitkin, M.D.: Yeah.

[00:11:12] David Shulkin, M.D,: Ed, you're telling a story that's very different than the one that I hear out there.

During COVID of course, everybody quickly gravitated towards virtual visits out of necessity. But once COVID was over, it seemed that most people went back to in person care rather than virtual care.

And even the payers have become much more restrictive on paying for telehealth visits. We're now in the midst of a government shutdown, where actually the telehealth regulations have completely been suspended, except for behavioral health care. In telehealth.

So how does your vision and these tremendous capabilities that you're describing, how does that interface with the reimbursement system and the business models that you see?

[00:12:00] Edmund Pribitkin, M.D.: It's absolutely a wonderful question.

And the truth is that we made a very firm decision at the start of the government shutdown that we were going to continue providing virtual care. We may never be paid for that care, but what I will tell you is that is the right thing to do. We need to keep moving forward because patients would like it, doctors appreciate it, and ultimately, it's better care.

I'm not saying that virtual care is better than in person care, but what I'm saying is that it can be quicker. It can bring the care to the patient in their own home. There are many areas where virtual care is going to be what needs to happen in order for healthcare to be successful.

And payers and the federal government have got to get behind this. You know, whatever we can do to let this happen, force it to happen, we need to do. Why healthcare today bricks and mortar healthcare is unsustainable.

You cannot run a system like Jefferson's and keep opening big buildings like the Honickman Center offices everywhere. You just can't do it. And there's no way to break that cost curve. You can't say I'm just going to have 10% less employees. I'm going to put AI everywhere I can. It's not going to be enough. What you can do though is you can take physicians and you can have them do telemedicine and virtual care at a fraction of the cost, bricks and mortar, etc. That you would if you were trying to grow your enterprise.

We have endocrinologists that don't see patients in person. We have headache doctors that rarely see patients in person. There are many specialties and every time you take a specialist like that and you turn part of their day into virtual care, you create that office space for another physician and you haven't really increased your marginal costs, you know, so, so I. It's the only way that we're going to be able to provide care for our communities.

[00:14:31] David Shulkin, M.D,: Well, let's talk a little bit about that. You know, as I mentioned, you know, federal government not paying for it right now, a lot of the commercial payers cutting back on paying for telehealth. Jefferson now owns a health plan. Jefferson also has tens of thousands of employees in the self-insured plan.

So, what are some of the financial incentives that Jefferson is doing to try to encourage the use of telehealth well.

[00:15:00] Edmund Pribitkin, M.D.: Again, I think you're bending the cost curve like I talked about. You know, when you have physicians that are able to see folks virtually, it just costs a lot less than when you see people, people in person.

In addition, what we do is there are areas where we need to manage care better. So, if you can have a continuous engagement with the patient, what we've started to do is to do really visits with the patient within seven days of discharge in order to prevent that patient having coming back into the hospital. So, when you're able to do that through telemedicine, you're not actually going to be paid for that anyway, right? There's a global period, let's say if you have surgery or something else while you're in the hospital, so the visit with the physician isn't paid, you know, but if we can get that visit done through telemedicine and a less expensive and a more continuous type of engagement, then we can prevent the readmissions and the complications that come from sending somebody home and saying, hey, I'll see you in a week or two in my office.

That's not ideal care. In the future, we're going to have folks that are actually going to be monitored when they get sent home, but at the very least we can start that engagement to call the people to get them in to be able to do the virtual visits that generally don't get done.

[00:16:38] Seth Ciabotti: So just to go on a little further, we're seeing a lot of employers with health systems that have, have a health plan and even, you know, part of larger universities. So AMC is they are offering virtual care for their employees as, as a free. As a free service.

[00:16:53] Seth Ciabotti: Is that something that is. Is within Jefferson's health system?

[00:16:57] Edmund Pribitkin, M.D.: So we pay for it, right? There are employees. So essentially it becomes that way. You know, I mean, we're paying for it. So essential something that we want to do another really cool program. We have GLP1s fantastic, right? People lose weight, etc. Huge demand, no capacity. Right. I mean, it's really hard to get in to see an endocrinologist and give you a GLP one. It's hard to see your primary care doctor to do that. And a lot of times what we found early on was that they were being written for, shall we say, sort of borderline indications.

So what did we do? Under the leadership of our primary care doctors and with the help of our chief virtual care officer, we designed a system by which we would do virtual care for all our employees that are interested in getting GLP1s.

So, they actually get put into a virtual care visit with one of our nurse practitioners. We now have about 13 or 14 that do this and they go through the entire patient history, they look at the weights, they do everything, all the indications, and properly Prescribe not only GLP1s, but nutrition, et cetera, and they manage altogether the patient. And what we found actually is that we have decrease in the prescriptions that are inappropriate for GLP1s. We have very satisfied folks, and we've gotten the employees in to see the APC or the physician without taking a day off of our work, which saves us workforce dollars, and that they're very, very happy because their questions have been addressed.

So, you can make this part of a broader plan and you can look at those areas where you have gaps and where virtual care gives you solutions. You know, our chief virtual care officer does not report to it. They report to leadership, to us. And you know, Judd Hollander likes to say, if you've got problems, we have solutions. And that's essentially the way that we look at it. We look at these gaps in employee health care, we look at these gaps in terms of treating vulnerable populations, and we try to solve it in a different way with, with virtual care. That's been the way that Jefferson has looked at this and the way that we're going to continue to do this program.

[00:19:34] Seth Ciabotti: Sound amazing. Is there the future for Jefferson? Is there one place in virtual care that you think this is? It's one of your ideas and it's where, you know, this is in the next couple of years, you want to… Try to make it go there. Just a big idea of virtual care for Jefferson. Not that you haven't done that a lot already. Yeah, but like, what's the next big idea coming out?

[00:19:52] Edmund Pribitkin, M.D.: Well, I think we talk a lot about taking these devices that are technologically enabled to give information to the doctor. And I think that's going to be the next big thing for Jefferson. You know, we also have a lot of areas that we're looking to see: Can we bring this technology in as an ecosystem?

So, you really don't want to just have a one-point solution, a one trick pony. What you really want to do is build an ecosystem around a series of solutions. And that's what we're trying to do with Jefferson. We want virtual checkout everywhere. We want virtual tele-triage in the emergency rooms and urgent care everywhere so that people actually talk to the nurse virtually or the intake individual virtually, and they get their MRI before they actually see the emergency room doctor, we actually had that happen last two weeks ago. Lady came in, did a virtual triage visit and they said, well, gee, you've got some pretty serious symptoms if you can't really walk and you've got pain down your legs. And they actually got their MRI before they saw the emergency room doctor. They had cauda equina on the MRI. They were in the operating room that day.

They might have been paralyzed for life, you know, so I think there are lots and lots of situations like this. And what you have to do, what Jefferson has done is we've said, you know, this is a way of delivering care that is going to be part of our DNA. This is not a one trick pony. This is just a point solution. And as we partner with other companies, as we partner with AI technology, as we build out some of our intellectual property, we're going to get better and better at this. And yes, it really has to be something that is built into--This is another solution. Let's not build another medical office building in this area, let's actually build a virtual medical office there. Let's

figure out ways where we can do films in one area and have them read all across the system. Cytology, you know, let's have a woman, instead of coming in for a Pap smear, do a cervical smear herself and then have that read by the cytologist, you know, and never see the doctor, so to speak, but yet find out that, oh my goodness, the Pap smear is suspicious, that I did myself for a cervical cancer and then all of a sudden immediately get a same day, next day visit and perhaps find something early that is now taken care of. And you've done that all virtually up until the time where you actually need the treatment.

How much does that save over the course of a year, two years, three years of delivering health care? That's why I say this is foolishness on the part of the payers. It's restricting care that can save lives. And so, we're committed to continuing virtual care for honestly, all of our communities and patients and you know what, the doctors and the nurses and the nurse practitioners, we've all become used to it. It's part of our toolbox.

And I think that that's what I would love in five years that, you know, it's no longer any podcast on virtual care in and of itself. It's just part of the ecosystem. Everybody accepts it, everybody knows what it can do.

And it's oftentimes the first step in delivering the right care at the right moment in the right place.

[00:23:56] Seth Ciabotti: I'd say that Jefferson's the innovation or the virtual care is just, it's amazing. mean, it's really. You're a leader, I would say, within the country.

[00:24:05] David Shulkin, M.D,: Oh, thanks for joining us today. Really appreciate your thoughts.

[00:24:09] Edmund Pribitkin, M.D.: Absolute pleasure. Maybe I'll come back in five years.

But I may just come here virtually.

[00:24:15] Seth Ciabotti: Yes.

[00:24:18] Edmund Pribitkin, M.D.: Thank you.

[00:24:27] Narrator: Alvarez and Marsal, Leadership Action results.

ABOUT ALVAREZ & MARSAL

Companies, investors and government entities around the world turn to Alvarez & Marsal (A&M) for leadership, action and results. Privately held since its founding in 1983, A&M is a leading global professional services firm that provides advisory, business performance improvement and turnaround management services. When conventional approaches are not enough to create transformation and drive change, clients seek our deep expertise and ability to deliver practical solutions to their unique problems.

With over 12,000 people across four continents, we deliver tangible results for corporates, boards, private equity firms, law firms and government agencies facing complex challenges. Our senior leaders, and their teams, leverage A&M's restructuring heritage to help companies act decisively, catapult growth and accelerate results. We are experienced operators, world-class consultants, former regulators and industry authorities with a shared commitment to telling clients what's really needed for turning change into a strategic business asset, managing risk and unlocking value at every stage of growth.

To learn more, visit: AlvarezandMarsal.com. Follow A&M on LinkedIn, X and Facebook.