Gray Miller
Video Transcript

Intro by Stephen Moegling
When I learned about Gray and Titanium Healthcare and the success that his firm has had, I thought, well, he must be on to something. Because great ideas no matter how beautiful they are often have a very hard time getting traction in health care.

Gray has been staring at some of the most complex issues facing health care today. We've heard about the rising cost of health care. We also know what it's like to work and help the sickest of the patients. And what Gray has done, is he's looked at these very complex issues and he has brought forward a very elegant, straightforward, simple solution—not easy—but simple.

And it is my great pleasure to welcome Gray Miller to the stage.

Gray Miller:
Thank you Stephen. And thank you Hailey Sault for hosting this meeting.

What he didn't say is that I started my career on a submarine. On a submarine. Can you imagine 130 twenty-year-old guys locked in a tin can for 90 days. For 90 days! So, we knew everything about the person next to us—every date they ever had, every family secret, everything else. So, looking at data for health care is a lot better than being underwater for three months, I can tell you that.

Interestingly, I've been a fixer of processes for most of my career. And it started on the submarine actually. So, a submarine is 300 feet long. If you can believe that. And so you had 130 people on the sub. But what we noticed was the logs were reflecting later and later the same event as we got from the front of the ship to the back of the ship. So, surface of the submarine happened at 9:20 in the stern, but it happened at 9:00 in the front. Well, how can that be? How can that be? Well, we realized that the clocks were later and later. So, the clocks in the bow of the ship were 9 o'clock, 9:10 in the middle, 9:20 in the back. So, as a future process re-engineer, I ask the guy, why are the clocks later and later. He said, Well, I don't know. I wrote the time down on this card and I set the clocks to the right time, I'll tell you that.

I think he's a CEO of a health care company actually.

But what I want to take you through is a very, very simple approach. Let me start with, the world's economy is about 80-trillion right? 80-trillion of which the U.S. has 25 percent of it. So, how many people here believe we have the best health care in the world? (pause for response) Not one of us. Okay. How many of us have seen a loved one be treated horribly in the system? So, we are from the most prosperous country in the world and we all think our system is a bit bad. And in fact, my stepfather nearly died because of just a domino effect of bad stuff. And so, I set up this company really just to give people a doc who without any kind of convolution is there to help them stay out of the hospital. That's it. That's it!

So, Titanium Healthcare. Because I was a nuclear guy, I like the element titanium. It's strong. It's the closest I ever want to get to a submarine.

But, I am going to talk you through what the company is all about. We'll walk through some global stats in health care, most of which you may have seen. But then we'll take the Titanium algorithms and how we identify those patients with multiple chronic conditions and specifically what we do to help them. And then results. Results talk, right? That's the point.

So, today we are a risk partner delivering better quality and lower cost. We started in 2016. We've got a million people being supported in Greater Los Angeles. So, I thought—you know, I live in Carmel, California, if anybody ever heard of Carmel? I know, smug bastard. It's a nice place to live, but when I was setting up the company I really thought maybe it would be San Francisco Bay area. But, I was out sort of rubbing up against everybody to see if anybody would actually jump into the concept and L.A. MediCal which is our version of Medicaid was the first one we got.

Oh man, Medicaid. Oh with all the behavioral. And the substance abuse. And homeless. It's going to be tough. And it's actually worked out to be the best experience of my life. So, I'll talk you through that.

So first, we are a company that provides a doctor to a patient who is at high risk of hospitalization. Again, we don't pollute it with fee-for-service. We give them that private doctor to keep them home. So, we do what is called a high-risk medical home. Post discharge patient management, so we catch them when they come out of the hospital and then help them get back to primary care. So, we will see them for 30 days and help them get access to all the social services, FQHC's we have a lot of in Los Angeles, behavioral health. We really see to it that when they come out of the hospital that they get a successful handoff to primary care.

We're hospital bundles. Do you know about the BCPIA bundles? This is a Medicare, actually one that I like, where they are forcing hospitals, voluntary now, to be responsible for spend, 90 days post-acute. So, it is an opportunity for hospitals who can manage a little bit like health plans to take money from the post acute spend episode and pull it into their P & L. But

what it really does is it holds them accountable for what happens after the patient is discharged. And so we are partnering with a hospital in Los Angeles to do that. And then annual wellness visits.

But let me start with the United States of opportunity. Because it is broken, but it is also a huge opportunity. So, this is the data that we have. So, we are that giant sequoia, that redwood off to the right. Unbelievable really when you think about it that we spend over 10,000 per person per year. It is an insane number. And none of us believe we have the best health care right? Not one of us. And yet we pay almost 2x. The next one in line according to this data is Switzerland … Norway …. You can read the list. But I want to pull out one or two of them that are particularly key. Japan. Japan is paying a lot less. They have the longest life expectancy in the whole world at 82. Now some people are going to say behavioral health, but the variation within the United States is huge too. And, we'll get to that. But you can see that we are prominent in our spend as Americans.

And really what's interesting is that the spend is getting worse. So we are spending more and more. We've got, what, 17 percent of our gross domestic product is actually spent on health care. And it's going to be over 20 percent by 2025—22 percent. So, you can see that the trend is not the way we want it, clearly. It would be all right I guess, if the outcomes warranted it.

But this is what I find interesting. So, life expectancy. So, if you spend a lot and you lived longer you would feel like—oh, okay, that might be all right. But you can see that we are distant. That Japan is actually 83 years or so and then we've got Switzerland, Spain, Italy all the way down to the U.S. of A. at 78 percent. It's going down. It's going down, and a lot of it is related to obesity.

This is the map though that is really I think very interesting. So, this is life expectancy by county. So, you really want to know how long somebody is going to live? Find out their zip code. We have a 20-year variance in life expectancy across our land. The worst is in South Dakota. The best is in Colorado at 88. But you really think about it in Oakland, where I'm close to, the flatbed is about 65 years old for life expectancy, the hills a couple miles away is 80, 84. So, it is phenomenal within a 10-mile radius that the life expectancy could be that much different.

So, we put a clinic in Palo Alto and we put one in San Leandro. And the difference in the way people could talk about their health was unbelievable. One population could talk about their LDLs and the trends and how they're exercising and they're reaching their desired heart rate and such and such and the other one had no health literacy whatsoever. And so our epidemic is really in the backyard.

So, with all this variation—66 to 86—with an average of 78 in our country and we're paying the most in the world by a factor of 2x, it is outrageous. It is outrageous that we in a developed country can put up with this garbage. Which is why I am here.

So, I already said this. Everybody comes into health conferences and they say the same kind of stuff, right? It's broken, listen to the customer, listen to the patient, design a patient process. The problem is, it's not that easy. These problems are easy to spot. You can walk into any health organization and you can see it. You know we have patients who are having blood thinners from their cardiologist, primary care, recent hospitalization. They don't know it, they're taking all three of them, their primary care doesn't know it because they've only spent five minutes with them and so the break just continues and that's really what we're resolved to fix. So, Titanium Healthcare, that element that I love so much.

This is a breakdown of 285,000 Medicare Advantage lives. And what we try to do first is to understand just by looking at 20-some-odd different chronic conditions, what's the total count of the number of chronic conditions that each patient has. So, the way to read this is that in a Medicare Advantage population that nearly 100,000 have no chronic conditions. How likely do you think that is? This is claims data on a Medicare Advantage plan. Probably not real. I mean at least hypertension—a lot of people have hypertension. But, according to this data, most of them don't have anything.

Then there's a guy in Houston—23 chronic conditions. How does that person survive in our health care system where primary care can give him five or ten minutes. They can't. They can't.

But more interestingly you can see that three-plus chronic conditions and how this thing tapers off. It's the cost. So, now take each bucket and then assign the total amount of cost to that bucket. In other words, people with four or more chronic conditions were aggregated into a total cost bucket. So, the people, the nearly 100,000 people, don't have any of the cost. Really. So the wellness programs could really be funded out of the people out here where all the cost is. I think we've all seen the statistic where end-of-life care is over 80 percent of the total cost, in the last six months of somebody's life. So, for us just to bring this home, we have a population of 8,000 people within 20 miles of the clinic, so 8,000 people, and they cost about 120 million a year. So, it is about 15,000 per person, per year. Eight thousand people is sort of hard to get your head around, 'cuz that's a lot of people. But, of the 8,000, 280 are 40 million of it. Three percent of the people driving a third of the cost. And, so we're right there. We're right there with those people and they live within 10 miles of the clinic. If you help those people get access to care, then the 40 million is reduced and then that will pay for some of the wellness aspirations that we talk about.

So, our model is fix the really, really broken stuff first and then pay for the wellness visits.

But in this case it is 80 percent of the cost really from 30 percent of the members, as you can see.

Again, this is a bit of motherhood and apple pie, until you get to what does the patient actually need in the visit. So, what we do is we map them out. So, we use a probability of hospital admission and we're trying to find out where to put the intervention, identify access issues to care, even patterns related to specialty availability, drug-taking and the other things that can really be leading indicators of hospitalization. But again with the view that we are really attacking these high risk of hospitalization people. This is the great state of Florida. Not California, but it does apply.

But, interestingly, now we get to the patients themselves. So, the person on the left could be my mother. Could be my mother. At 90,000 a year in total medical costs. So this is a person that is a lot more than that 15,000 per year average that I was talking about. This is 90,000. Drugs constitute 26,000 of it.

A 67-year-old male with 22 different chronic conditions. Is anybody familiar with the Johns Hopkins ACG? Yeah—Phil, you would. It's the probability relative to the large population that's being analyzed as is to how much more likely that person is to be hospitalized, in this case in six months. So, the way to read the numbers: this person is 16 times more likely to be hospitalized in the next six months.

Well, but what's going on with him? They got 22 different chronic conditions—16 times more likely. We look at pharmacy gaps so if they don't fill their prescription within the time that they should, if they were taking the drugs, then we call that a gap. So, if you don't fill it and you had 30 pills and a month went by and you didn't fill it, you didn't take your drugs. Now granted there is a possibility that the patient could not be taking their drug and flushing them or whatever else, but this person's taking their drugs. But, they've been admitted five times. Three of which were through the ED and two were readmissions.

So, they got out of the hospital, like my mother. They didn't understand their plan of care, might or might not have seen the primary care and they went right back in.

Anybody know what the national average readmission rate is? Thirty days for any cause, once a patient leaves the hospital? It's 20, 21 percent actually. Twenty-one percent of the time as a country, we discharge somebody from the hospital and readmit them within 30 days. How? Why? Why is that even remotely acceptable?

So, this person was readmitted twice and they've got heart failure, depression, diabetes, cholesterol, hypertension, the usual suspects. The usual suspects. And they're just not getting the care they need. So, what do they do? They go to the ED. And the ED knows how to admit them. And so the wheel keeps spinning.

The woman on the right is even more compelling. One-hundred-and-sixty grand a year in cost. Drugs are 20,000 of it. Twenty-one chronic conditions, more likely to go in the hospital. Seven admits and you can see the list. By themselves not anything extraordinary, but in the aggregate, because there's so many different chronic conditions it's just a kind of patient that many primary cares just don't have the structure to easily support.

This is a patient who might show up on a gurney in the primary care office or require an hour-and-a-half of medicine reconciliation, family issues, coordination. And so that's what we're really resolved to do is give them what they need. Here's your doctor. Here's their cell phone. How many people have their doctor's cell phone? Call me if you need it. That's a great doctor. Right? And I'm not bashing doctors. It's really about giving them the opportunity to care for their patients in the way that they always wanted to do anyway. I mean how many doctors wanted to work in EMRs and see five minutes a patient, 25 patients in a day? Not very many that I know.

But anyway, what you can see is that this is the kind of patient that is failing in our primary care system. And there's this hole between the hospital and the primary care and in that dearth of support is our model.

But if you imagine a spreadsheet that was 285,000 people wide. So, remember we started with 285,000 people. We can analyze them for all kinds of different things. The risk score, the number of pharmacy gaps, look at the fourth column there, this guy. Sixty-six-year-old person. They've got 10 pharmacy gaps in the last year. They're not taking their drugs and if you look at some of these chronic conditions—CHF, they're in treatment for CHF and they're not taking their meds. Well, that's kind of predictable. You don't even need the Johns Hopkins ACG. You know what's going to happen. That person is going back in the hospital.

So, anyway, we really try and give these people the level of support, not that they need—but that they deserve. As if they were somebody we cared about, like my mom.

So, how have we done? Well, you know it's a relatively new company. We've got five locations. Three of which are full-time in Los Angeles. And, so far, we're pretty proud of it. Some of this is predictable and some of it was kind of a pleasant surprise. Costs are down by 23 percent. That's good. Obviously if you take that across the board that means that that 10,000 per person, per year is now 7,500. So, you just alleviated a lot of the financial burden on our system, to make those original trends look better.

Revenues. So our visits are actually 50 minutes. So we'll schedule about ten patients in a day. And, this is the one I didn't really, I didn't plan on. And that is because we have access to the hospital course of treatment and we have so much time with the patient, we increase the RAF scores by 30 percent.

Everybody familiar with RAF scores? So, basically the way the revenue is calculated for these plans and IPAs is that every patient has what's called a risk adjustment factor. And so it's a base rate times this risk factor, which basically gives the plan more money based on the illnesses and the documented problems with a patient.

So, a 30 percent increase in RAF score will increase the revenue to the plan by 30 percent, so that 10-grand a year becomes 13-grand a year. It's a really big deal in the revenue model to make sure these are captured very accurately.

The other thing that happens is if a patient goes more than one calendar year without documenting their problem, they lose the RAF score. So, every year in the last quarter there is this frantic need to get these annual wellnesses. Oh man, we're going to lose our RAF and then we're really screwed and all of our CAP checks are going to go away. So, we had a plan. Dump 2,500 of them on us and say can you get these patients in and do their annual wellness visit. But the 30 percent is real. Because it is money that would otherwise not be available.

This is the one I'm most proud of. I would like to spend just a second on it. So, we have a clinic that's a mile from skid row. Skid row is in Los Angeles, so there's 45,000 homeless people in Los Angeles. Twenty-two thousand of those are our patients. And you know what I would have said is that they would be horribly noncompliant. They are actually pretty compliant. And grateful for the fact that a doc would spend 50 minutes with them and exhaust their questions. I mean grateful to the point of waxing lyrical on their way out. And, you know it matters. It matters. And, I would have thought they would have been the least compliant of all. But they've actually been really good. One-point-seven percent, we started out 18 percent across 200,000 people in this population. And that one percent is the ones that we can get in. So, I will tell you that. But the global rate has gone from 18 percent to 13 percent. We've got to get the other ones in. And, so we're doing everything we can to get bedside with them, to help them get access to this care. Because in the end, if they don't get the care, they go back to the hospital and the whole thing cascades again.

ED visits and acute admits. So we're not a primary care. We really are a specialty practice that exists to help people land from their high-risk setting back to primary care. While they see us, it's a little like flying first class, I think. Once you've flown first class you really don't want to go back into economy. I say that as somebody who is just about to pass a million miles on United. A million miles at 400 miles a hour, that's like a 110 days of my life being abused by United. Anyway, I digress.

When they're with us though, their speciality visits and their primary care visits go down dramatically. But we co-manage to make sure that the primary cares are never displaced in this process, so they get our medicine reconciliation and a whole summary wrapped in a bow.

Because a lot of the primary cares, they're trying to get through, and what they need is to be able to lateral a patient to us, have us clean them up, and then get them back. But while they're with us, those visits go down pretty dramatically.

So, lastly you know when we started the business there was a couple practices in L.A. and it's kind of funny because one client of ours said, we'd like to call it the IOC. So, we're going to get these patients who are in the hospital who are identified as being at a high risk for readmission, we're going to call it the Intensive Outpatient Clinic. And I was thinking of my mom and thinking well, mom we're going to take you from the ICU to the medicine floor and then we're going to send you to the IOC. I could just hear her and she lives in Ohio and I could hear her. We wanted people to feel special. Because you are special, because you meet this special set of criteria that we are going to give you a private doctor to help you deal with all your multiple chronic conditions.

And, we've run about 170 surveys on patients and I know this is going to sound not believable, but we've only had I think two of them who wouldn't refer family members into the clinic. And one said just because I don't refer anybody. But we've never had less than a four out of five on overall satisfaction.

So, it really is I guess for me again as a submariner who came into health care thinking wow, well it must be pretty consistent because we've been doing it a long time. To come into health care and realize that it's just this human thing, it's not the telehealth and the screen, it's actually a doc who will sit with you without being in a hurry, uninhibited by the reimbursement models, who can have access to some technology to ferret out some of the risk factors, who can keep them home a lot more. And 1.7 percent on MediCal says that the model works. So, now it's a question of how can we take it and give people the care we want for our mothers and our fathers and our kids and our loved ones.

Anyway, that is a quick overview of Titanium Healthcare and ... alright.