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Top Listened to Industry Professionals Interviews from 2020

Trisha Talbot:	00:00	Welcome to the last episode in our series of episodes, featuring the top listened to interviews of 2020. We've listened to the top interviews with clinicians. We've listened to the top interviews with healthcare real estate investors. And this week, our episode features those sharing good information or advice on the healthcare industry, real estate or entrepreneurism. In episode two, we hear from commercial real estate veteran Pete Bolton of The Pete Bolton Company. He shares strategies on how to approach The Great Lockdown from an entrepreneurial perspective. David Berg, Chairman and Co-Founder of Redirect Health shares with us in episode five, how he created his company to allow small and medium-sized businesses to provide affordable healthcare to its employees. Episode three is the second part of the interview with Pete Bolton where he discusses how his question listening and expansion training can help physicians listen better to key words, to help ask more specific questions when diagnosing patients and how this is so important as telemedicine becomes more prolific in healthcare. The next few clips are from episode 33 and 34, where I interviewed Vini Singh, Assistant Professor in Resource Economics at the University of Massachusetts Amherst, where she shares economic statistics of our current healthcare system and some thoughts on how we might be able to improve efficiencies and costs. I look forward to returning with you to our regular format in next week's episode.
Trisha Talbot:	01:27	This is the Provider's Properties and Performance Podcast, the podcast that brings together leaders in healthcare and investment real estate to consider the possibilities and future at the intersection of practicing medicine and healthcare real estate investment returns. Welcome to the Providers Properties and Performance Podcast. I am your host Trisha Talbot. As a Healthcare Real Estate Advisor to providers and investors, the best solutions occur when the two collaborate together as partners in delivering better patient care. Providers can deliver care to their patients when and where they need it. And investors realize the returns to build and manage facilities. We explore changes in medicine and wellness, the future of healthcare and using real estate as a strategic and financial tool.
Narrator:	02:09	Episode Two: The Great Lockdown. Rethink, Regroup and Recoup.

Pete Bolton:	02:15	There has never been a shutdown of business and virtually every business, even during The Great Recession. That's never happened.
Trisha Talbot:	02:26	In this two-part episode, we hear from commercial real estate industry veteran, Pete Bolton. In the first part, we expand on his editorial in episode one with his strategy on how to approach the current economic downturn he calls The Great Lockdown. We further dive into his experience with other downturns and his outlook of a post COVID-19 economy. The second part of the episode, we discuss the Pete Bolton Company and his executive coaching services and QLE training, where he teaches executives and professionals, the benefits of listening and asking clarifying questions. I asked him to discuss how QLE can benefit providers when asking questions to help better diagnose their patients.
Trisha Talbot:	03:07	In today's episode, I welcome Pete Bolton, President of the Pete Bolton Company, offering executive coaching using tools to improve communication skills, allowing professionals to change the behaviors and build strategic plans to get on their next career level. I'm very excited to have Pete as my guest. Thank you, Pete, for your time.
Pete Bolton:	03:24	My pleasure.
Trisha Talbot:	03:26	Pete, I want to first discuss the editorial from the first podcast episode, discussing your perspective on the current economic downturn as your eighth, as you said. And then I want to dive into the tools you use with coaching executives to improve professional performance, specifically QLE, and then how the audience can, in the healthcare real estate industry, may use this to implement some post COVID-19 strategies first, but then get to their next career level as the ultimate goal, no matter what situation they're in. So, I want to start with sharing with the listeners where you were in your career during some of the other downturns.
Pete Bolton:	04:03	Oh my. Well, there's been so many, Trisha, that you've forced me by asking me to do this, to go back and look at how many I've been through. And I think I sent you a message on this. I have been through eight of these. Now, nothing like the most recent one, but all the way from gas lines, waiting in line during the embargoes from Iran and Russia, et cetera, to the RTC days, which commercial real estate literally disappeared. And you can go on and on and on. And then of course The Great Recession and now The Great Lockdown, as they call it, which I think is an absolute appropriate term. So, how is this like the rest of them? This is completely unique. There has never been a shutdown of

business and virtually every business. That's never happened. Even during The Great Recession or the RTC days, it affected commercial real estate tremendously, but obviously other businesses were still productive, so to speak. So, this one has been very unique and I think we'll see from the very interesting laws that have been broken by governments here that this will prove to change America substantially, unlike the other ones. And I could go on and on, on that one, but I'll take your lead.

Trisha Talbot: 05:49 Well, you mentioned that the other ones, as you do said here, and also in your editorial that there was some causation, there was some tangible causation of the other downturns and this one, there's this intangible fear. Do you think we're past the panic stage and starting to reach the stage of courage, even though I'm not sure there's any more certainty than any other point other than this will pass?

Pete Bolton: 06:15 With any of the other ones, the only fear we had was losing jobs. Everyone could back up and go to work Costco or go to work at McDonald's or do something. But when you are in a mandatory lockdown by governments, that changes the scope of everything. And then what happened is after about two weeks of this lockdown, that fear started to set in, and that was absolutely the coup de gras for Americans and business. I've never seen this country act like this, and frankly, so much of it is unnecessary. And frankly, it's depressing to see how people have been divided on this issue. So yes, this caused an unprecedented amount of fear that has never been witnessed in my decades in business.

Trisha Talbot: 07:20 Well, when do you think people will be able to develop courage from this fear? When do you think we'll turn the tide and go from starting to create courage to squash out the fear or another emotion, but I think I'm thinking courage is the only thing that can, but what thoughts do you have?

Pete Bolton: 07:39 Yeah. Well, there's a great saying out there that says, 'you never go to war with the information you need. You go to war with the information you have.' And so consequently, we went to war with all kinds of different information, different information from the doctors. And one of the things I lamented after two weeks of this, as I said, this country is no longer being run by government and by the people and the media did such a wonderful job of inducing fear into so many people that if there's a finger to point anywhere it's that group of individuals. It started out from an informational standpoint and then it went to 'how sensational can we make this?'

Narrator:	08:32	Episode Five: Using Healthcare Real Estate to Provide Affordable Healthcare. Part One of Two.
David Berg:	08:40	I want all of our clients to be able to confidently provide free healthcare to their employees and their families in such a way that it costs very little or nothing to the employer.
Trisha Talbot:	08:53	Today's episode is the first of a two-part interview with David Berg chairman and co-founder of Redirect Health. David shares with us how his company allows small to medium-sized businesses provide affordable healthcare to its employees. David elaborates on how he used real estate as a financial tool and technology investments to continue enhancing Redirect Health's operations. Next week in part two of this interview, David describes how Redirect Health was already positioned to effectively absorb and manage patients with COVID-19 and where it is heading in the future.
Trisha Talbot:	09:25	Today I'm grateful to interview David Berg, Chairman and Co-Founder of Redirect Health. Please listen, as we hear the Redirect Health story from David and how its real estate strategy helped it achieve its operational goal of providing affordable healthcare. Thank you, David. And I will just let you tell the story how Redirect Health came to be and what inspired you to create it.
David Berg:	09:47	Hi Trisha. So, what inspired me to create it? I guess it comes down to, I had a business to run and I could not find affordable healthcare that I could afford to buy such that my employees can afford to use it. And so, there was nothing useful on the market for me. And after years of asking for it, nobody would create it for me or it didn't exist. So, I just built it on my own. And I built it slowly, such that it met all our needs, whatever they were. Many of our employees may $13, $14 an hour at that time. And of course, there were some others that made more than that, but we had to find a solution that they could afford the monthly payments for, I could afford the monthly payments for that when they did see doctors, they could afford the co-pays and the deductibles. And when somebody makes $13, $14, $15 an hour, they don't usually have $500 in savings. So, what good at that time was a thousand dollars deductible. Well, today they're $5,000 deductibles. What good are they? They're useless for the majority of American workers. So, I just created it on my own.
Trisha Talbot:	10:51	Can you explain the self-funded insurance model of Redirect Health?
David Berg:	10:56	Yeah, sure. Self-funded just means that it's a platform that allows the flexibility that's needed in order to provide the right care that

people need with the right logistics, the right timing and at the right price. So I see self-funding as just a really good platform, but I've seen more self-funded plans that are just garbage. They just don't work because they're not designed right. They're not engineered right. So, as much as being self-funded is important, it is only a platform that allows the flexibility and it allows the purchaser and the user to get what they want out of the system. In a non-self-funded environment, it really is impossible today for a business to get what they need for their employees, in my opinion. It's just like Microsoft Word does not write a novel for you, but it's a lot easier to write a novel via Microsoft word. Similarly, self-funded plan does not create a great health plan, but it becomes a lot easier to create a great health plan if you have a self-funded model. Plus puts you under federal law, which is the term is called ERISA, and there's a lot more flexibility there than there is under the state laws.

Trisha Talbot: 12:02 And your clients are small and medium-sized businesses.

David Berg: 12:06 Every one of them. They need us the most.

Trisha Talbot: 12:10 And your customers are the employees of these businesses. And these employees are also patients at Redirect Health centers.

David Berg: 12:19 Well, those are traditional words. And I guess the way we look at it is we create a collaboration between the business, the owner and the management and the employees. And so, if you want to, we'll refer to the businesses as clients and the employees and their families as members. So, there's the purchaser and the user, there's the client and the member. That's how we've referred to it. But those are just words. As far as the word patient, we really try to stay away from that word. We want all our members to stay members. When they become patients, that means something's gone wrong. We do not want our members to be patients. We want to help them not be patients. Think about as a family member, right? If I'm a dad and I'm a physician, I do not want my daughter, my son, my wife, my family members to ever become patients. And as soon as they become a patient, I am doing everything I can to 'unpatient' them. Now, that is so different than how doctors make money and hospitals make money and drug companies make money and insurance companies make money. So, it required a complete paradigm shift. Even the language is different. The philosophy is different. We do not want our members to be patients. But when they are, that's when we kick it into high gear and we help them become 'unpatient.'

Trisha Talbot:	13:33	So, would you say you focus on keeping your members well and preventing illnesses?
David Berg:	13:39	So as much as we can, but the biggest help that we give them is when they do have illnesses, to make sure those illnesses never become acute, they stay chronic, they don't affect their work, don't affect their health, they get the right medications. If somebody's got asthma, we want to make sure that they always have an asthma inhaler and they know how to use it, and they can always afford it and they never run out and they never have to use an emergency room. I don't want them to be a patient of emergency room.
Narrator:	14:05	Episode Three: Listening, Diagnosing, and Telemedicine.
Pete Bolton:	14:15	what I've learned over the years. There are very special words that our clients use, not just our clients, that we use. Words like 'maybe,' 'I think,' 'that sounds okay.' They're, non-committal, nuance words that we take as a definition of 'let's go forward.'
Trisha Talbot:	14:34	In this two-part episode, we hear from commercial real estate industry veteran, Pete Bolton. In this second part of the episode, we discuss the Pete Bolton Company and his executive coaching services and QLE training where he teaches executives and professionals the benefits of listening and asking clarifying questions. I asked him to discuss how QLE can benefit providers when asking questions, to help better diagnose their patients.
Trisha Talbot:	14:59	And as you know, in my world, my clients are in commercial real estate as investors or they're providers in the healthcare industry. And I remember when I first talked to you about this podcast, I said 'I think that perhaps QLE could be applied in the healthcare industry because doctors are, this was before we were all on the shutdown, but doctors, they're constantly being squeezed for time and they could use it to perhaps use that 15 minutes that they happened to be with a patient, and use it to be more effective with the patient.' And one of the things speaking to providers through this pandemic is, they've constantly said to me 'what do you think about telemedicine?'
Trisha Talbot:	15:42	And I said, 'well I think that there are certain applications for it, but obviously you can't perform surgery via telemedicine.' But some have actually said, 'well before, insurance companies, payers, they weren't paying for any telemedicine visits. So, we were doing them very infrequently.' But what has happened is that telemedicine has now become a necessity because they couldn't see patients in as much volume and they had to be, I think, more severe. So, do you see that QLE could be an

important skill that a provider could use to make the most out of a telemedicine visit and then translate it into being more effective in an inpatient visit?

Pete Bolton: 16:26 Absolutely. So, what separates a diagnosis from successful to possibly not successful diagnosis? And that is the doctor's ability to listen and take the time to listen to what a client is saying. And we've all got horror stories about somebody going in and talking about X, the doctor didn't particularly understand what they were talking about and the first thing they say is, 'oh, I know what's wrong with you.' And you start on that road and that road turns out to be completely worthless or absolutely detrimental. And the reason is, is because we didn't listen to the client, therefore we didn't diagnose the problem properly. So getting back to telemedicine, you better have some very well-trained people on the other end of that phone to listen to the nuance words that we talked about earlier in this podcast. Is that when somebody said, 'yeah, it kind of hurts over here.'

Pete Bolton: 17:35 Well, and people go, 'oh, really? What kind of hurt from zero to 10?' No, wait a minute. What do you mean by kind of? It either does or doesn't and then when does it, and when doesn't it? 'My back me, when I lift that 60 pound block that I have to move around every day on the machine.' But if they say it kind of hurts all day and you go, 'okay, that's great. Come on in, we'll get your brace.' Wrong. You're doing something that's going to kill you. So, the diagnostic tool is answering questions with questions and defining exactly what the client is feeling. And sometimes Trisha, they don't even know. They don't even know. Like you say it kind of hurts here. Does it hurt? Tell me about 'kind of.' 'Oh yeah, it really affects my back,' whatever it happens to be, 'or my shoulders.'

Pete Bolton: 18:34 Well, why would that be? 'Well, after I lift it, I have to turn sideways.' Maybe they would have never gotten to that if they weren't listening to those specific words. So, to diagnose over the phone, when you can't see somebody, you better have phenomenal listening skills and questioning skills, very, very important. And we're all interesting people truly, and the medical world is interested in their clients, but what you want to be is you're interesting as a doctor, a provider, et cetera, but you want to be interested in the correct diagnosis.

Trisha Talbot: 19:16 Well, they're human and they're trying to diagnose other humans. And if the other human is unclear and then the doctor doesn't know the right questions to ask, you can see that there could be a miscommunication issue, for sure.

Pete Bolton:	19:34	Absolutely. And the other side of this too, is the way you mentioned it earlier, how the reimbursement through the insurance companies is, and Medicare and Medicaid and all those things. You're not getting reimbursed for your time, specifically. So, the more it's quantity, maybe, quantity over quality. 'Oh, I've heard this one before. Okay, let's get this done. Go see this person. Go to physical therapy and get that done for two months and come back and see me.' So, it's just a lot deeper. And if you don't take the time to listen properly, then the misdiagnosis is probably very possible.
Narrator:	20:24	Episode 33: Healthcare's Cost Versus Quality. Where Are We? Part One of Two with guest Vini Singh, Assistant Professor in the department of Resource Economics at the University of Massachusetts Amherst.
Vini Singh:	20:42	You can't have it both ways. If you want to keep a capitalist, well-functioning market in healthcare, you have to have regulations to avoid it from spiraling into either caring for the richest people. So, it's really, again, distilling back to your values. What do you care about? Or the alternative is single pair, which I know for a fact, isn't very popular with a lot of free market enthusiasts.
Trisha Talbot:	21:08	This week and next week's podcasts are a two part interview with Vini Singh, an assistant professor in the department of Resource Economics at the University of Massachusetts Amherst with a PhD in Health Economics and policy. In today's episode, we discuss the current cost and quality of healthcare in the United States and where we stand with other comparable developed countries. We look at the current state of the ACA and how we might progress on the healthcare insurance front in the United States to reduce costs and improve quality of care. Next week, Vini shares some challenges the U.S. faces regarding the concept of universal healthcare and how information sharing, risk sharing and simplifying the reimbursement system are ideas that can help to reduce healthcare costs and improve quality.
Trisha Talbot:	21:51	Okay Vini, a warm welcome to the Providers Properties and Performance Podcast.
Vini Singh:	21:55	Thank you. Thanks for having me. I'm very excited to be here.
Trisha Talbot:	21:58	I'm excited to interview you. Like I've said, I have to say the recent American Health Policy in 2020 webinar that you and your colleagues prepared has been one of the most engaging I've seen addressing health policy and for our listeners, this webinar is now available on YouTube and I'll have it in the show notes. Being that you are a health economist, I'm really looking forward to

discussing with you what healthcare looks like today in the U.S., the current state of the affordable care act, what changes can improve cost and quality of care, and then options to consider surrounding health policy and ideas as we move forward.

Vini Singh: 22:30 Absolutely. Yeah.

Trisha Talbot: 22:31 So before we start, I just want the listeners to understand the value of your insights based on your impressive academic pedigree, your bachelor's was in Ecology and Evolutionary Biology from Rice University. You had a master's in International Health, Health Systems from John Hopkins University and your PhD in Health Economics and Policy from Emory university. So basically, you know what you're talking about, and we should listen to some of the research you've completed and your ideas on health policy.

Vini Singh: 22:55 I'll have some addenda to it later on.

Trisha Talbot: 22:59 Starting with what healthcare looks like in the U.S. today, I wanted to share the statistics expressed on the webinar. And these are high level. Obviously there are some more detailed ones. But currently the U.S. healthcare industry is 17% of GDP and $3.3 trillion. Rounding this up, It's almost 20% of GDP. So, one fifth of every dollar in the U.S. is spent on healthcare. On average, $10,000 a year is spent per person on healthcare in the U.S. On the quality side, I was surprised to hear the statistic offered on the webinar regarding the metric that tracks deaths preventable by treatment. And the U.S. is ranked 34. Compared to similar developed countries that do a form of universal healthcare, they spend on average nine to 11% of GDP, and $1.3 trillion. And their cost per person is $3,500 to $6,000. So in these countries, healthcare is approximately 30% less, I think is what I heard, for services and 50% to 60% less than the cost of prescription medication. So, if the U.S. spends all of this on healthcare, why can we not expect that the quality is better than these countries?

Vini Singh: 24:01 That is a complicated question. And people have actually spent their entire lives studying a very small part of it. And there's still research being developed on each of these parts. But I don't know if I can speak to why it doesn't translate to better quality, but there is definitely a very different system in the United States. And that's because of this tripod that drives healthcare and that's the way healthcare is provided and the way it's reimbursed. So, I think I mentioned in the webinar, I had an infographic, which showed that the three drivers, the central players in U.S. healthcare are the patient, the provider, and the

provider is usually the doctor or the hospital, and then there's the insurer. And the insurer is, there's two categories of insurers. The biggest insurer probably would be the government because they provide Medicare and Medicaid, but a very large insurer are like this hodgepodge of private insurance companies that also insure the process of healthcare provision.

Vini Singh: 25:07 So, because of this sort of like, it's very fragmented because the people who provide the care are not directly responsible for insuring it. And the insurers are on a separate leg that creates all these efficiencies that sort of lead to the prices of care skyrocketing in the U.S. compared to other countries. And people often ask 'why is the United States healthcare so expensive?' And the reason anything is expensive is either you buy a lot of it or the price of each thing you buy is really high. And while there's some evidence that the United States uses a lot of care, there's a lot more evidence that the price of care is so much higher in the U.S. And there's a lot of reasons for that. I can talk about it in more detail, but that's sort of one of the big reasons it's so expensive, but it doesn't really translate to high quality. It's just a de facto system that's put together, seemingly almost at random.

Trisha Talbot: 26:12 Talking about that, additional statistics was that the number of people that are uninsured and under-insured and privately insured and mostly through employers, so it depends on employment numbers, but 40% of the U.S. population, or 132 million is uninsured or under-insured. And for the under-insured can we assume that they do not seek care for preventative care and sometimes even chronic care and basically have insurance to cover them for only traumatic healthcare needs?

Vini Singh: 26:41 Absolutely. So, under insurance means that you theoretically have insurance, but it might as well just be catastrophic insurance, which is what happens if you get into a car accident. But sort of the day-to-day of what it takes to be a healthy person is largely denied with these individuals.

Trisha Talbot: 27:01 What it takes to be a healthy person.

Vini Singh: 27:04 Yes, it's so hard because especially in the United States, there's this thing, there's this concept where if you're in bad health, it's your fault. It's a moral failing. But all of us are going to, at some point lose our health temporarily or for a long time, but we're all going to fall sick. And especially in the U.S. Because of this conception about health, some people find it easier to stay healthy, and some people find it harder. That's, sort of what I mean by what it takes to be a healthy person.

Narrator:	27:41	Episode 34: Healthcare's Cost Versus Quality. Where Are We? Part Two of Two with guest Vini Singh, Assistant Professor in the department of Resource Economics at the University of Massachusetts Amherst.
Vini Singh:	27:57	And I also want to point out more sociological factors that prohibit us from being like other countries. People always point to Sweden and Norway and other European countries, or even Taiwan. And all these countries that seem to have great single payer systems. And it's because at a very core level in these countries, the populations are much more homogenous than the U.S. Everyone's white or everyone's Asian, or everyone's a certain way. And there's all this psychology and sociology research that shows that I'm more willing to take a tax to pay more if I know I'm supporting someone who looks like me.
Trisha Talbot:	28:32	Welcome back to the second part of a two-part episode with Vini Singh, an assistant professor in the department of Resource Economics at the University of Massachusetts Amherst with a PhD in Health Economics and Policy. Today, Vini discusses why the U.S. has challenges with getting its citizens to accept universal healthcare. And she shares ideas all aimed at simplifying our very complicated healthcare industry that can potentially reduce the cost and improve the quality of healthcare. In last week's episode, Vini and I discussed statistics about the current state of the U.S. healthcare system compared to other comparable developed countries, the current state of the ACA, and what is working and what still needs to be improved.
Trisha Talbot:	29:16	Do you see in your research some of the next steps in the ACA to make it more understandable for the layperson, or do you see some of the confusion surrounding it? I understand the paperwork to enroll is incredibly difficult to understand to do it correctly.
Vini Singh:	29:30	So, just healthcare by itself is so complicated that I just, I'm not sure what an easy system would even look like. I think Taiwan has a really good, one thing that could make it easy for everyone is sort of allow information sharing. Right now, my insurer has part of the information, the provider has part of the information. I don't have my own medical information. If there was like a central hub where doctors could see my medical background, even if I haven't been to that state ever in my life or that hospital ever in my life. CVS does it. I can go into a different CVS in a different state and they will know. They have my information. So, I think something that would make understanding this a bit salient to us that our healthcare is improving, the ACA could do

something like that. But the actual rules of the ACA or any healthcare bill, if it's easy to understand I'm not sure I would trust it.

Vini Singh: 30:36 Just because then it could mean that it's just blanket applying rules to people, and there's just too much variation in needs and how rich people are and where they live and what they believe in, and where they're getting their care for it to be, so, yes, maybe it would make you understand it better, but I think people would be unhappier because they would just be like, 'well, this doesn't apply to me.' Lots to do. I really don't want to say that the ACA is perfect, far from it, but it's not the destination, is how I think of it. It's like one imperfect step towards,

Trisha Talbot: 31:17 a bigger goal.

Vini Singh: 31:19 Yeah and I also want to point out more sociological factors that prohibit us from being like other countries. People always point to Sweden and Norway and other European countries, or even Taiwan. And all these countries that seem to have great single payer systems. And it's because at a very core level in these countries, the populations are much more homogenous than the U.S. Everyone's white or everyone's Asian, or everyone's a certain way. And there's all this psychology and sociology research that shows that I'm more willing to take a tax to pay more if I know I'm supporting someone who looks like me and in the US. it's just like, there's this sort of like non heterogeneity in how we look and who we worship, or our cultures. There are barriers to many other things, but also the concept that 'I should pay for your healthcare when you might have a very different lifestyle than me.' And when you look different, it sort of amplifies these differences. There's a lot.

Trisha Talbot: 32:24 There is a lot. And I would say these differences, one: it's what the U.S. was built on to protect everyone's differences. And in that time it was religion specifically because everyone that came over here, well, everyone that came over here willingly was white. But I think our heterogeneity is what makes us different and is one of our best qualities if we can.

Vini Singh: 32:45 Yeah. Yeah, absolutely. So, when you asked me whether the ACA has been built on the value that the poor people should be helped, and if it's at the expense of richer people, then it is fine because the rich people can handle it. But that value might not be shared by everyone. And I understand if it isn't. But all policies are made with the fundamental value at heart. And there's going to be losers and there's going to be winners. And whoever decides the winners and losers decides so based on what they

		believe. So, in what the ACA believed, it has accomplished to a large extent that the health and the insurance status of poor people and disadvantaged people has gotten better. And even like middling people, it's like the reverse trickle down. It's like the grassroots. If the bottom tier is healthy, then the higher tiers are less likely to bear that burden. So, I have a positive view of the ACA. I can also see why other people might not.
Trisha Talbot:	33:54	I'm grateful for you tuning in to the Providers, Properties and Performance Podcast. If you enjoyed it, please subscribe, rate, review, and share the podcast with others. As a disclaimer, this podcast is intended for educational and entertainment purposes only, and not intended for specific real estate investment advice.