HEALTHCARE INDUSTRY GROUP

What's Your Moonshot?

A Podcast Series Where World-Class Healthcare Leaders Seek To Solve Big Problems

Stony Brook Looks to Personalized Health to Transform the Patient Experience

Transcript

[00:00:00] Harold (Hal) Paz, M.D.: In my moonshot, it's the opportunity to do as much as we possibly can in the home setting, to do a lot of this virtually when it makes sense to do it digitally, but then to make sure that we have deep resources in the outpatient setting. Many of the things that a couple of decades ago we would do in an inpatient facility, we can now do in an outpatient facility closer to home. There's a future for that as long as I can see forward in the hospital setting. Hospitals are not going away. They're just going to be highly sophisticated. They're going to offer the services that are not available anywhere else and that's what we don't all want.

[00:00:58] Larry Kaiser, M.D., FACS: Welcome to A&M's *What's Your Moonshot Podcast*. My name's Larry Kaiser, and I'm a managing director in Alvarez Marsal's Healthcare Industry Group. I'm here today with my co-host, the Honorable Secretary, Dr. David Shulkin. David, it's my pleasure to welcome to the podcast Dr. Harold, otherwise known as Hal Paz, Executive Vice President for Health Sciences at Stony Brook University of the State University of New York, Dr. Paz joined Stony Brook this past October, having come from the Ohio State University and Wexner Medical Center, where he served in a similar role.

In addition to his nearly 25 years of leadership in healthcare and academic medicine, which included stints in leadership roles at UMDNJ and Penn State Hershey, he also served as the executive vice president and chief medical officer for CVS Health Aetna providing clinical leadership for the company's domestic and global businesses. Dr. Paz, we're very pleased to welcome you to the podcast today.

[00:01:54] Hal: Well, thank you so much. It's a privilege to be with both of you.

[00:01:59] David Shuklin, M.D.: Well, Hal, it's great that you could join Larry and I for this and we're really looking forward to it because a lot of people now are talking about what's different about the patient experience, and given all of your background in both the payer, the provider world, and we've known each other for a long, long time, we're really excited to hear about your moonshot that my understanding involves using personalized health to begin to transform that patient experience. Can you tell us a little bit about what your moonshot might be?

[00:02:31] Hal: Absolutely, David. My moonshot is can we create a personalized health experience for each individual before they become a patient. Really thinking about what are the things that we can do to allow everyone to have an opportunity to be well, to focus on health and wellbeing, and do everything we possibly can to avoid unnecessary premature death. Those are the two indicators that we have to work with. If we look at how we define health in this country, it's really about an individual's health and wellbeing. There are metrics measures out there like healthy days which it's a recall test. In the past 30 days, how many days were you not healthy? Did you not have good mental health or social health? Or did

you live to the age that you were predicted to live to based on your gender and the year of birth that you have?

That's the best we can do in terms of measurement, but those are really important measures. We know and this really frame my experience going back to the mid-1990s when I was Dean of what was the original Rutgers Medical School, the Robert Wood Johnson Medical School. Where a lot of our thinking was informed by work going on at the Robert Wood Johnson Foundation. Back then there was the realization that healthcare per see, attributes to about 20% or so of those two indicators, premature death, and health and wellbeing, about 20%.

There are four other determinants of health genetics for a population that's about 10%. For individual, if they have a lethal genetic disease it's 100%, but across the population, it's about 10%. Then the balance of the 70 or so percent are social determinants of health, behavioral determinants of health, and even environmental determinants of health. For many individuals, the social determinants of health are enormously impactful in terms of their ability to achieve health and wellbeing and to avoid unnecessary premature death.

Those are things that we don't often think about, we didn't often teach about in terms of education, socioeconomic status, transportation, housing, food insecurity, racism, violence, crime. These are huge events for individuals. It results in the frequent saying now that your zip code matters more than your genetic code in many respects, but behavioral determinants, addiction to alcohol, tobacco, opioids, the pandemic has been absolutely tragic, but at the same time this past year there have been over 100,000 opioid deaths in this country.

David, you and I, when you were in Washington at the veteran's administration we actually came together around the opioid epidemic. When I was at CVS Health Aetna because of just the impact it had then, it's only increased with the pandemic. We know obesity and exercise are enormously important as behavioral determinants of health. Now more recently, even environmental determinants of health. When I was a fellow in environmental health sciences in Baltimore we talked a lot about ozone as a contributor, but we know now that the changes, the effects of climate change on a whole array of different determinants of health are going to become increasingly visible and important around some of the things I just described.

[00:06:17] Larry: Well, Hal, when we start talking about social determinants of health and as you pointed out, so much of the health of a population is dependent on those social determinants. Addressing social determinants like you're trying to do requires significant resource allocation and collaboration among numerous stakeholders to be sure. With access to all of the resources of a university like Stony Brook that potentially you have at your disposal, tell us how you're leveraging those assets to address health and wellbeing in the community served by Stony Brook and for that matter, community at large.

[00:06:52] Hal: Sure. Well, it starts with the education. We are a university and in the health sciences, five schools, including not just the medical school, but we have a dental school, nursing school, school of social work, and school of health professions, which alone has over 1300 students in it. We have a graduate program, public health, that I hope in the not too distant future will be a school as well. I think that's very, very important.

As we look at these six enterprises, it is so apparent that we need to focus on interprofessional education. Educating those health profession students to work in teams and to begin their work in local communities. Beginning in the home to leverage the resources that exist in the home and around the home in the community because that's how

we impact the determinants of health, Larry, that you just spoke about. That's a starting point.

If we can get better and better in getting these students out of silos, teaching them a common language, teaching them pathways that are the same pathway to improve health and wellbeing, then learn that in a simulated setting first and then move on and progress them out into the clinical realm, we increase the likelihood that that generation will be well prepared for these enormous fundamental changes that are going on, not just in society but also in the way that we deliver care in the future.

We have a number of different outreach programs at Stony Brook Medicine that I serve as CEO of Stony Brook University Medicine, where we are reaching out into the community across Suffolk County, in particular, working locally with organizations to address many of these fundamental and basic determinants of health and wellbeing. Not just through our 230 ambulatory care sites, an area that we've really emphasized over the past several years, but going beyond that into the community. Because we see that creating these partnerships between our academic health center and community organizations is certainly, without a doubt, a way to get to addressing many of these multiple determinants at the same time.

[00:09:12] David: You know how over the past couple of years during the pandemic we've seen such an acceleration of the use of technology. When you think about what you're trying to do, I just wondered about your thoughts about technology. Some of what we've begun to see is people, on the provider side, have returned to the old ways of doing things. While they were using telehealth when people were restricted to coming into offices they've returned back to the old way of seeing patients.

I wonder how you're thinking about technology and whether you think that we're now entering a different period of time that you're going to be able to advantage of what we have learned and propel that forward?

[00:10:00] Hal: Great question, David. When I left Penn State to join Aetna which became CVS Health Aetna, one of the things I did in the first year was launch Aetna Care which was about hiring nurses that could go in the home using a telehealth platform. We used TytoCare at the time it was in 2017, as I recall, 2016, 2017, the nurses would go in the home, they would interface with patients. They would connect the patient to a primary care doctor that was in an ACO part of a value-based arrangement contract with us.

They would do basic things that you would expect in terms of blood pressure checks and all the things for chronic illness, but just as importantly, they would open the medicine cabinet and what would they find? They would find that a patient with diabetes, for example, three months out from a prescription seeing the doctor and receiving a prescription was no longer taking their medicine. As a matter of fact, data shows that within three months of receiving a prescription, about 50% of patients are actually adherent to their meds in diabetes.

The doctor has no way of knowing that because the patient comes back for a visit and is embarrassed or forgetful and doesn't tell the physician that they're not taking their meds so what happens? The physician increases the dose hoping to get their glucose levels down or to address elevated hemoglobin A1C levels. Or they switch to a more expensive medication because they think that the first line has failed when it's something much more fundamental and something actually much tragically simpler, the patient's just not taking it.

Being able to go in the home and use technology and in the case of Aetna Care we were using telehealth but we were also using digital technology. Then creating a health ecosystem of solutions or around the patient to create this personalized health model

becomes a way to actually be I think much more effective in addressing what are the things that we can do to keep people healthy and out of the hospital.

In our early conversations, we said could we have those patients go to a CVS med clinic for example as opposed to showing up in the ED in a crowded emergency room to address a problem that we could either deal with in the home or in a setting like that. Could we avoid unnecessary and avoidable hospitalization? That was the fundamental model and I see that this is an opportunity to continue you to amplify that, why? Because the technology is only better.

We can now do telehealth visits in a very seamless fashion on an electronic health record platform which makes it even easier and it creates the interoperability that's so important. As a matter of fact, during the pandemic, we've always **[inaudible 00:13:04]** of necessity. One of the drivers quite frankly is the fact that he was getting paid for. When we did it under Aetna Care, we were, in fact, through supporting those nurses paying for it and creating a value proposition by putting it into a value-based contract. We were working with the pharmaceutical companies because we put their drugs for diabetes in a value-based contract. So we created this win-win scenario.

During the pandemic, there was reimbursement for telehealth services, and that supported the growth that I just described. As a matter of fact, at Stony Brook Medicine, we went from 100 visits per month to 20,000 interactions per month across the system. That literally evolved enormously quickly after I think all the elective services had to shut down because of the pandemic. We're seeing that telehealth utilization now has stabilized nationally at 38 times higher than before the pandemic. Yes, without a doubt, there will be some receding, some backing off from that because now patients can safely come back in the office. There are no longer, in most cases, mandates suspending elective surgeries, elective visits into the office.

I think we're going to go from almost no interactions over technology like telehealth to virtually everything being over telehealth unless it's an emergency to now some a steady-state, some a midpoint. I think that's expected and it's normal and it's frankly a good thing. In my moonshot, it's the opportunity to do as much as we possibly can in the home setting, to do a lot of this virtually when it makes sense to do it digitally, but then to make sure that we have deep resources in the outpatient setting. Many of the things that a couple of decades ago we would do in an inpatient facility, we can now do in an outpatient facility closer to home, but at the same time, there are going to be things we certainly can't do in the outpatient setting.

I'm a pulmonary and critical care physician, I can't envision as I sit here today not having intensive care units in the operating room. Larry, I can't imagine doing thoracic surgery in the outpatient setting, I just can't. I mean there's a future for that as long as I can see forward in the hospital setting. Hospitals are not going away they're just going to be highly sophisticated, they're going to offer the services that are not available anywhere else and that's what we'd all want.

When you leave the hospital we want to make sure that you go home if at all possible and it's really gratifying to see all the progress that has been made in hospital in the home approaches. Mass General has literally a unit that is a hospital but it's in the home, they treat it like they would treat a floor inside the hospital. They have a certain number of beds that are managed in people's homes.

There are companies that do this work as well that literally go in your home and create a hospital setting which is based on visits and based on the technology to support it or other types of post-acute care which I think are enormously important. The progress that it's been

made in palliative care, the opportunities to address nursing home care and sniff, and in even ways that there's been a restructuring or reimbursement to help people stay at home as opposed to have to go into some of those post-acute care settings because they can't find a way to get coverage without having to do that.

[00:16:47] David: Hal, so much of what you've talked about is this intersection or alignment between what's the right thing clinically for a patient but also being able to get paid for it and having that financial alignment and I think we all know how important that is. When you talk about your moonshot with social determinants really being 80% of the impact and you wanting to impact many of these things that are absolutely aspirational, when you P&L responsibility over a health center like yours, how do you begin to think about being able to put resources as Larry was talking about towards these social determinants? Do you think it's going to take a new type of payment system to do this or do you think that you're going to find a way to do it even if you're not paid for it?

[00:17:43] Hal: It's a great question and it's a very complicated one. No question that traditional fee-for-service reimbursement creates a headwind towards moving to the types of models that I've described. Because in a perfect world, wouldn't it be great if physicians and other clinicians involved in delivering care could make decisions around the best care at the right time and the right place irrespective of the payment mechanisms. Undoubtedly, one way to do that is in a capitation model where the physician has full risk and full reward both in terms of the quality of care that's provided but also in terms of being financially great stewards of that dollar.

I'm pretty certain that in most cases we're not going to be seeing that in the very near future. As I said before it was 2017, where we announced value-based contracts with pharma, for example. I look at the progress since then to today, we haven't moved wholesale into that type of reimbursement model, in general. We're still basically in fee-for-service. Quite frankly in the case of many of the value-based reimbursement models, it's on a fee-for-service chassis with some upside gain and some downside risk. Overall, I heard one statistic recently about 8% or so of the reimbursement models are sitting in that space in aggregate across the country.

Now I think there are isolated cases and examples of where a lot of progress can be made, there are some systems that are payer-provider systems. In my former life when I was at Aetna, we did partnerships with five major systems. Some of them were academic health systems where we created with them their own population-based insurance model so that they could get into a framework where they could be paid and made decisions based on the population they cared for and benefit in this partnership with the upside gain and ways to minimize the downside risk for them.

To the best of my knowledge, all five of them are still up and running. I think that speaks volumes about these approaches where payer and provider organizations can partner together to create these very dynamic models or where provider organizations can go into it on their own. At Ohio state Wexford Medical Center, we had responsibility for the entire Ohio state university population of about 80,000 covered lives. Similarly, in Penn State, we had full risk responsibility for the entire Penn state population. Employer provider models are also another good example of that too.

I think we're going to continue to see this evolution. Even where we don't see that alignment, I think there really are meaningful ways in a fee-for-service model to make progress, David, and to find ways to help pay for things that sit outside the traditional four walls of the academic medical center or the health system, in general. Why do I say that? Well, there have been at least two major studies that have looked at the entire healthcare spend in this country.

Again, think about it, healthcare per se, and we can argue the percentages is it 15%, is it 20%, is it 25%, directly attribute to health and wellbeing and avoiding unnecessary premature death of all five of the determinants. In this country, we spend over $4 trillion on that 20%. We spend 18% of the nation's GDP on that. At least two studies have demonstrated that roughly one-quarter of that goes to total waste for an array of different reasons. We could go through the litany of reasons, but arguably over a trillion dollars a year because of different types of inefficiencies, a lack of alignment, a lack of connectivity, a whole group of different issues, create waste in the system.

If we can figure out ways to capture some of that waste and redeploy it in local communities, I think we have huge opportunities to improve health and wellbeing. If we got rewarded for doing that in value-based or capitated arrangements, would we get there faster? I personally believe so, but even absent that, I think there are enormous opportunities to create these improved alignments and in doing so redirect dollars that are being wasted today in these systems, not because of any fault of the systems themselves, but because of the structures that they have to work in. I think the right leadership, the right strategy, the right thinking, and the ability to partner with communities can get us to a place where we're going to have much better value propositions in a much shorter period of time.

[00:23:07] Larry: Well, Hal, you've covered a lot of ground today and a lot of territory. As you point out, we still are in very much a fee-for-service model despite the fact that CMS has talked about alternative payment models now for a number of years, but we're not really seeing the rapidity with which I thought we would move to some of these alternative payment models that initially was postulated. Yet, as you point out, clearly there is an advantage to these.

It really is been very interesting to hear how you're taking patient experience and personalized care to the next level, recognizing providing outstanding care in the most efficient and cost-efficient environment. I'm sure there's been a lot of lessons learned so far on your journey, the multiple areas in which you've served, that be valuable for other organizations across the country. Given that, what knowledge and advice would you share with your peers relating to many of the issues that you've talked about today?

[00:24:10] Hal: There are a couple, I think that the strategy is exceptionally important, but we all know that culture eats strategy for lunch. It's really more important even to communicate frequently with everybody in the organization. That's something, no matter where I've worked, we've really put a lot of energy and effort into that, which is to work hard, to develop these strategies, but to work doubly hard to communicate them and to make sure or the communication throughout the organization and then across the entire community that we serve is bidirectional. It's really, really important.

It's really important to gather lots of data both in terms of how we're operating as an organization against external benchmarks, but to gather huge amounts of data on patient experience and employee experience, and then to execute against that, to look at best performers, to look at where we have gaps, and then to come up with ways to narrow those gaps and close them to continue to aspire, to be in the top decile of whatever space we're looking at and whatever work we do.

Then last but not least, this is a bit tactical, this notion that I described before of moving from a health system to a health platform that is real and virtual, real in terms of bricks and mortar, virtual in terms of digital health, telehealth solutions, getting into the home with individuals, nurses, social workers, community health workers, in the home and in the local community is extraordinarily important. The way that I've done it is rather than go out and try to build all these things de novo, to do them organically, to use our own dry powder necessarily to get that done.

What I've done is to go out and partner with the best performers externally be they in the not-for-profit space or for-profit space, quite frankly, and to create these partnerships with them to create win-wins. I've done that previously in terms of mobile health services, in terms of home health services, and looking for ways and even in primary care, quite frankly, to say, "Look these are the things that we are exceptionally strong at. These are the areas that we need to grow. Sure, we could take five years to grow them and develop them, but you're doing it somewhere else in another part of the country today, you have the resources, you have the cash, you have the know-how. Come into this community, we'll create a partnership with you. We can get off the ground in less than a year's time."

One of the caveats I always use is do they have the contracts with the payers? As I learned, when I was on the other side, there are three things to success with any type of company, be they a disruptor or an established company, their business has to, not only create a value but it has to be interoperable with the systems that you're partnering with and it has to be scalable. If you can't do those three things, the interoperable, scalable, and create value, the chances of success are de minimis. We look for those talents among these companies that we select to be our partners. We bring them in the community, and we worked towards creating this platform across the entire region that we serve.

[00:27:47] Larry: Well, as I mentioned, you have covered a lot of ground today, but I think one of the things that I thought really resonated was the discussion you had about education being so critical, and inter-professional education being so critical, especially when addressing these social determinants. As you said, you have responsibility for all of these other schools as well.

You think about something like dentistry and the lack of oral care in so many parts of the country and what that means in terms of cardiovascular disease and obesity but I think the big issue here also is the centrality of medical care no longer is the inpatient setting. You've got to have a robust outpatient strategy. You've got to be able to take care of people in a more convenient location but still efficiently and much of that can be done in the home. In many respects, we are actually going back to the start of the hospital movement, where the only time people ever came to the hospital was at the last-ditch effort basically, and that most people tried to stay out of the hospital.

I think that should be the case now, but also the use of technology as you point out is so critically important. David, final comments for Hal.

[00:29:02] David: No, I think this is really exciting. I think, Hal, your vision resonates with a lot of people and I'm sure resonating with your employees who are looking for reasons to stay engaged at work. This is really the right path to go down. Thank you for joining us today on *What's Your Moonshot.*

[00:29:24] Hal: I just wanted to maybe mention this, I'm talking to two eminent physicians from Philadelphia and I always would start my lectures to the public health students with the following. What were there before there were hospitals? I would get puzzled looks from all the students and I'd say, "The first hospital in America was the Pennsylvania Hospital in 1752. Where did you get care before that hospital was built? In the home."

[00:29:52] Larry: Exactly. You never wanted-- people would not go to the hospital unless it was absolutely necessary. Absolutely right. Thank you, Hal.

[00:30:00] Hal: Thank you. Great to see you both. Really appreciate the opportunity, and be well.

[00:30:22] David: Larry, it was really interesting to hear from Hal today. I think he's got such an interesting perspective because he's worked in both the payer community as the chief medical officer for Aetna, but also in so many of these provider organizations and in and both academics as well as clinical settings. For him to have this vision of trying to create a broader view of the definition of health is really interesting.

[00:30:58] Larry: Yes. I think as you point out, his perspective I think is a unique one, having been both on the provider side and then on the payer side with Aetna. Being with them, with the merger with CVS, as he mentioned, affiliating with a number of health systems from the payer-provider perspective. It's fascinating that he really does see this as much more than just treating sickness, but also maintaining health. Doing that is so critically important to address these social determinants.

In order to do that, you have to have that outreach to the community and really the community at large. It does take resources and hopefully, he will have the resources to realize this. I think the use of technology as he points out, as we've heard before, is going to be critically important. Much of healthcare interaction can be done digitally with patients staying in their home. There will always be a need for hospitals though. Again, I think it will be for the critical care problems.

I think the perspective of his moonshot, I think he really does see the whole big picture much of that due to his incredible background.

[00:32:12] David: Yes. I think the real challenge though as we speak to leaders on the *What's Your Moonshot* Program across the country, it's really heartening to see the right type of vision being put forth in these organizations. At the same time, as we know, the pandemic subsidies are ending, the inflationary costs on hospitals are incredible. The workforce issues, we've never seen such a challenging time so if you're running a system, you're looking at traveling nurses and the costs are just extreme.

How do you, at one sense, drive an organization that's probably going to be financially challenged in ways that we haven't seen and yet create this type of vision and moonshot to do much, much more to impact your communities? I just think that this is going to be something that is going to be very challenging from a leadership position.

[00:33:16] Larry: Well, as you point out, the challenges are incredible, from the workforce issues and the cost of trying to get people back into the workforce, people who have left. Paying more because you had to increase wages. Use of travelers, which hopefully will begin to decrease. Everybody is being challenged by this. The other is, as the cares money and the money from the federal government has dried up, as institutions emerge from the pandemic, they're going to be looking at their own financial structure and see some of that cash has been gone. Now you're challenged with supply chain issues as well. Not only paying more for various pharmaceuticals as well as supplies but just trying to get them is becoming incredibly more difficult.

I think there's going to be some real challenges from a financial perspective from even the bigger systems. I think some of these smaller independent systems are going to find that whether or not they can remain independent without joining a bigger system is going to be incredibly challenging. You're absolutely right. From the standpoint of somebody managing a system like this, running a system like this, the challenges are really incredible and yet the perspective still has to be what's best for the patient and where can we best provide healthcare most efficiently.

[00:34:36] David: That's what I love about our conversations with these leaders, Larry. You have to have both, you have to have the reality of what you have to do to keep shop running

day-to-day, but you can't do it without having that type of vision about where you want to go. It's that intersection that I think is so fascinating when we talk to these leaders like Hal Paz.

[00:35:02] Larry: Yes, it was a fascinating conversation.