Transcript

[00:00:00] Sachin H. Jain, M.D., MBA: These days, I think, post-pandemic, it's become very commonplace to talk about loneliness as an American epidemic. I would say it's an epidemic that got started even far before the pandemic that had a lot to do with how our society was evolving. We just started asking our patients about whether they were lonely and even sent letters asking them whether they were lonely, and literally, hundreds of patients came out from the woodwork saying, "Yes, I would sign up for a program that would help me address my loneliness."

[00:00:56] Kristina Park: Welcome to A&M's *What's Your Moonshot?* Podcast. My name's Kristina Park, and I'm a managing director in Alvarez & Marsal's Healthcare Industry Group. I'm joined here today with my co-host, the honorable secretary David Shulkin. It is our pleasure to welcome to the podcast President and Chief Executive Officer of SCAN Group and SCAN Health Plan, Dr. Sachin Jain.

SCAN Health Plan is one of the nation's largest not-for-profit Medicare Advantage plans serving senior residents across California, Nevada, and Arizona. Dr. Jain was named President and Chief Executive Officer of SCAN Group and Health Plan in June 2020. In his role, he's charged with leading their growth, diversification, and emerging efforts to reduce healthcare disparities. Under Dr. Jain's leadership, SCAN has maintained its four and a half star rating for a fifth consecutive year in a row.

Dr. Jain is also an adjunct professor of medicine at Stanford University School of Medicine and is regularly recognized as a Top 50 Most Influential Clinical Leader and 100 Most Influential People in US Healthcare by Modern Healthcare. He was named Top Voice for Healthcare in LinkedIn, and we are very glad and welcome you to our podcast today Dr. Jain. Thank you for joining us.

[00:02:13] Sachin: Well, it's an honor to be here. Thank you so much for having me.

[00:02:17] David Shulkin, M.D.: Sachin, I too want to thank you for joining us today and we're really excited because this is a podcast that's called *What's Your Moonshot*. It really is about leaders like yourself, who dream big, who want to have a big impact, and really to have you share what you're trying to accomplish and what those aspirations are. Usually, a leader has to think about what that moonshot might be, what they're really trying to leave behind his legacy, but with you, I know that's not going to be difficult. In fact, I think you even have two moonshots to share with us.

[00:02:54] Sachin: Maybe three, David, maybe three.

[00:02:58] David: That way, you're assured of at least getting one of them done, right?

[00:03:02] Sachin: Sure.

[00:03:02] David: I know that the pandemic has been challenging in that some of the things that I know that you are passionate about have actually worsened during the pandemic. We want to talk about that, but specifically given what the role SCAN is, your leadership there, to try to improve the lives of seniors, tell us about what these moonshots are and how they might impact the senior community.

[00:03:29] Sachin: Sure thing. David, first off, speaking of people who had moonshots, you're the original healthcare moonshot person, so what an honor to be here with you. What I'll say is we've got three major areas of focus at SCAN right now, as it relates to big aspirational high risk, high reward initiatives. The first is around really trying to leverage the principles of managed care to better serve people experiencing homelessness.

We, I think, have mischaracterized homelessness in this country as a housing issue when, in fact, I truly believe it is a healthcare issue. Solving homelessness will require us to build new models of healthcare and we are hard at work doing that through our Healthcare in Action medical group.

The second area of focus for me is really reducing healthcare disparities in the Medicare Advantage population and actually creating financial incentives for our teams to actually reduce those disparities. There's a lot of talk in this industry and a lot of virtue signaling, David, as you know, related to how do we actually reduce healthcare disparities, talking about healthcare disparities. We've taken the bold step of actually tying executive compensation to closing healthcare disparities. I think that that's been super meaningful and we think it's a model for the industry. The third thing that we're working on is something that predates my arrival at SCAN, which is addressing senior loneliness. These days, I think post-pandemic, it's become very commonplace to talk about loneliness as an American epidemic. I would say it's an epidemic that started even far before the pandemic that had a lot to do with how our society was evolving.

In our very small modest way, first in CareMore, now it's SCAN, have been really just trying to address the problem through enhanced outreach to some of our most frail, vulnerable, and socially isolated members of society. I think we've seen some encouraging progress along those dimensions, but I would say, one of the bigger challenges we have is we tend to, as a health care system, feel responsible for every problem that everyone walks into our offices with.

I think as leaders, we need to start thinking even bigger and start thinking about how do we actually generate and prompt social change, along with delivering these interventions that I think make a difference. Those are my three moonshots, and I'm happy to dig in wherever you want to take the conversation.

[00:06:20] Kristina: That sounds great. I think that's exactly where we do want to start digging in, Dr. Jain. Just an incredible point of view on really how all of these social disparities and all health disparities come together and need to be addressed in a very holistic, personalized way for members of the community. It's amazing to hear. We also know you launched a Togetherness Program, to support the effects of that social isolation, especially related to COVID isolation on seniors. In today's world, everybody has some element and can relate to some of these experiences.

Can you tell us a little bit about the program and the response and impact on the community that you've seen thus far as part of the rollout of this program?

[00:07:08] Sachin: Absolutely. The first time I launched the Togetherness Program was at CareMore. That's the organization that I was a part of before I joined SCAN. It really came from this observation that I had as a physician that at almost every clinical encounter with a

patient, there's this unspoken issue, which is the fact that many of our most frail and vulnerable patients were aging by themselves without anyone's real support.

In absence of that support, there was not just a physical deterioration, but I think there was a mental or emotional deterioration that went unaddressed. I think one of the things you learn as a physician, one of the unspoken rules of being a physician is we don't really ask people about problems when we don't have solutions to offer them. A lot of times, it really requires that you're building a solution in order to create a greater consciousness around detecting that problem, addressing that problem.

We just started asking our patients whether they were lonely and even sent letters asking them whether they were lonely. Literally, hundreds of patients came out from the woodwork saying, "Yes, I would sign up for a program that would help me address my loneliness." We tried to destigmatize it by calling it the Togetherness Program because no one likes to self-identify as lonely.

At CareMore, we addressed this problem in more than 2,000 patients. Coming over to SCAN, serving an even bigger population, wanted to make an even bigger impact. One of the, I think, parts of the DNA here at SCAN that I think is really fabulous is this notion of peer support. Rather than medicalizing this and creating an intervention team that was really focused on reaching out to people who had either self identify or had clinicians that identified as being lonely, we actually are leveraging SCAN members.

These are member advocates, peer advocates, who reach out to one another and support each other. Have been really proud to see this program take off. We've also broadened the set of volunteers that we've made available to serve seniors by actually enlisting all SCAN employees who would like to work as volunteers, and we've literally increased our capacity by hundreds by actually reaching into our employee base.

I think from that perspective, it's just a fabulous connection back to our mission. One of the things that's been most rewarding about this program is just seeing other organizations pick up the mantle of loneliness and start to do things about it. A little bit after we got started at CareMore, you saw Cigna, you saw Humana, you saw other organizations borrow pages from our playbook and start to do things in this area. I think for me, on this subject of moonshots, it's made me realize the extraordinary value that inspiration can have in actually catalyzing social change.

When I started working in loneliness, we were the only organization that was actually doing anything in the space, lots of folks talking about it, but not a lot doing. Then when you show people the art of the possible, you realize that imitation is the best form of flattery. It's just been fabulous to see this become a nationally-recognized problem and something that others have taken on in the ways that they have.

[00:10:45] David: Sachin, I couldn't agree more. I think it's really important what you're doing, and it doesn't surprise me that others are following. When you think about loneliness, some have called it the new smoking, in terms of the impact on health. How do you think about measuring the impact of your programs? Are you thinking about patient-reported outcomes, reserving your patients, or are you thinking about it otherwise? Also, do you expect for it to ultimately show up in the total cost of care? Is there going to be a financial measure, or is this going to be more on the comorbidity and on the medical measure?

[00:11:28] Sachin: I can say we're still in the early innings that SCAN in terms of measuring the impact. What we were able to demonstrate at CareMore was lower admission rates, greater participation rates in preventative health screenings, and lower readmission rates. I

think when you have someone reaching out to you and encouraging you to participate in your health, it's no secret, you actually participate more in your healthcare.

I view the impact of interventions around loneliness as being akin to some of the work that's been done with community health workers. It's having people who are prompting you, nudging you to be more engaged in society, to be more engaged in your own healthcare, that starts to make subtle differences in what you do and how you engage. While I'm not sure there's a direct line in the way that we'd like there to be, I think for some subset of patients, it's going to be a real difference-maker.

[00:12:37] David: I also wanted to pick up a little bit on one of your other moonshots, and that's homelessness. As you know, and I know that you're very familiar with the work that's been done in the Department of Veteran Affairs, President Obama, in 2010, gave his moonshot to end veteran homelessness. At the time, there were 100,000 veterans. Since then, there've literally been billions of dollars put into the effort. Today, we've cut that down about half, so there's around 45,000 homeless veterans.

What you learn in this is it's a constant effort because when you housed people, additional people can come out of secure housing, so it's a problem that you're always sticking with it. You really got my attention when you said you don't think this is a housing-first problem, you think this is a healthcare problem.

The Department of Veteran Affairs has primarily approached this as a housing problem, using its HUD-VASH vouchers, even though it's run out of the Health Administration. What's different about your approach? What do you mean when you say it's a healthcare problem first?

[00:13:48] Sachin: I think you have to start by asking, "Why are these folks homeless in the first place?" I would say many of them have untreated, severe mental illness, serious mental illness. I would say others suffer from addiction issues, and then others have chronic diseases that got them out of the workplace and that have been exacerbated pretty significantly.

When you look at the true number of people who are homeless, purely just because they can't afford housing, I think it's a smaller number than the folks who are homeless because they had some antecedent cause. That's not to say housing solutions are not helpful, that we shouldn't continue to pursue housing solutions, we have affordable healthcare issues around the country.

That said no, no one ever said, "If you're homeless, you have to live in Los Angeles or you have to live in San Francisco." There are lots of pockets of this country where housing is affordable. The issue that I think we struggle with though is that many of these folks have burnt their social capital, have very serious problems which make it impossible for them to live what I call an organized life, where you're housed, where you're employed.

I think our biggest opportunity to support people is actually to start to address the underlying issues which actually landed them where they are in the first place. What you see is across the healthcare industry, there's a movement to try to bring care to the home. We hear this at every healthcare conference, "We want to bring care to the home." Well, why do we want to bring care to the home? We want to bring care to the home because, for many people, it's really difficult to actually access care in other settings.

What if your home is the street? It starts with trying to bring care to the street. Some of my inspiration to pursue a career in medicine came from early work with homeless advocacy groups in Boston, and 20 years later when I was leading CareMore, I looked at the pockets

of patients that we really poorly served, people experiencing homelessness were at the very top of the list. We were enrolling people in our Medicare Advantage plan who were experiencing homelessness, but we had nothing special to offer them.

As you know, when you're in Medicare Advantage, you're actually paid based on your level of risk, and it turns out that people experiencing homelessness actually have a lot of risk factors. They have mental health issues, they have chronic diseases, and when you actually look at the RAF scores, so to speak, which are the risk adjustment factors that get applied to your overall payment, the average RAF score of a SCAN member who's experiencing homelessness is roughly 2.7 which corresponds to a $25,000 to $35,000 per member per year payment.

If you look at what SCAN is spending that $25,000 to $35,000 on, we're spending it on emergency room visits, we're spending it on ICU stays, we're spending it on hospitalizations. What if we took that money and we started allocating it to intensive outpatient primary care, psychiatric care on the streets, addiction care on the streets, and potentially transitional housing?

What you find is that many folks actually have people in their lives who want to help them, but they are so far down the road of mental illness or addiction that those folks have largely disappeared from their lives. If you're able to pull them forward to back where their conditions are better managed, then all of a sudden a lot of social safety net starts to kick in, both formal and informal. That's where we think the opportunity is. If we can actually better manage these underlying conditions, we might be able to actually have these folks in a place where they can be better served.

We've got just a phenomenal team leading this. Michael Hochman is a physician that we recruited over from USC who's now leading this effort. We've got vans on the streets all over LA, we've just seen our 150th patient, so we're quite excited about the opportunity to make a difference here.

[00:17:56] Kristina: That's fantastic. Is all of this part of an integrated delivery-of-care model as you move forward with the experience, and is it part of what SCAN has been looking to do as part of their healthcare in action program?

[00:18:12] Sachin: Yes. SCAN was founded in 1977 by a group of racially and gender diverse community activists who said aging in America isn't what we want it to be and it could be better. If you actually were to project their slides right now, you would see that they were talking about all the same things that we're talking about today. What is old is new, and what is new is old. They were the original so-called social determinants people. They didn't call it that back then, but everyone in the industry right now is talking about how important social determinants are.

SCAN was one of the first organizations to really embrace this. I think a lot of what we feel is a responsibility, what our board feels, what our management team feels is an obligation to those 12 angry seniors, that's what we call them, to try to make right on the vision that they had to invent a better future for aging. That includes people who are largely forgotten, and that includes people experiencing homelessness. One of the most sobering statistics is that the fastest group of people experiencing homelessness is actually people over the age of 65. We feel a real obligation to be part of solution building in that space.

[00:19:24] David: Sachin, I think the elephant in the room is this. A lot of people who are going to be listening are going to be shaking their head, agreeing with you, and saying, "This is really where we can make a huge difference, and it's the right thing to do, but in my organization, it seems like the costs are too tight. There's not the margin to do these things.

How could my organization take on these massive problems? This is really a issue for government or an issue for public-private partnerships or maybe even bigger than that." How is it that you can have the audacity to say, as a health plan, we're going to tackle these issues? Is there really a financial way that you can solve these problems and still run your organization to be a profitable organization?

[00:20:24] Sachin: David, I'm going to be really harsh for a second. There's a lot of leaders of so-called nonprofit health systems across the country, health plans, as well as healthcare delivery organizations who die on the sword of No Margin, No Mission, and in the process, have created massive reserves, and will still die on the sword of No Margin, No Mission.

The issue I have with the No Margin, No Mission statement is, is your mission actually just? If your mission is to take care of sick people when they get into the hospital, that is one kind of mission. There's another kind of mission, which is to make sure people don't get sick enough to get into the hospital in the first place. You have to evaluate the morality of your mission before you die on the sword of No Margin, No Mission.

I will say lots of organizations are sitting on big reserves waiting for a rainy day that has never come. SCAN has not as such reserves, but I would say our board has really committed to being a mission-first organization and has stood behind us as we've launched these new initiatives and new ventures to solve some of society's biggest issues and biggest problems.

David, you and I have been in this game, you longer than me, but we've both been in this game of trying to change healthcare and make it better for a few decades, more than a few decades. My personal view is our biggest deficit is not policy, it's not new payment models. I think all of that now suddenly exists through President Obama's leadership, through some of what came after him.

I think the biggest deficit we have right now is leadership and will and momentum. I do think people should have a hard look at what they're doing, whether it makes sense. I spent a lot of time recently thinking about the concept of value-based care. Value-based care is really wonderful if it actually produces the outcomes that you seek, but in the real world, what it often does is it just creates a lot of cost production which doesn't lead to better care for patients, doesn't lead to better outcomes.

Again, I think we have to stop normalizing the abnormal, and that's a big part of what I think we struggle with as a healthcare industry right now is we have to some large extent normalize the abnormal.

[00:22:50] David: Let me just follow up with one piece of that, Sachin, because I think what you've said is very powerful and very controversial, which I think doesn't surprise me that you're being as candid as you are about this issue because I know how passionate you are about it. When you think about the ability to accomplish the goals, does Medicare Advantage allow you to do this in a way that Medicare fee-for-service couldn't? If you're in a traditional health system that doesn't have much MA, is it harder to do this?

[00:23:29] Sachin: If a traditional health system doesn't have MA, it's probably because they don't want to have it, so we can start there. The second place we can go is, yes, I think when you have Medicare Advantage, you have control over the total cost of care. You have the full premium, so to speak when you are taking care of a Medicare Advantage patient, or you may be delegated for the risk for taking care of a total population or for a patient.

I think that does unlock opportunities to do more and to think more holistically about what it actually takes to manage the care of patients. That said, look, fee-for-service has its place

too in certain parts of our healthcare system. Again, it goes back to this question of what are we in the business of doing? Are we in the business of taking care of sick people? Are we in the business of keeping communities healthy?

I think 99 out of 100 healthcare organizations would say they're in the business of keeping communities healthy, but when you actually look at what they say their mission is versus what they're actually doing in practice, they're largely keeping beds filled at hospitals. They're admitting people who probably don't necessarily need to be treated in the hospital because it pays them to do that. Then they hide behind No Margin, No Mission, and then they set up venture funds, to invest for reasons that make me scratch my head.

I think we have to take a hard look at governance of large healthcare organizations and get people focused again on what they were created to do as opposed to what they've kind of Frankensteined themselves into doing over the last 20 or 30 years.

[00:25:10] Kristina: It's helpful. Dr. Jain, I think the other piece of this too, is what I love about kind of all of your moonshots, is on the last piece. It feels like in that third moonshot that you bring out as well, it's, "And then how do we hold executives and the leadership in the industry accountable for getting to those outcomes and making sure that there's connectivity between sort of what those missions are and reevaluating those and making sure that they're delivering on those?" Is there anything else you'd like to kind of add or like bring to light on your third moonshot?

[00:25:44] Sachin: Yes. At the end of the day, you have to put your money where your mouth is and you have to align incentives. Incentives are super, super powerful. We tied 10% of our executive compensation at the director level and above to whether or not we close medication adherence gaps between our Caucasian members and our African American, Latinx members. We recognized there was a big delta in the adherence levels in those populations.

Six months into last year, we listed green on all of our goals except for that one, and we were red there. I can tell you it mobilized a lot of action. When people say, "Oh, it's really hard to move disparities," well, it's because we're not necessarily focused on them in the way that we need to be. Before long, we were able to close the gap by about 35%, so that shows that when you actually align incentives and point everyone in the same direction, you can actually make a big difference in areas where people have previously said, "Oh--" throw their hands up in the air and said, "Oh, it's too hard. It's too systemic. It happens outside the walls of the healthcare system."

Nonsense. At the end of the day, a lot of change is possible. You just have to ask for it, you just have to demand it and create the burning platform and incentives to make people want to do it.

[00:27:00] David: Sachin, I think this has been such an amazing conversation and has given people a lot to think about. Maybe to wrap up, as we begin to hopefully find our way out of the COVID pandemic, maybe the public health emergency begins to wind down, do you find yourself as you talk to your colleagues across the country and you look at the landscape across Washington, do you find yourself more optimistic that we're going to be moving towards solving some of these bigger issues, or do you find yourself with a healthy skepticism about whether we're finally going to find our way to a place where everybody agrees that these types of issues need to be tackled?

[00:27:47] Sachin: Look, I'm an optimist, David, by nature, but what I can say is that we need a hard look at governance of organizations. I think that everyone is saying the right things, but when you actually look at whether the actions line up with the statements, there's

a big gap there. I'm encouraged, I'll say I'm optimistic that everyone's saying the right things because that's a big step forward. Where I would like to see more action is seeing organizations walking their talk. That's what I'm hoping we will see more of over the next couple of years.

[00:28:28] David: Well, thank you for joining us today. It's been an amazing conversation and we're going to be following your progress with a lot of interest.

[00:28:36] Sachin: Thanks for having me. It's great to be with you all.

[00:28:38] Kristina: Thanks so much for joining us on our podcast, and good luck with hear with your moonshots.

[00:28:43] Sachin: Thanks so much.

[00:29:11] David: Kristina, thanks for joining us. This was really a really interesting podcast with Sachin Jain. You don't hear too many people willing to come out and actually be somewhat critical of the industry for not taking on these hard issues.

[00:29:32] Kristina: I loved what he said. It is a provocative and challenging mindset that he has for executives in healthcare today. I think as we look at some of these systemic issues across the healthcare industry, he's tackling some of the hardest between homelessness and the root causes and being able to address that as part of the healthcare ecosystem as well as the pervasiveness of social isolation, and what we're seeing, not only in the seniors across our country but across all populations. Working with many different health plans, it's always a challenge, but to see where he's really getting to the heart of what's causing some of the healthcare issues and the healthcare costs, quite frankly, across the country is really good to see. It's very heartening to see.

[00:30:26] David: Before Dr. Kaiser jumps in with his comments, I think one of the nice things about Sachin is he's willing to be pretty open and transparent. He was willing to share some numbers, the 10% of his executive team that has an incentive for closing disparities, the fact that using the RAF scores on his homeless members, that the payment turns out to be about $25,000 a year.

I know that when we were working to get homeless veterans off the street in Washington DC, that the average homeless person cost the District of Columbia $400,000 per year because of the constant need to be brought to emergency rooms and for the type of care that they received when they got admitted. From an economic point of view, I think that his strategy actually does make sense.

[00:31:27] Larry Kaiser, M.D., FACS: So much of this does come back to, and he mentioned it, behavioral health. Many of these people on the street, as you know, have mental health issues. It also has an influence on our criminal justice system, since many of these people wind up in the criminal justice system.

When I was the president in Houston, the largest purveyor of major psychiatric drugs was the Harris County Jail. These people are in and out, they're homeless. Again, I think what he's doing, obviously, is critically important. They're not the only ones. Many of the health systems that he pointed out are strictly in it for the margin, are actually doing this on a regular basis.

Montefiore in New York had people on the street treating homeless people for many, many years now, and has been very successful with that, recognizing the particular needs of those individuals. I think many systems around the country, despite, yes, there is some

concentration on margin, are addressing these needs. The Kaiser system certainly is doing it. I know, at Temple, they're doing it right now, so many of these are addressing these issues of homelessness, and food insecurity with food prescriptions, in fact.

What he's doing, I think, really does align with what many of these health systems are also doing. Hopefully, we'll continue to be successful at it. As he points out, it's more than just treating sick people. This is ideally maintaining and promoting health in a population.

[00:32:56] David: I think that's right, Larry. I think that what we're beginning to see as more and more leaders across the country begin to get clear about what their objectives are, the difference between wanting to do the right thing, which I believe most leaders of these healthcare organizations truly do want to do the right thing, but the difference between that and truly making sure that you're making the progress that you feel that you can and challenging your organization is setting specific objectives and being able to measure whether you're achieving those objectives.

I do think that Sachin is moving the ball down the court by setting executive measures, trying to hold his team accountable to it, and being able to let people know that this is important to him as the leader of the organization.

[00:33:50] Kristina: The other thing you saw on that, just to back it up, was his transparency around the scorecard. When they looked at some of the star metrics and noticed that the medication adherence between White Caucasians and African-Americans they were able to very clearly see where there were disparities and align, given the fact that their executives are all looking at this, they were able to align their response, align the mobilization of some solutions to actually tackle what was still an outstanding issue for them, and a clear disparity in how they were delivering care, and be able to address that very clearly.