Transcript

[00:00:00] Jaewon Ryu, M.D.: Another example is our 65 Forward program, which is a concierge primary care program for those 65 and older, as the name would suggest, panel sizes about a fifth of the size of what you would see in a traditional primary care practice and co-locating health and wellness programming in one location. It's been a homerun with our patients. Again, less ER use, less hospitalization, patient satisfaction score's above the 97th, 98th percentile. Those that we manage, we have about 5,000 patients in that model right now and growing across 9 or 10 sites, and again, expanding more of those, but that's been another huge benefit.

[00:01:04] Larry Kaiser, M.D., FACS: Welcome to A&M's *What's Your Moonshot?* podcast. My name's Larry Kaiser. I'm a managing director at Alvarez and Marsal's Healthcare Industry Group. I'm here today with my co-host, the honorable ninth secretary of the Veterans Administration, Dr. David Shulkin. David, it's my pleasure to welcome to the podcast, Dr. Jaewon Ryu, President and Chief Executive Officer of Geisinger.

After earning his bachelor's degree from Yale, he completed both an MD degree and a JD degree from the University of Chicago. He completed a residency in emergency medicine at the Harbor UCLA Medical Center. He joined Geisinger as executive vice president and chief medical officer in 2016, where he oversaw all aspects of patient care, working to improve the quality, affordability, and experience of care delivered across the enterprise.

In 2018, upon the exit of David Feinberg, and following a national search he became president and CEO. Since his joining the organization, he's cultivated a spirit of innovation and transformation, driving new approaches to some of healthcare's most complex problems. Dr. Ryu was selected for a top 20 spot on Modern Healthcare's Most Influential Clinical Executives list in 2019. We're glad to welcome you to the podcast today.

[00:02:18] Dr. Ryu: Thanks for having me, Larry. Thank you, Secretary Shulkin. David, it's good to see you again.

[00:02:24] David Shulkin, M.D.: Great. Thanks so much. We are really excited to have you on the *What's Your Moonshot?* podcast today, Jaewon, because we know that Geisinger has a history of being one of the innovators in healthcare and using its unique financing and care delivery models to change healthcare for the better. We know that that's very much about what your leadership has been about as well. Thinking about value-based medicine and addressing some of the issues in health disparities and health inequality, I wonder if you wouldn't tell us a little bit more about what your vision is, and about your moonshot for healthcare?

[00:03:06] Dr. Ryu: I think I would start with, somewhere healthcare got it wrong. We have the financial accountability that's been bifurcated or separated from the clinical accountability. The financial accountability is traditionally resided within insurance

companies, and of course, the clinical accountability typically sits with providers and health systems and so forth.

I think that's where things got off kilter. I think, and we've always seen at Geisinger the value of bringing those two worlds together and the closer you could have the financial accountability aligned with the clinical accountability, it just opens the door on a whole bunch of programming to go further upstream with people's health, and keep them healthy, develop programs to keep them out of the ERs, out of the hospitals. That only becomes possible, or most easily becomes possible when you marry up the financing and the clinical.

I think when we do that, we've seen that it also leads to a more equitable result in healthcare because you don't have to worry, or health systems aren't swayed inadvertently, or God forbid, even purposefully around the rates of payment that they may get, which may be different across the different kinds of populations across Medicaid versus Medicare or commercially insured, for example. But in a value-based world where you're taking risk for the population, you're really freed up from some of those dynamics and just able to focus on better health and what makes things easier for people.

[00:04:47] Larry: You mentioned that you're working in a value-based care environment. Jaewon, as people know, you are both a payer and a provider at Geisinger. You've done it extremely well. The example has been cited by the federal government, by both the past administration and the current administration, really as a model. How can the rest of the country as the rest of the country is moving into value-based care in a way that benefits payers, providers and patients alike, do you have some examples you could share with us as to the kinds of things that Geisinger has done using really the unique system that you have?

[00:05:27] Dr. Ryu: I should clarify as well, we're probably in this 50/50 hybrid world. I know that there are systems, Kaiser Permanente probably being the best example where they're more integrated almost to an entirety where the health plan member is the patient, the patient is the health plan member. In our world, we like to think of it as a 50/50 model, where about half of our world is exactly that, and then the other half, we continue to have the honor and privilege of taking care of other payers members, and that's still important to us. But to the extent that we're able to develop innovative care programs, a lot of that has been more so where we bear the risk on the population. Some of that is through our own health plan, we also have a ACO through the Medicare MSSP program, that gives us risk on another 75,000 or so Medicare beneficiaries.

Some examples of what that model has enabled us to do, between the ACO and our own health plan, we, early on, gosh, it was probably four years ago, we started the Geisinger at Home model, which takes essentially our sickest 3% of our patient population. These are folks who have difficulty getting to care. What we started doing is bringing care to the patient, started out as care coordination in the home and then we started actually delivering more care and services in the home.

What we saw was 35% reductions in the rate of hospitalization, 25% reductions in the rate of ER visits. Of course, when you have fewer ER visits, fewer hospitalizations, the total cost of care also drops precipitously, total cost of care as measured through a PMPM insurance model, I think for us was around $450 PMPM less expensive. Of course, the model itself bears quite a bit of cost because it is a high touch model, but there's still significant net savings that come out of that. That's one example where we didn't have to worry about, is it a billable service to hang an IV from a hook in the ceiling that's supposed to hold flower plants? We didn't have to worry about whether there was a CPT code for that. We were able to do it because that kept someone out of the ED, or out of the hospital.

Another example is our 65 Forward program, which is a concierge primary care program for those 65 and older as the name would suggest, panel sizes about a fifth of the size of what you would see in a traditional primary care practice and co-locating health and wellness programming in one location. It's been a homerun with our patients. Again, less ER use, less hospitalization, patient satisfaction score's above the 97th, 98th percentile. Those that we manage, we have about 5,000 patients in that model right now and growing across 9 or 10 sites, and again, expanding more of those, but that's been another huge benefit.

Another good example is our pace program called life Geisinger. These are truly frail and elderly patients, but as a result of introducing a lot of very intensive day programming services, we're able to keep them independent and out of institutionalized environments. When we do that, we've been able to see inpatient use rates that are below what the insurance actuaries would call well-managed levels. Again, patient satisfaction above the 95th percentile in those models.

I can go on and on. There are a lot of these, but many of these, I think the common theme is, services and capabilities that you really can't bill and collect for in a traditional fee for service world, that we're able to introduce, it becomes a huge patience satisfier, and helps to reduce the total cost of care.

[00:09:32] David: Jaewon, those are really good examples. They're good examples of things that make sense that Geisinger would be really good at, which is managing complex issues and knowing how to treat patients. You're also in a very complex environment being a rural healthcare system. I'm sure you have to deal with the intersection between what we call the social determinants, things like food insecurity, issues related to income and disparities in education and in different cultural issues. How does Geisinger think about tackling some of those traditional non-medical issues as well?

[00:10:17] Dr. Ryu: I think you raise a great point, David. I think the challenge with, and many of our markets are rural, but some are actually smaller urban. What we see is across the board though, there are challenges and barriers to people getting healthy and food is probably the best example. I think it's important that we not try to medicalize these social determinants, so to speak, but at the same time, the reality and the practicality is that health systems and providers, physicians, care teams, they are often in the best position to tackle these issues. I think food is a great example.

You've probably heard from many physicians over the course of your career that are extremely frustrated when they try to get a diabetic patient and their blood sugar under control, but it becomes that much more difficult when they have trouble accessing healthy foods. That was the mindset on which our Fresh Food Farmacy was born a few years ago, the idea being food insecure patients who are also diabetic, poorly controlled blood sugars, get them enrolled in a program where they have access not only to fresh produce and lean meats but also the diet support, dietician support, nutritionist support, coaching education in terms of how to prep those meals in a more healthy way.

When we were able to pair up the food and the coaching program and the wraparound program, we saw a hemoglobin A1C average reduction of two to three points, which is actually double or triple the impact that we've seen when we optimize a diabetic on the absolute perfect medication regimen. It's a good reminder that food sometimes is better than medicine, but at the same time when we produce those kinds of results we've seen the resounding theme of today's conversation, 20% reduction in ER use rates, 20% to 25% reduction in acute admissions, and interestingly enough, a 20% increase in the rate at which those folks are pursuing primary care services.

We think that's a reflection of them being more engaged with their health outcomes. At this stage, we're serving over 20,000-25,000 meals a week I believe, and expanding the program beyond diabetes to other chronic conditions that are very sensitive to diet, whether it's chronic kidney disease or even congestive heart failure. That's the food program.

There's also some things we're doing with opiate-dependent new moms and getting their babies and helping them provide some wraparound social support so that the babies are able to get back with mom and mom is able to get back on her feet again in terms of jobs and sustainable support that would help them emerge out of addiction, if you will.

At the same time, we have programs around transportation and various other things. The 65 Forward model and the Geisinger at Home Model that I mentioned earlier, I think those are also ways to, especially in a rural population, colocation and bringing services into the home, it matters even more because there are wide distances that people have to travel, talk about another barrier to care.

Yes, telemedicine is a huge opportunity, but at the same time, we know that there are significant areas that don't even have broadband. I think all of these programs taken in aggregate really deliver the right set of capabilities and offerings to make a difference in our community's health.

[00:14:05] Larry: Once again, the way your system is constructed and has been able to carry out many of these programs that you mentioned, that would be difficult in a fee-for-service environment where you're working either with a commercial payer or the government. Providing meals. That's something clearly that you've been able to do that certainly has benefited the health of many of the individuals that you mentioned.

Again, so much of health itself is based on these social determinants much more so than the interventions that we provide when somebody gets sick. It's about maintaining health just as you've pointed out. Now, you mentioned telemedicine, you mentioned the Geisinger Care at Home program. How does technology remove some of those barriers and help providers get upstream to address issues before they actually happen?

You mentioned, clearly there are areas where broadband is not as good or maybe even doesn't exist, although we'd like to think that broadband is like energy and water nowadays, but so how are you using technology in some of your programs?

[00:15:13] Dr. Ryu: Larry, I think you nailed it. You hit it on the head because for us technology is, it's an enabler, but I want to be careful because sometimes it becomes the end as opposed to the means to the end, and we would say it's a means to the end, it's an enabler. If you take our Geisinger at Home program, that's a good example, we use the telemedicine to provide a tether to other specialists and other physicians or other members of the care team.

Maybe it's a clinical pharmacist, maybe it's a social worker that may not be physically in the home with whoever we do have in the home but can quickly be brought in for the conversation. Of course, it's dependent on broadband. Yes, we get those things, but when we're able to make that happen, it just augments the reach of how comprehensive of a care team can we bring literally physically, or virtually into the home?

I think another example is the use of data. We talk a lot nowadays across the industry about labor and the labor challenges and labor shortages. In order to really put the best use of all of these programs, identifying the segment of the population that really needs to be prioritized that could benefit the most from some of these interventions, that becomes mission-critical.

A good example of what we've done there, we've partnered with a company called Medial EarlySign. Think back to early on in the pandemic, all of those elective procedures being postponed, and there was a backlog of a lot of these elective procedures, a big one was colonoscopy, at least for us. Before we knew it, we had thousands of colonoscopies that were waiting to get in in the summer of 2020.

The question was, "Well, which ones do you get to first? Because surely some of those actually are undiscovered cancers in the making and you want to get to them as quickly as possible." We developed an algorithm using machine learning cranking out tons and tons of data points that fed that model and identified a higher risk cohort.

In that cohort, 1 out of every 13 colonoscopies revealed an actual concerning finding versus what you would normally see. in an undifferentiated population you'd see one out of every 154 or so. Takes us back, David, Larry, and I, you learned about number needed to treat in medical school. The number needed to treat in a typical colonoscopy population, 154 to discover 1 concerning finding.

We were able to identify the segment of the population, especially at higher risk, so that number needed to treat dropped to 13. That's pretty good use of resources at that point. Of course we get to the others too, because they need the preventive screening services, but as far as who to pay the most attention to early on and prioritize, it's a good example of the use of data, the power of analytics. I know that's not quite "technology" but it's a good illustration of the kinds of capabilities that make it all work.

[00:18:28] David: Yes. Jaewon, these are really good examples. I think for lots of your colleagues that are watching, they're looking at this and they're saying, "I wish we, in some ways, could be like Geisinger because they are structured in a way to have this payer-provider arm." You had mentioned at one point that up to 50% of your revenue is driven at-risk revenue, so it gives you the opportunity to do much of this innovative work and have an alignment with your financial parts of your system. But if one of your colleagues that is working much more still in a traditional fee-for-service environment, 5% to 10% of value-based contracts, is there a tipping point before really reaching in the way that you have make sense, or would you recommend that people start driving this really fast, even if they don't have the full financial alignment yet?

[00:19:29] Dr. Ryu: Yes. I think it gets to be a little chicken and eggish, to be honest with you, because even in a 50/50 world, I would argue it still doesn't feel like we have enough substrate to flow and power the model. Maybe partly it never feels like you're truly at that tipping point. I think the key is just to grab those opportunities and to get started. The other way to look at this is especially now with so many companies and organizations, and frankly even "disruptors" out there trying to win the hearts of consumers, a lot of how they're going about winning the hearts of those consumers is by offering things that are a lot less clunky, and a lot more convenient than what traditional healthcare delivery looks like.

I think, in some ways, there's a burning platform, even aside from the payment model because if we don't get to a more consumer-friendly, and to me, that means upstream, if we don't get to that model, I think there are many others that will, and so if anything, I would say flip it around a little bit, maybe that's imperative and incentive for us to change the payment methodologies to further support this direction.

I think the other thing that we have going for us now, which we, gosh, didn't even a few years ago was the alternative payment models have really picked up some steam directly through CMS. In the Medicare world, at least, there are channels to at least take meaningful steps to get chunks of your population in this value-based payment arrangement, whether it's in a population-based model, iI.E., an ACO, or even in an episode-based model with

some of the bundles that are out there. I think it all feeds the same kind of substrate that helps to build this muscle.

[00:21:22] Larry: Well, it seems the way your system is constituted, you're in an ideal position to take advantage of some of these alternative payment models, whether its value-based, whether it's bundled care models, but you really are in an ideal position to do that. I would say that Geisinger is unique, but it really isn't unique, and that there are others who are doing it, but you're doing it perhaps better than most of the others.

It's the reason why Geisinger has been cited really as a model of a way of delivering health care that is incredibly consumer-friendly, just as you point out, which I think is going to be imperative for any system moving forward, but you're very well-suited to do that. The fact that you are both payer and provider, that you include others, others can enroll in that I think also is a tremendous advantage. You've touched on a number of issues for us today, Jaewon, and we want to thank you very much for participating. David, additional comments.

[00:22:23] David: No. I think it's inspirational. I just wanted to ask you, finally, Jaewon, how do you describe the vision to your employees? How do you connect to them in a way that this rings true because we can see the passion that you have for this, but how do you get them excited about this?

[00:22:43] Dr. Ryu: Well, first of all, a couple of things. Larry, super nice comments, but we're still nowhere near where we want to go and where we believe we can go. Yes, we have made some good progress over the years. I think it gets to your question, David, how do you make it compelling for the employees? I think it's an ongoing piece of work where you have to show them that it allows you to build these models, and they see what the models do.

They hear the feedback, they hear it in the community, and connecting the dots for them to show that these models are made possible because of the payment model and bringing things together with partnerships with payers, or with the CMS, or with our own payer. I think that's been a big part of the ongoing journey around messaging and communicating to help connect those dots. Otherwise, it happens in the background and to the day-to-day work, sometimes it becomes less obvious and so that's a big part of what we've tried to do and really appreciate you all letting us share a part of that with you all as far as telling some of these stories.

[00:23:53] Larry: Let me just add one thing to what David said, Jaewon, and that is, so much of the centrality of medical care now is no longer in the inpatient setting. You own a bunch of hospitals, and you've mentioned a number of the examples where you're working on the outpatient side, what's the outpatient strategy? I assume you have the ambulatory surgical centers, are you looking at shifting some of these procedures that are currently done inpatient to the outpatient side?

[00:24:21] Dr. Ryu: Yes, your exactly right. We're doing that much like many other health systems. Here sometimes we talked about moving everything one click to the right. What that means is things that are inpatient, can you move them into the ER so they're able to be treated and sent home? Things that are in the ER or in the hospital, can you move it into a clinic or an ambulatory surgery environment or an ambulatory setting? Things that are in that ambulatory setting, can you move it into a virtual setting, can you move it into home?

That's what we mean when we say move everything one click over, and that's what we're trying to do. Now what that means is you can't have everything in the home. You can't have everything virtually, you do need sites of care, you do need clinics, and you got to try to get

them as close to people and communities as possible and so building out that programming and moving it out of these larger tertiary care campuses, that's been a big part of our focus.

[00:25:17] Larry: Well, again, we really appreciate your participating with us. Your comments have been superb, and as we said, Geisinger truly is a model.

[00:25:27] Dr. Ryu: Thank you so much.

[00:25:28] David: Thank you.

[music]

[00:25:39] Speaker 1: Alvarez and Marsal. Leadership. Action. Results.

[00:25:57] David: You know, Larry, what's so interesting in talking to leaders like Jaewon Ryu is that this is really the new breed of leadership. People who have trained in traditional medical settings who are now taking on responsibility for a much broader set of objectives than they ever have before to address all these inequities and to address these social determinants.

[00:26:25] Larry: You know, Dave, they're so well-positioned to be able to do this as the fact that they've been successful as both payer and provider. He mentioned how many thousands of meals they're serving each week, nobody wants to pay for that, yet they can pay for that within the realm of the way they do business. I assume they're doing some direct contracting with employers as well, which I think is ideal, but again, segmenting the population, looking at those over 65, doing what essentially ChenMed and Oak Tree Healthcare are doing where they have focused in on a particular population and really address the needs of that population. Providing, I hate to call it daycare, but providing something for many of these seniors to do in the daytime, for that matter. Providing, really, wellness benefits along with what they're doing in treating their health issues. So they're ideally positioned to move into many of these innovative models as both he and you point out.

[00:27:28] David: One of the interesting things is in the past whenever I've mentioned Geisinger as a model or a model health system, people sometimes can pooh it because they say, "Well, look, they don't have any competition. Who else is out there in the middle of Pennsylvania? And so they can do all these things."

If you listen to Jaewon, what to me was so interesting is he's not looking at it that way. He sees that if he stays with the status quo, that these companies that are out there that are making healthcare more accessible, easier to use, what he refers to as the disruptors, really will begin to start challenging his business. Interestingly, this virtual model now makes everybody a competitor and not just your traditional health systems that aren't in the middle of Pennsylvania, so he's using that as a reason to keep his system on the cutting edge to keep moving forward, to keep innovating.

[00:28:31] Larry: He has competition like anybody else has competition, and in terms of selling their insurance policy to those outside of their network, again, as he said, this is not the Kaiser network where when you're a beneficiary on their insurance plan, you're a beneficiary of the care of the providers. Here, you can have Geisinger insurance and go to whatever other provider that you may choose.

They've done some joint ventures as well in other locations, but on the one hand, yes, they're out in a rural area but the challenges in treating a rural population are sizable, and they've met those challenges, I think extremely well. As I've pointed out, they have been

used as an example of the type of system that has been able to keep their costs low, work in settings that are most efficient, and highest quality. That's what Geisinger is all about. Again, they're not unique anymore, but they certainly do it perhaps better than most.

[00:29:34] David: I'm glad you mentioned his examples with data because Geisinger has invested a considerable amount of resources and time into their data analytics. That example of colonoscopy where they're able to really refine a strategy to get much more of a result out of their efforts I think is a good example. You don't hear a lot of specifics like that. I think that that really is encouraging that by getting ahold of your own data resources and in this case, it sounds like he partnered with an outside company, they're really able to impact patient care.

[00:30:16] Larry: They have the advantage of being the payer as well, so their claims data is their data. They have this huge population of patients in their system that they have been able to utilize for that type of data collection, utilizing artificial intelligence, and natural language processing, to really be able to hone in on an at-risk population for whatever disease they choose. Diabetes, managing them with diet, whatever it may be. That's another tremendous advantage that they have had is to be able to utilize this incredible wealth of data that they've collected internally.

[00:30:49] David: Well, they're definitely going to stay on our system to watch as the world continues to evolve. I think Geisinger will be right there.

[00:30:57] Larry: I completely agree.