Transcript

[00:00:01] Omar B. Lateef: We are judged, as hospitals, based on our quality by a wide variety of different metrics. What makes your experience good when you're sick is one, obviously, your outcomes, but two, your patient experience. We set our goals at the beginning of the year, not around finances. We set our goals to be number one in quality and we set our goals to be in the top percentile in patient experience.

What differentiates Rush is a vicious tireless pursuit of trying to maintain highest quality and highest patient experience in the country, measured objectively by external sources. We were the only hospital that was in the top decile and patient experience that was rated number one in the Vizient database in quality and outcomes and safety and accountability in the United States of America. What differentiates us is that's who we are. We are a gritty healthcare-providing institution.

We certainly have research, we're very proud of our research, we're very proud of our medical school, but we're an institution that during the pandemic, during a time where black and brown people were dying at three times higher mortality, opened our doors, took a 1000 transfers into the organization, got the top 10 outcomes in the United States, regardless of the severity of illness of those patients. We're differentiated based on quality.

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[00:01:15] Announcer: Welcome to A&M Healthcare Industry Group's, *What's Your Moonshot Podcast Series*, where World World-class healthcare leaders seek to solve big problems. Listen, as we talk to today's health system CEOs about the journey to achieve their moonshots.

[00:01:33] Larry Kaiser: Welcome to A&M's *What's Your Moonshot Podcas*t. I'm Larry Kaiser, I'm Managing Director in Alvarez & Marsal's Healthcare Industry Group. I'm joined today by my co-host, the ninth Secretary of the Veterans Administration, the Honorable Secretary, Dr. David Shulkin. David, we are fortunate today to welcome to the podcast the President and Chief Executive Officer of Rush University System for Health and Rush University Medical Center, Dr. Omar Lateef.

Dr. Lateef became CEO of Rush in July 2022. He was appointed president of Rush University System for Health in 2021 and has been president and CEO of Rush University Medical Center since May 2019. Prior to becoming president and CEO of the Medical Center, Omar was the Chief Medical Officer. Under his leadership, the medical center has received national attention for its ongoing effective management of the pandemic, which included building a forward triage, deploying early testing, acceptance of critically-ill patient transfers, especially from communities hit hardest by the pandemic and being one of the first to offer antibody testing.

Modern Healthcare named Dr. Lateef to their 2021 list of the 100 most influential people in healthcare and in October 2022, named him one of the nation's top 25 diversity leaders citing him with advancing equitable healthcare policy, care delivery in inclusivity within Rush and the healthcare industry. Dr. Lateef, we are thrilled you are here to talk with us on the podcast today.

[00:03:03] David Shulkin: Omar, it's so nice of you to join us and Larry and I have a special place in our hearts for physicians that run healthcare systems and so there's so many things we could talk to you about today, but we really wanted to focus in on one of your key areas given your background in history, in quality and in safety.

I know that value-based healthcare is really where you're trying to drive your organization. You know, Omar, there's some controversy about whether there's enough uptake in value-based healthcare and whether it's really bending the curve. I wanted to see whether you would share with us today a little bit about where you're trying to drive Rush and where you think value-based healthcare is headed.

[00:03:52] Omar: Yes, well so first, thanks for having me. It's an honor to be around both of you. I've admired you both and you're both legends so it's cool to be on the phone and on a podcast with you both. Value-Based care is just the word value and then based care is important when you think about it. When you talk about phrases like is the uptake enough? If there's not uptake, then there's not people taking up the concept of providing a better value for a higher quality care.

If you take a step back and you start from the premise that value-based care should be a win-win for everybody. Should be a win for providers, it should be a win for patients, it should be a win for broader society. I don't think anybody wakes up and says 50%, 60%, 70% of our healthcare dollars should be used in our last 10 days of life in this country and we've seen numbers like that every day.

If that a massive amount of money could be shared over the duration of a person's life, we'd offer higher-quality care and get a better standard of life. We know how to mitigate disease, we know how to provide preventive care in this country in so many amazing ways, but we haven't optimized it. We've optimized it for people with access to that healthcare and not to broader swaths of the population.

The United States government's move to really encourage programs around shared savings and move to create really broader value-based care services can only be considered right. Offering a higher quality product that actually impacts people's lives in real time earlier than the last 10 days of life has to be what we do. The reason there's limited uptake is because we're not built around that model. We're built around another model. We've built hospitals that are phenomenal.

We can put a person on ECMO inside about 15 minutes from arrival to our institution. We can take a patient off a helicopter who's overdosed from something we've never seen and get them on a machine that acts as their heart and lung and have four people in the room, again, within 15 minutes dialed in, organized. Figuring out how to do a well visit and capturing the documentation in the right way so that eight different regulatory services believe we've done it the right way, takes a massive lift. It's not how we're built.

We have to fundamentally change in so many ways the larger academic medical centers and how we were designed, which was large inpatient, high acuity rescue hospitals into a more outpatient model based on the longitudinal care of a person's life. Because we're not built for it, there's more resistance to it. We have to continuously evolve and we have to have the right triggers in place and stimulus in place to make it happen.

[00:06:21] Larry: The whole value-based care model has had different levels of penetration depending upon the market. Tell us a little bit about the penetration of the value-based care and value-based purchasing in the Chicago market. Tell us a little bit about your primary care network. Do you have a clinically-integrated network? Do you have patients under capitated contracts? How has your system performed on some of these at-risk contracts?

The other thing I'd like for you to discuss, Omar, is tell us a little bit about your outpatient strategy. As you mentioned, the inpatient side is no longer the centrality of medical care. So much has moved to the outpatient setting and so much about what we're talking about is providing the highest quality care at the most efficient setting. Tell us a little bit about that.

[00:07:02] Omar: In 2020 and 2021, we saved Medicare about $20 million and $10 million respectively in the subsequent year by relying on a value-based care approach. That was over 31,000 covered lives of Medicare beneficiaries. Our value-based care programs have more now than 150,000 attributed lives, Medicare about 40,000, commercial, about 68, 70,000, Medicaid 21,000, and we have employee-sponsored around 20,000. Our value-care programs, when you net them together, it's pretty large for our net population in the city of Chicago.

Ultimately, the value-based approach we believe will reward providers in hospitals as long as you can hit the metrics that are set in each individual program. You have to have the infrastructure to not only understand what the metrics are, but to track your data in real time so you're not left burnt at the end. We've been on the right side of that cost equation as well as care equation because during that same period of time we got ranked as in the top outcomes in the United States in Vizient we were ranked number one and in the honor roll in the US news and World Report.

I tell you that to say that we didn't sacrifice outcomes. Your point on penetration in the market is very powerful. If you go out on the west coast, you see value-based care took a foothold much earlier than it's done in the Midwest. The reason that is, frankly, is that we were built, designed under a fee-for-service model. If you didn't have to change your model, what was the motivation to change your model?

[00:08:32] Larry: Sure.

[00:08:33] Omar: Is the number of fee-for-service patients in a geographical area decreases or the primary employers in a geographical area force programs like this, you'll get earlier uptake or you'll get uptake, you'll get adoption. It's no different than anything else in the market. We're starting to see that in the Midwest, albeit slower than it hit the West Coast.

We can learn from the lessons of success and failure of other larger programs, especially academic programs that building these value-based care programs to scale and in a broader population. Unanswered questions are that if you can make 20 million on 30, 40,000 covered lives, is that proportional? If I increase that number to 80,000 covered lives, do I make 90 million and whatnot?

Those questions haven't been answered and I would argue those questions are going to be answered geographically different. As we know that our health varies based on our population and the cost of care varies based on that population. Slower uptake in the Midwest, we are aggressively involved in value-based care programs and our outpatient strategy is to expand. We're a very mission-based organization. Rush is committed to decreasing the death gap in the city of Chicago.

I'll tell you why I'm telling you that because it creates a problem with what we're talking about. If you want to say if you're born on Michigan Avenue where all the stores are in Chicago, you'll live 16 years longer than if you're born five subway stops West. Every city has a death gap. You can get published very easily writing about it. It's much harder to get published when you try to solve it because trying to solve it means you're going to open up access to clinical areas in areas where there is a lower payer mix.

If you're built around a fee for service model, the more you open up access in those areas, the less revenue you'll make. Trying to decrease the death gap is geometrically opposed to trying to increase your revenue you of your healthcare system. Doing what's right in health care currently under that model will lose money. Totally happy to answer questions about why I can make a statement of that bold, but that's what the math shows.

Now value based care programs are coming as an attempt to try to solve that. The question is, can you risk adjust the population in the right way so that you're providing access for a sicker population in some regions and a healthier population than others and still be profitable? That model has to be done before we jump in because our margins in health care are so low right now.

Before you burn the boats on value-based care in a geographical area, you have to make sure that you're going to be able to provide care. You're going to have to make sure that you're able to do it. We're working through those models now, as are every other academic, medical center, and healthcare system in America is working through those models. You're really as good as your model is.

[00:11:24] David: I think our listeners are getting a sense about the type of leader you are. You not only are mission driven and have a vision, but you are very analytical and the people like me who know you understand, you really do understand the details of how to do these risk adjustments and modeling in the way that's very different and maybe Omar, this is the reason why you may be able to pull it off. Many hospital CEOs now facing the financial challenges that they're facing are as committed as you are on the mission side, but are saying it's really difficult to stick to a mission of decreasing disparities and moving towards value when our finances are so terrible.

If I heard you correctly, you're saying that, that just is going to require you to refine the modeling even more, to be able to figure out a way to keep this mission going forward but still keep the finances on track. Can you talk a little bit about how you're trying to balance your financial condition with this continued vision you have?

[00:12:38] Omar: Yes, for sure. Historically, you could run a healthcare system, I would say 10 years ago, 15 years ago, and know in general, if I build a heart program, it's going to be advantageous. If your margin is 10% or 12% or 15% and you invest in the logical areas and you grow. If the margin is 1% or 50% of hospitals in America are below zero on an operating margin, you have to know exactly where you're going to invest every dollar in. You have to put the rigor around your analytics that every other industry has done historically for a long period of time. I believe that healthcare is probably lagged as a general statement behind that analytical rigor. I'll start out with that.

You have to know what are the right programs to invest in, and are there programs that you have to just maintain now and perhaps divest in? Not everybody can do everything. Health care is incredibly fragmented. The example I'll give you is when Ebola hit the United States of America and Secretary Shulkin, you were in government, and there were a lot of people scrambling and saying, we only have 14 Ebola beds in this country, and there was an outbreak. This is going back to 2016. In Chicago, there's a lot of really good medical centers. Each medical center put up some tieback screens and said, "We're ready," and we'll put a team together. We'll do it.

We doubled the volume in Chicago with 16 beds, potentially. Rush is a unique institution that built a massive inpatient center, high-volume transfers, a new facility, underground water containment units. We were able to actually make an actual physical Ebola unit. We went to the other hospitals in the city and said, "Let's work together. Would there be a way to work together?" Every hospital wanted their own Ebola unit. That shouldn't be a surprise to

anybody. I wanted my own Ebola unit. I'm no different than anybody else, right? That's the level of fragmentation that we have in healthcare. We created something called CERN or the Chicago Ebola Response Network, where we took turns. It wasn't a free for all.

The city would get a call, the city would call up, who's next? That person would stand up. All we did was take a bunch of young volunteers and rule out malaria in very fancy units for about two months. There are only four or five patients in the America that came with it, but the amount of resources we put in our Ebola preparation was staggering. Now fast forward and say, "Do we need five different rehab centers? If you have one of the best rehab centers in the world in your city." Do we need three pediatric hospitals or four pediatric heart surgery programs in every city or 13 adult heart programs? We're going to have to get to a point for value-based care to work.

We're going to have to get to a point where as a nation, as states, and as cities, we understand that the broader care for the swath of a community has to be offered. Who gets credit for that is not as important. We have to model it out so that everybody can win. Perhaps we don't need four different independent heart programs for kids because none of them have high enough numbers for clinical excellence. We know in studies that Dr. Kaiser's friends put out that you need 150 hearts a year to really be strong in this area, or 100 hearts a year.

[00:15:51] Larry: Minimum.

[00:15:52] Omar: We have six programs in a city, each with 30. The reason that exists is the driver of our reactivity to healthcare challenges currently. We're reacting right now to the challenges instead of proactively saying, "How do we create the right model in the city of Chicago to take care of all people in Chicago in the best way?" That means we have to re-envision Rush, re-envision all the other healthcare systems, and actually work together. That's a defragmentation we haven't been able to do. We danced around it with the pandemic, but even during the pandemic, we haven't come together as healthcare systems.

[00:16:27] Larry: Yes, because everyone is after the almighty dollar and as long as fee for service persists, people will still continue to be going after the almighty dollar. The Canadians, in many respects, have it figured out. They've regionalized. Many of these higher-end, complex services. Let me just get back to your system for a second here. You've had some recent changes in leadership at Rush. Previously, one person controlled both the university and the health system but several years ago, that changed. There was a president of the university, and you as the head of the health system. Has the change in administrative structure been viewed positively? For that matter, how really has it worked?

I know there's been some more changes recently.

[00:17:04] Omar: I think there's no healthcare institution right now that I think the days of the 15-year CEO are probably gone and the 15-year president are probably gone if I had to guess, I think time will tell. I think there's changes happening all over at a rate that I think has been unprecedented in healthcare and certainly in healthcare leadership in Chicago. All our institutions, almost each one, has a new leader in the same year. It's just worth noting the split of the universities.

There's a lot of regulation in health care and certainly in academia and there's a Higher Learning Commission, which accredits our institution, really encourage having separate, unique leadership so that both groups can be represented in the right way. Splitting out the university from the larger hospital was a way to make sure both have their independence and no one gets abused.

This was done all over the country, certainly not at Rush. We followed that same model. What can't be lost is integration. You can't have medical education without a medical school. You can't have a nursing school without real integration into a hospital. As long as in the integration and this is naive, I'm probably the dumbest person that's ever been on one of your podcasts so I just speak very honestly around this. It's not about who the leaders are or what the leaders positions are, or what the organizational chart is.

If there's integration between a hospital and a school, you know it. You know it in the culture, you know it when you walk in, and you know it in the programs because the people are valued. You know that the students and the education model and that model exists and persists. What I can say is, we've always been incredibly integrated as an organization. That didn't change when we had two leaders, and it certainly is not going to change in the future. However, there are organizations where when you change leaders, you create fee domes.

I think fee domes and fragmentation is incredibly bad, especially in education, especially in a time where if you think about how upside down we are, we need healthcare providers in just about everything. I get letters every day from people who are trying to get into healthcare schools. They can't get in. We have a mismatch of what we need, what we're educating and so much of this has to do with the number of training spots we have. If we don't integrate universities with hospitals, we'll have even less training spots for all allied health fields. It didn't negatively impact Rush. I think one of the strengths of Rush is that integration.

[00:19:25] Larry: Let me just ask, you in a very competitive market in Chicago, what differentiates Rush from your competitors? Are there areas where Rush dominates the market? What are the differentiators?

[00:19:35] Omar: Quality as measured in healthcare has been one of the more frustrating challenges for every healthcare leader I know. I have never met a doctor in any hospital in Chicago, I've never met a nurse in any hospital in Chicago or anywhere in America that comes to work to do a bad job. Saying good versus bad quality, it's a very powerful statement. You better be sure you're right before you say it. We are judged as hospitals based on our quality by a wide variety of different metrics.

The US News and World Report now, Newsweek, Leapfrog, all kinds of different sources come in from the outside and say you're good versus bad. What makes it your experience good when you're sick is one, obviously your outcomes, but two, your patient experience. Your question is what differentiates Rush? We set our goals at the beginning of the year, not around finances. We set our goals to be number one in quality and we set our goals to be in the top percentile inpatient experience. To hit margins, we have to be in the top decile just for it not to on our tracking boards.

What differentiates Rush is a vicious, tireless pursuit of trying to maintain highest quality and highest patient experience in the country, measured objectively by external sources. We were the only hospital that was in the top decile in patient experience that was rated number one in the Vizient database and quality and outcomes in safety and accountability in the United States of America. What differentiates us is that's who we are. We are a gritty healthcare-providing institution.

We certainly have research, we're very proud of our research, we're very proud of our medical school, but we're an institution that during the pandemic, during a time where black and brown people were dying at three times higher mortality, opened our doors, took a thousand transfers into the organization and got the top 10 outcomes in the United States regardless of the severity of illness of those patients, so we're differentiated based on quality.

[00:21:29] Larry: Great.

[00:21:29] David: I think that's something that you should be very proud of and I know that providers feel good about working for an organization that has its goals, so we want to thank you today for spending time with us. I think this has been an extraordinary glimpse into the way that you're viewing healthcare and gives people a lot of challenges to think about. Thank you again for being with us on *What's Your Moonshot.*

[00:21:55] Omar: It's an honor. Thank you.

[00:21:56] Larry: We really do appreciate it and I think it's very clear to us that the Rush System of Health is in really outstanding hands despite the competitive market, the quality issue. As you pointed out, I think the most significant thing I heard you say is we don't start our year looking at the finances, we start our year looking at how we can provide the best quality and access for patients, which is so critically important. Once again, let me add my thanks in addition to Secretary Shulkin's thanks, really appreciate you participating. Great to see you.

[00:22:25] Omar: Take care.

[00:22:25] David: Thanks.

[00:22:26] Larry: Bye-bye.

[music]

[00:22:35] Announcer: Alvarez & Marsal, leadership, action, results.

[music]

[00:22:52] David: Well, Larry, I thought that it was really fascinating to speak to Dr. Lateef. I think one of the things that's really clear is he came up as pulmonary critical care doctor and very much thinks every day about the impact on patients. He also is really one of these guys who dug into the data. He understands how to assess quality, he understands how risk adjustments work, he understands how the interplay between quality and financial systems work. I think that in managing today in a very, very tight margin environment, that actually helps being a leader who understands that stuff.

[00:23:35] Larry: Yes, he definitely, David, as you point out, comes from a quality background. He is very invested in quality and you can hear the passion with which he speaks when it comes to quality. As I said, it was so resonating to me to hear him say clearly they look at the finances, but they're much more concerned about what are we doing for quality and the fact that they are where they are in the Vizient database. When you look at the dashboards on a quarterly basis and you look at each of the various domains, they are always up at the top.

It is something that is built into that place despite the competitive marketplace, despite the demographics with which they deal, he's very invested in managed care, in value-based care, and recognizing that you got to treat the whole population and to try to do that on a fee for service basis disadvantages you in many respects, especially you dealing with the underserved population. That's why it's so important, I think, to really specialize and really be concerned about access quality. You mentioned their outpatient strategy as well, which I think is so critically important.

[00:24:40] David: The other two things that really jumped out of me after listening to him was one, his humility. He's one of those servant leaders that sits there and says, this isn't about me and I may not know all the answers, but that's really nice to see in a leader. The other thing is that he clearly is focused on details, but he still has the aspirations to see the system change at the top. When he talks about the coordination of resources across systems and what's needed and how do we provide greater access to care to all populations. That type of commitment to mission is really what I think is still so desperately needed in healthcare.

[00:25:28] Larry: Yes. I think he's also very engaged in the academic mission as well. The fact they have the medical school, the fact that they have the health profession schools, nursing school, the health professions, whatever, it's all very much integrated into the enterprise. Despite the fact they may have separate leadership, it's all very integrated. I think it was excellent, I think he really hit on some really key points.

[00:25:52] [END OF AUDIO]