One Impact

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One Impact:
A Leader's Perspective on Changing the Mindset

Governance Institute faculty member Kevin Barnett, Dr.P.H., M.P.H., M.C.P., of the Center to Advance Community Health and Equity at the Public Health Institute, and TGI's own Editor in Chief and Senior Director Kathryn C. Peisert, recently spoke with Dr. Stephen K. Klasko, former CEO of Jefferson Health, as part of our ongoing One Impact campaign to improve the financial health of patients and communities. The following article features highlights from our conversation.

Stephen K. Klasko, M.D., M.B.A., is Chair of the Board of DocGo, a leading provider of technology-enabled mobile health services and Executive in Residence at General Catalyst, one of the world's largest healthcare transformation companies.

Between 2013 and 2022, he served as President and CEO of Thomas Jefferson University and Jefferson Health, where he directed a merger between a two-century old health science university and a nationally ranked university for design and architecture. He also presided over the growth of the system from $1.5 billion to $10 billion including the acquisition of Health Partners Plan, making Jefferson Health the first integrated delivery and financial system in Philadelphia history, and the largest health system in Philadelphia.

This article is part of a series of interviews we have conducted with executive leaders from hospitals and health systems who have demonstrated both courage and a commitment to better serve our communities and our nation. In this troubling time for the healthcare sector, there are a growing number of observers who have concluded that there is a lack of internal will to make necessary changes to proactively address improving the health of our communities. We're looking to leaders such as Dr. Klasko to help us chart a path forward.

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Stephen Klasko (SK): The unavoidable fact is that we have a broken, fragmented, expensive and inequitable health system that it is not in anyone's short term interest to fix. The bottom line is that healthcare seems to be working but only for the health systems, payers, pharma, PBMs and other traditional healthcare entities that are profiting from its fragmentation.

Kevin Barnett (KB): *Your story is consistent with my own observation that we couldn't have a more dysfunctional healthcare system if we had explicitly planned for it.*

SK: There was a Harris poll finding that 62 percent of people think that we intentionally make healthcare confusing so they can't get care. While it might not be intentional, if anyone has had to deal with the disconnect between your provider and the insurer's willingness to pay for your care, you would be among that 62 percent!

KB: *It appears that the federal government has deluded itself that it is protecting dynamic, competitive regional healthcare markets. The reality is that the number 2 and 3 hospitals in their regional markets find it difficult, if not impossible, to negotiate with payers for shared-risk payment structures. At the same time, there's typically a dominant hospital, often an academic medical center, that is in a disproportionately powerful position to negotiate with payers. They are in a position to drive up costs, which ends up costing us all more money. What's missing from my description?*

SK: The balance of power shifts at different times. The observation you shared was predominantly true through the first part of my career. Jefferson merged with Main Line Health before I got there. A primary reason they merged, in my opinion, was to give them dominance in the regional market. Main Line served a wealthier market. That dynamic has changed. Many of my negotiations with insurers was literally like dealing with the personification of the Mafia in TV shows. Their message was that you'll accept our offer, or we'll be happy to send all your patients to your academic competitor. Whether it's the payers or the hospitals, both scenarios are bad for patients. While there are many examples of health systems using their dominance to drive up costs, in Philadelphia we had a dominant insurer that used their influence to make the system work for them.

KB: *And patients are in the middle…*

SK: That's right. At Jefferson I did seven hospital mergers, with governance as currency. I think it makes a huge difference because at the end of the day, my board effectively represented those seven communities. Thomas Jefferson University Hospital, our major academic hospital, was only one-seventh of my board. The core question that board asked me was, "How are you going to take the best care of our community?" We also acquired

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a Medicaid and Medicare Advantage company that allowed us to understand first dollar premium and get into patients' homes.

With a focus on population health, we would, for example, look at 30 patients who came in through our EDs six times or more a year with asthma. These were also people for whom we weren't getting paid or we were getting underpaid. The typical hospital CEO would say, "How do we take care of those patients but do it with less cost to ourselves?" But now that Jefferson has Health Partners Plan, which supports home visits, they have addressed the mold that was driving the ED visits [for these patients]. It just makes sense to hire workers for $60,000 a year to go into homes and address root causes. So, now the question is how do we expand upon these models?

One of the newest jobs that I have is as board chair for DocGo. It's a NASDAQ-listed company. We had a joint venture with them at Jefferson with the concept of healthcare at any address. Is it Jefferson that I access on my phone or Jefferson at many service entry points? When we talk about the location of Apple, it's their research and development operations. (We don't talk about where the sick iPhones go.) But we often define ourselves in academic medicine by the places where we fail to keep people healthy. Hospitals are doing commercials about how they are better than the competition. Insurers are busy doing 30-second commercials about how awesome they are. In the meantime, care continues to get more expensive with mixed results related to outcomes.

In most urban communities, AMCs have some level of market dominance, partly because they're the largest employer. The systemic problem is a lack of transparency and cost-outcome -quality objective metrics. At Jefferson, we had perhaps the best pancreatic cancer surgeon in the country. From my experience, there are doctors in this country that do Whipple procedures or robotic surgery that probably shouldn't. If you can demonstrate positive outcomes and reasonable cost, you should be doing these surgeries.

KB: *What is your judgment about the degree to which the market economic conditions that Adam Smith[1] articulated apply to healthcare, given problems such as barriers to market entry, and imperfect information, to name a couple of examples?*

Like many, I don't shop for healthcare providers. I at least have the connections to select my primary care provider (in most cases they are appointed), and they refer me to specialists and send me to the hospital where they have admitting privileges. For people on Medicaid, they have no way of navigating other than hopefully to get appointed a primary care provider and maybe at some point have a visit with that primary care provider, and they're going to go to the hospital that's most proximal.

1 Adam Smith was a Scottish philosopher and economist who authored *The Wealth of Nations* in 1776, which attempted to describe the industrialized capitalist system (reliant on competitive, free markets) that was upending the mercantilist system at the time.

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SK: One of my mentors was Bill Kissick, who wrote *Medicine's Dilemmas: Infinite Needs and Finite Resources* (1994). He was the first one to talk about the iron triangle of access, quality, and costs. He said, "If you're going to increase access, you have to increase cost or decrease quality." He also said, "If anybody ever tells you we're going to increase access, increase quality, and decrease costs, and they will be able to do this without painful disruption, they're lying."

KB: *Given market failures, could one create a logical Adam Smith-type system?*

SK: When the ACA passed, President Obama said it would increase access, increase quality, and decrease cost, *and* it won't be painful. But it was watered down.

We gathered eight New York Stock Exchange board physicians together in December 2008 and had a great meeting about what could get done. At the end of the day, as it was implemented, the ACA was an incremental positive change, but not a "Kissick" change.

We now have a $175,000 to $1 million spread in salary from PCP to dermatologist or orthopedic surgeon. [At Jefferson] I had 149 orthopedic surgeons through a private group called Rothman Institute. Their salaries were several-fold higher than our primary care physicians who we asked to "quarterback the system." They did not take Medicaid. I had to hire a whole separate group to take care of Medicaid patients. There is no sane healthcare system in the world where the government is the major insurer and lets providers choose not to take Medicaid or its equivalent.

KB: *In the research I've conducted on community benefit, among the failures is a tendency in public policy to have a narrow focus on financial volume. The truth is, we have data to validate strategic investments in specific communities where health inequities are concentrated, and doing so would reduce the demand for costly treatment of preventable conditions in ED and inpatient settings. Yet the continued dominance of fee-for-service payment creates a disincentive for investments in prevention. If you do a good job reducing preventable admissions, you reduce revenue for your hospital. The net result is that hospitals simply tally up losses from costly clinical services and limit prevention to a small scale that won't have a measurable impact.*

SK: The first step might be to better define what it means to be a non-profit hospital. [Too many non-profit hospitals are calculating community benefit by including the amount that insurance companies don't pay. Bottom line, in some markets, there's not that much difference between the behavior of non-profit and investor-owned hospitals.

I went on 20 different non-profit hospital Web sites and looked for keywords such as community engagement, diversity, underserved people, etc. I took the top 10 for each

"In private business you would have removed all the middlemen. In healthcare, the middlemen stocks (e.g., pharma, PBMs, etc.) have gone up by eight to 10 times. We are just pretending to bring costs down. The problem isn't in the economics; it's the inability to make hard decisions."
—Stephen K. Klasko, M.D., M.B.A.

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site; then I called the CEO and said, "I love your Web site. Here's the 10 keywords that I assume guide your payment incentives, right?" And of course, the answer was "no." Incentives were guided by hospital census, EBIDA, doctors picked off from competitors, and high ratings in *US News and World Report*.

I think that every non-profit board should have at least two or three real people from the community. They need people who are informed and experienced in the realities of life in low-income communities. If you had non-profit hospitals in one region with these kinds of boards, those people might get together and say, how do we answer Kevin's question?

David Nash was Dean of [Jefferson] College of Population Health and is the godfather of population health. I have a lot of respect for David. We were giving a Governance Institute talk one time for mostly rural health systems. David gave a serious talk about population health as a science. His last 10 minutes was about Philadelphia as an example, with a 21-year discrepancy in life expectancy depending upon the neighborhood and zip code. So, this guy in a cowboy hat from Idaho stands up and says, "I know this is probably a stupid question, Dr. Nash, because I'm just a chief medical officer for a 30-bed hospital, but if you've been the dean of population health in a major health system in Philadelphia for 20 years, why is population health in Philadelphia still so bad?"

KB: *In your most recent book you note that 25 percent of your at-risk compensation was tied to reducing health inequities in Philadelphia. How is that measured?*

SK: It's not easy to measure, but we took a few parameters, and I didn't have any control over those parameters. Frankly, it required me to get out and do deals with a number of key community leaders. You can't do that from your office. I traveled to South Philadelphia where the underserved Southeast Asian community was not receiving culturally competent primary care. We received a several-million-dollar gift to create a targeted clinic in South Philadelphia. We partnered with Esperanza, a Latino social organization and with African American leaders in North Philadelphia.

To give you another great example, Ken Frazier, former CEO of Merck, grew up in a very poor area of Philadelphia and he said, "If I still lived where I was born as an African American man, I'd have a 15-times greater chance of having a large stroke just because of my zip code." He committed a large gift and took the map of Philly and pointed to where he was born, and drew a small circle.

He said, "I want the investment there." I noted that it happened to be right next door to Temple University. He said, "You're the guy doing all the creative talks, figure it out." So I called Dick Englert, the President of Temple, and said, "Dick, it's Klasko at Jefferson.

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I'd like to give you $5 million." He said, "Steve, nice to hear from you. My mom told me if I have ever got a call like this, it would be a Nigerian Prince, and I should hang up right away. But hey, I know you're not a Prince. And I'm going to listen little bit more, because yeah, that would be nice." I told him the story, and we split the match to Ken Frazier's contribution. We located a free clinic in a strip mall right next to Temple. It turns out that one of our donors owned that strip mall. So, they gave us a 10-year no-rent lease.

Now, again, I'm not sure that I wouldn't have done that anyhow. But these incentives were focusing my attention, and my team's attention, on doing something that made a difference. We had to show what I said I would do, which was being out in the community, bringing in new money, and affecting population health. The Frazier gift was a trifecta of philanthropy, innovation, and population health and involved cooperation with our competitor.

We also did a deal with Novartis. I could have talked to them about a lot of things such as a gift for drug development in our research labs. But instead, we developed a joint venture to address health inequities in cardiovascular. That's where the incentives matter.

KB: *Did you have similar incentives for the rest of your team?*

SK: Yes, but I changed who reported to me. First of all, we had a four-pillar model—clinical, academic, innovation, and philanthropy. I viewed all four pillars equally. So, the person in charge of our 18 hospitals, the person leading our multi-campus university (because I was also president of the university), the person who ran our innovation pillar, and our Executive Vice President of Philanthropy all reported to me equally and were cross-incentivized. That made innovation and philanthropy a higher mission for us than some other AMCs. The fourth pillar was philanthropy and community building. By also having our Executive Vice President of Diversity and our CMSMIO [chief medical social media information officer] report to me, it sends a signal to the rest of our staff as to what's important.

So, here's where the change in orientation matters. My chief growth officer says, "Steve, I want you to put an extra two million dollars in the budget. We did this analysis, and concluded that if we do 30-second commercials we can get a half market share from Penn." My response was, "That doesn't excite me."

Around the same time, my team did an analysis of people trying to get an appointment at Jefferson several years ago. We found that 15 percent of people who call for an appointment never get one, either because they get frustrated or because it's not being scheduled soon enough, or they just hang up after being on hold for too long. So, you

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want me to spend $2 million so I can do 30-second commercials to get people from our competitor and they get frustrated that they can't. How about if I give you $2 million to create a digital front door and at least get everybody that has already decided they want to come to Jefferson an easily scheduled and timely appointment. Then we'll talk about getting new patients. I'm just giving an example of how that changes the whole mindset.

What happens when you go from being a nimble, flexible, agile, 200-year-old academic medical center thinking like a startup company, to being an 18-hospital, 10-campus university and health system, with an insurance company, a $10 billion entity? The key is maintaining that ability to be nimble, flexible, and agile. Jefferson had a great board that was willing to take some risks. That is not true everywhere. There's a great cartoon I use in my talk that shows a hospital board chair saying, "Instead of taking any risks, let's continue our slow decline to obsolescence."

KB: *While policy change at the national level appears to be out of reach at the moment, there is growing pressure for action, spurred on in part by stories like recent revelations about organizations like Multiplan. What can and should we expect in the coming months and years?*

SK: Here's what I believe you can expect:

1. Non-contiguous consolidations, like Kaiser-Geisinger-Risant or Aurora-Advocate; geography will no longer be a limiting factor.
2. Non-traditional owners of integrated delivery networks and health systems. Hemant Taneja and I wrote a book together called *UnHealthcare: A Manifesto for Health Assurance* in 2020. General Catalyst is now actualizing that through HATCO, which partners with over 20 health systems and is looking to purchase Summa Health in Ohio.
3. Generative AI and LLMs working to solve the healthcare workforce crisis. Companies like Hippocratic AI combating the worldwide nursing shortage by creating generative AI powered auto pilot agents that conduct patient facing clinical nursing tasks safely for $9 an hour. Ellipsis Health has a vision of being the first NCQA accredited AI care management program.
4. From hospitals as "brick and mortar" to healthcare at any address. DocGo is partnering with health systems, payers and governments around the world to do many things that would have required a hospital to bring them closer to home including AI driven transportation, home visits, labs and radiology.
5. The new roles for the "human in the middle." In the age of AI, it is crazy to accept medical students based on science GPA, MCATs and organic chemistry grades and then be amazed that doctors aren't more empathetic, communicative, and creative!

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6. AI will finally allow population health, social determinants and health equity to move from philosophy and academics to the mainstream of clinical care and payment models suing seamless data and coordinated wearables.
7. Healthcare will finally figure out the magic of consumer segmentation. Amazon, Netflix, and Google know everything about us *individually* and tailor their offerings to each individual. We still talk about hospitals being "patient-centric" as if there was one patient. Patients that allow us to follow their everyday lives will be able to get customized care based on nutrition, exercise, and lifestyle in a new age of behavioral economics.
8. Finally, unintended consequences are not unintended if you know they are going to happen. Privacy, cybersecurity, and bad actors will become larger issues in this new fourth industrial revolution era.

Books by Dr. Stephen Klasko:

- Feelin'Alright: How the Message in the Music Can Make Healthcare Healthier (2023)
- UnHealthcare: A Manifesto for Health Assurance with Hemant Taneja (2020)
- *Bless This Mess: A Picture Story of Healthcare in America* (2018)
- *We Can Fix Healthcare: The 12 Disruptors That Will Create Transformation* (2017)

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