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ProHEALTH℠ Care

Zeyad Baker, President & CEO of ProHEALTH

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Our Managing Director of Platform Development, **Billy Ingram**, had the opportunity to speak with **Dr. Zeyad Baker**, President and CEO of ProHEALTH Care NY, about his experience building the largest non-hospital, independent, physician-led health system in the country.

Zeyad, thanks for taking the time to talk with us. To start, I'd be curious to hear a little bit about your background.

I'm a pediatrician by training. I started a practice, Riverside Medical Group, alongside my brother who has a background in primary care. We acquired a practice and turned it into a group with 110 doctors at 40 locations. We sold it to Optum in June 2016 and then in the third quarter of 2018, Optum called and asked if I could help them run a practice that they acquired in 2014, which was ProHEALTH, and had over 1,000 clinicians.

When I hear that you guys at Scale are helping private groups achieve scale and success in an environment where it's not easy, where most of the scaling is on the hospital and non-for-profit side, I think that's a beautiful thing.

What precipitated the move from clinical care to management? Describe the transition.

It happened organically. I wasn't one of those guys who after seven years of practicing decided I'd had enough. I love my work and taking care of kids, I find that the opposite of work. What happened was, we saw an opportunity in the marketplace to scale: On the one hand, our practice was growing due to our patients receiving better care, through greater access and referral management, on the other side, we noticed that a lot of doctors needed a home, because every doctor was saying, "I'm getting paid less, expenses are higher, so soon I'm going to be forced to work for a hospital system."

So, we thought, let's fix the consumer problem as we see it, which can be solved through scale, and let's solve the physician problem by giving them an alternative to the hospital – an independent practice model. And once you start growing quickly, as we did at Riverside, it becomes difficult to do a really good job overseeing the business if you see patients, and so it became necessary to spend more and more of my time on the management side. For a while I would continue seeing patients seven days a week, from 6:00 AM to 8:30 AM before rounds, but that became difficult, as often patients and their families want the flexibility of afternoon and evening visits and eventually I decided I couldn't keep the standards I wanted to maintain as a pediatrician, only being available in the mornings.

The other thing I came to terms with, is the concept that if I could be a business leader and help 1,000 doctors be better, then I'm affecting a million patients, not just my panel of 2,000.

With such a large network of clinicians and dispersed locations, how do you maintain operational consistency across the network?

There are a lot of IPAs out there where different groups and locations are unified in the CEO's mind, but for all intents and purposes they have nothing to do with each other in any material way, other than that they bill together.

You need to commit to being extremely upfront to any practice that is considering joining you and you need to maintain a very high standard of integration, which equates to having a strong sense of identity. It would be easier for me to acquire doctors if I told them they could do whatever they wanted in terms of quality and protocols. More doctors would join me, but it would mean that our mission, to provide better and more consistent care, would be compromised.

So if I wanted to help provide better access then I needed to provide consistent standards of access where all my practices are paired into central care coordinators, whereby the new doctors give up some of their local autonomy and cede it the larger practice's oversight so that patients can be referred to where they will be seen right away.

Doctors all like doing things their own way and so it's difficult. Doctors got into this thing to be the best at delivering quality care. They don't want to change just because they are being told to, so it is important to take time, at the outset, to explain our protocols and systems and the reasons we have implemented them, and show them the improved NPF scores and outcomes.

What about operational performance – how do you track performance across your network?

One big metric that we monitor is the percentage of abandoned calls in our offices. It may sound simple, or trivial, but it's one of the two most common complaints that US patients have with their doctors: that they can't get through when they call. If any of our offices has a more than 20% abandoned call rate, we plug them into our Care Coordination Center where we have a couple of hundred employees. Once we have addressed the issues at the office and reasons for the high abandon rate, we can cede the phone answering back to the office. The Care Coordination Center has answered over 300,000 calls within its first few months of launch; patients spend an average of less than 30 seconds in queue before speaking to someone. It's been a tremendously successful program for the offices whose calls go to the call center and it is rapidly expanding to more practices in ProHEALTH and beyond.

Another is accessibility. We consider accessibility the first component of quality.

We opened an after-hours clinic on our main campus that is open from 8PM until midnight – it's not urgent care, but a practice where patients can schedule visits in the evening. Based on the success of the first Extended Hours Clinic, we've already opened our second in Bethpage to give access to more of our patient base. As an output of this, we track our ER admission rate, where the standard is in the high 30s per 10,000 patients, and we are at 20, so almost half the average. We attribute a lot of this success to accessibility.

In terms of quality indicators, we have 25 people in our ACO and quality department. For instance, we have 100,000 diabetics in our network and we need to check: are they getting their screenings — ophthalmology and podiatry etc., and if not then our team in the centralized department for quality and care will contact that patient and get them to come in. We provide doctors feedback on if their diabetic patients are hitting their target scores, what their ER patients' utilization rate is etc. As long as the doctors are practicing good medicine, a lot of those metrics are to do with things outside their control and so we provide the back-office support to make sure the patients are being monitored outside the office and are called to come in if they aren't being compliant.

Additionally, we have a hospitalist program in where doctors live inside the hospital, and all that work and monitoring is aimed to decrease length of stay by one day, and they're doing just that. The goal is to deliver the best care for patients and decrease overall cost of care.

It seems like a lot of the focus is on accessibility and monitoring patients outside of the exam room.

I think people will look back and be amazed that people once thought what we did in our exam room was more important than what we didn't do outside of it.

Our patients these days are far more vulnerable, both economically and clinically than ever before, and for us to be: I'm your doctor and I'm responsible for your health, but only in the 1% of the time when we're together and only in your office, is ridiculous. I think people will look back and be amazed that people once thought what we did in our exam room was more important than what we didn't do outside of it – what happened outside

the office matters, and to not work with that thesis is actually negligent. We spend a lot of time focusing on outside the office compliance, wearing monitoring devices, providing feedback and so forth – that is what is going to define the relationship with the patient, and the touch point – by that I mean meeting with the doctor, will be considered the outskirts of the relationship.

What are a few operational topics that keep you up at night? How do you seek to mitigate risk in these areas?

Anything that has to do with external interface, for instance if a patient is away in Connecticut on a weekend and uses a hospital there – how do we get the data, how do we use it. Anything to do with IT interfaces. That's when a staff member will spend hours trying to get someone on the other side, there is a lot of operational friction from dealing with someone outside our network.

We have relationships with multiple hospital partners and each system has their own culture and own way of doing things. There is a lot of what I would call unwarranted differentiation in practice and the quality of care delivery. One place will do non-interventional care for heart failure, in another they'll do more intervention. Even though we have hospitalists on site in can be difficult to achieve our standard of quality because we don't control the patient.

And another one is now with telehealth. We want to create telehealth, we have a bit, mainly telepsych, but all the issues that you need to overcome – issues with HIPPA compliance, different platforms and interfaces and how to plug it into your revenue cycle and EMR and so on – makes it very difficult.

How do you approach payor contracting? I assume that's done in house. Is that a big focus?

Yes, we do it ourselves. I'm very involved in that personally. Our payor contracting at Pro Health is unique because we emphasize preventative care and wellness in a way that nobody in the market does. And allow me to explain; if you were the hospital system, your biggest expense is all the brick and mortar real estate and fancy equipment. Well, the only way to pay for your OR's is to keep them full, and the only way that you are incentivizing a prospective cardiac surgeon is with a lot of cardiac transplants. Those things only come when there's a high disease burden in the community. So intrinsically, if you're a hospital system, while your billboards may hope for wellness in the community, your balance sheet certain doesn't. And at ProHEALTH, what we don't have, are hospital beds and what we don't have, is an emergency room.

What we have is clinicians who are interested in wellness and our revenue model works when you come in for a preventative visit — that's our life blood.

And so, keeping you healthy is in our best interests. Similarly, we have 31 urgent care centers, which are one fifth as expensive to the system as an ER.

All of this helps my patient, but it hurts the hospital system. When I approach the payers, even though we're at the scale of any hospital (our budget is actually bigger than most hospitals in America), that's not our pitch, it's not about leverage. Instead it is approaching the payors and talking to them about prevention, wellness and keeping patients out of the hospital. And so, not surprisingly, the payors are actually really, really big fans of our model and when we go talk and it's less of a negotiation and more of a partnership.

What's the biggest difference between your role as a CEO at Riverside and now being CEO of ProHEALTH?

The scale: we had about 20 something specialties out of Riverside, we have about 102 specialties at ProHEALTH. We have assets that some academic medical centers don't have and which no community hospitals have, so for instance, we have four radiation oncology centers, we have over 20 imaging centers in the community. We have two ambulatory surgery centers with over 10 ORs. You're talking about the scale of tertiary academic medical centers.

The way I would look at it: Riverside is a very large medical group. Pro Health is a very large health system.

Now, remember we're both part of Optum and we're starting to merge best practices and me and my brother are cooperating as a two-leader heads, and we view it as a multi-state health system with best practices across the board. And the patients in New Jersey and New York travel quite a bit between the two states. So, one difference is the scale and the depth and breadth that ProHEALTH represents. The second thing I would say is that the New Jersey market, where Riverside's practices are located, is different.

I think the thing I'm most proud of is that when Optum does surveys on our doctors they say that they feel very empowered.

How are the markets different in New Jersey versus NYC and the North East?

Recruiting doctors. Yep, so in Jersey, you've got Hackensack Meridian, Robert Wood Johnson, Barnabas but you also have Riverside medical group, Summit Medical Group, very strong brands. What I'll tell you is most doctors in New Jersey come running to the independent physician market first and foremost, and it's usually only when a doctor can't find a home due to whatever reason, maybe the independent group is not seeking to employ that doctor, that then the doctor will end up at New Jersey hospital, as a plan B. In New Jersey, when we met with a doctor that Riverside wanted to employ, the deal was basically done.

Compare that to New York, where you're talking about some of the top academic brands in America: when you talk about Presbyterian or Mount Sinai, it's a little bit harder to recruit. These NYC hospitals represent an attractive alternative for doctors – they have cachet and their comp is generous.

Remember, at these New York hospitals, patients come from out of state, including New Jersey. That's not the case for New Jersey. You don't have patients from New York wanting to get their hip transplant at New Jersey hospital, but you certainly have the inverse. Here in New York the hospitals employ a lot of physicians and they don't do a bad job of it and they have the bonus allure of a good academic pedigree. And so, when we meet with the doctor in the NY catchment area, we actually have to explain a little more about the value proposition, and it becomes a real decision for doctors.

What's the board structure of ProHEALTH, how does reporting work?

Our board structure is different from a hospital system. We don't have a traditional board in that sense. So, it's me for ProHEALTH in New York, my brother for the Jersey market and so on. And we have meetings pretty frequently, on a quarterly basis. We just had one in Manhattan, talking about the local market and talking about our regional plan. The real focus at the board level is to drive down the cost of care for the marketplace and drive up quality outcomes.

And that's really the charge that Optum has for me and this array of ambulatory services and doctors that are unique in the market: to impact the total cost of care while maintaining quality. We want to be 10% lower than the next lowest provider of scale in the market on cost. And we want to be number one on clinical outcomes, all outcomes, so things like utilization, NPF scores, patient satisfaction, and so on.

We see CEOs utilize different strategies to manage their senior leadership teams. How do you communicate to your senior leadership team to monitor their performance?

I'm a big believer in flat organizations. I remember when I wasn't CEO in my career and when I would look up to the head person, and how I liked to be managed. We welcome feedback and treat the team as one team where everybody has an equal voice. We got where we wanted to go a lot faster than if we did one on one because you were basically taking the best of everybody competing and fighting and putting your best foot forward in those weird kind of, you know, leadership, hierarchical, knockdown and so on.

I empower my employees to better serve the patients, not to tell my employees what to do. I spent the last nine months more than anything else, recruiting top talent and now I'm going to have to unleash what I put together.

And so that's the flat organization long story short.

It would be easier for me to acquire doctors if I told them they could do whatever they wanted in terms of quality and protocols, but it would mean that our mission, to provide better and more consistent care, would be compromised.

How does provider compensation work across the network? Is there a consistent model or formula? What's that based on?

Our compensation model is pretty standard. We have gradually shifted towards a model that is part productivity based, RVUs etc. But a big part of the goal is achieving procedural integration in order to achieve consistent quality outcomes. This means that one patient-measure we track, and for which doctors are accountable, is what steps doctors are taking towards making sure our patients don't end up in the ER when they could've gone to one of our urgent care sites and making sure the patient gets a procedure at in-network ASC instead of an out of network hospital. And so, part of our RVUs program is to reward our doctors for considering and the impact they have on the patients outside the exam room as well. As the saying goes, "there's not bad people, but bad incentives".

So, when you say part of the doctors' consideration for performance is based on referring to say an in-network ASC, how is that measured, and how do you adjudicate it?

Yeah, so when we meet with our doctors, we explain to them that one in four Americans that we take care of say that if they got a $400 a surprise medical bill tomorrow, they wouldn't be able to pay it. And if they got a $3,000 bill that they had to pay, they would file for personal bankruptcy. The number one reason for personal bankruptcy in New York, New Jersey and the markets we're in, is private healthcare costs: and that's for patients with insurance, not patients without insurance.

So, we tell our doctors, "so many of your patients come to you at your office and you're looking at them because they have high blood pressure. You're concerned about their high blood pressure. They're concerned about their high blood pressure too, but they're actually a lot more concerned about the bills that they're going to rack up from all the testing you're about to send them to."

Most patients will tell you they go to the doctor more nervous about all the referrals and potential costs than they are about the reason for the visit and that's a really, really sad proposition and most practices these days, the doctors are incentivized to not necessarily consider what happens to your patient once you give them 10 referrals to go get pictures and blood work.

What I'm saying is we've, you order doctors in their comp models if they consider, and actually their staff and our care coordination center are supporting them that we're going to direct you. You have to take it up. We're going to make sure you go to a specialist who takes Cigna and who, by the way, we know has good outcomes. We have that data.

What's it like for a doctor working at ProHEALTH. Do they feel they have a voice regarding the direction of the organization and its strategy, or do they just come in and do their job and not worry about it?

I think the thing I'm most proud of is that when Optum does surveys on our doctors they say that they feel very empowered. We currently have quarterly chair meetings with over 20 chairs and quarterly chiefs meetings, with over 35 chiefs. They play a critical role in our organization and are highly respected for their work as clinicians and academics; as well as their leadership within ProHEALTH. They often serve as mentors for new physicians.

We have quarterly physician meetings, where usually we have over 500 of the doctors on site and another few hundred on via webex. I also do outreach. So out of the 284 sites we have in the in the marketplace from Suffolk to the five boroughs of, each week I go out to a handful of sites, whether our urgent care or our imaging sites or primary care practices.

Once a month we take one of our specialties and we spend the whole night together talking about everything from updates and clinical programs to innovations in telemedicine. We spend a lot of time as a community of physicians and I'm truly just a member of that community. Now. Am I the guy who deals with the media, am I the guy who deals with their payors? Yes. Does that make me really kind of the most important or of the singular leader? Absolutely not. So, I'm the representative, but the doctors that I represent who are touching patients every day, they are the ones who come to me with direction and it's my job to execute on their vision of what they see.

One of the things I'm most proud of what we've built and continue to build is that it's a private sector business.

Any final thoughts on the future for ProHEALTH and US healthcare in general?

We are the largest, non-hospital, independent, physician-led health system in the country. Our model of ambulatory, value-driven care is strengthening the traditional doctor-patient relationship and is taking shape as the future of the healthcare system.

We're rapidly expanding and bringing in new physicians. We're also continuing to implement innovative programs in health care – like the extended hours center; the Care Coordination Center; the new Center of Excellence, the ProHEALTH Center for Neck and Back Pain, which takes advantage of our coordinated care system to deliver better care for patients.

One of the things I'm most proud of what we've built and continue to build is that it's a private sector business. I really enjoy improving my business and the healthcare landscape. And I think everybody's gotta be involved. Regulations, not for profits and so on, but particularly the private sector. And so, when I hear that you guys at Scale are helping private groups achieve scale and success in an environment where it's not easy, where most of the scaling is on the hospital and non-for-profit side, I think that's a beautiful thing.

Special thanks to Zeyad Baker, MD for his insights and our Executive for their participation in this discussion.