Podcast Episode: Leading health policy towards equity, peer mentorship, and taking advantage of a crack in the door. Featuring MaCalus Hogan, MD.

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As a physician interested in health policy, UPMC orthopedic surgeon MaCalus Hogan M.D., M.B.A., has helped develop cutting edge approaches. The University of Pittsburgh payer-provider model enables innovations in technology and delivery models, including value-based approaches that pre-date the Affordable Care Act era. Dr. Hogan discusses how modifiable risks can be identified and addressed prior to surgery, helping to foster an inclusive approach and protecting access for complex patients. Dr. Hogan also traces his career path as a high school football player in Alabama to his current position at UPMC, discussing the importance of mentors, taking advantage of a “crack in the door” and increasing workforce diversity. With Dr. Bonnie Simpson Mason.

Dr. Mason: Hello, and welcome to another episode of our Health Disparities Podcast, conversations about health disparities with people who are working to eliminate them. I am Dr. Bonnie Simpson Mason, and this week we are recording our conversations at the National Harbor in Maryland, where we are enjoying a program of speakers and workshops at the annual Movement Is Life Caucus. It is my absolute pleasure to interview today, one of my former mentees, Dr. MaCalus Hogan, who is the Vice-Chair of Education and the Residency Program Director in the Department of Orthopedic Surgery at the University of Pittsburgh Medical Center. Prior to joining UPMC, he completed his orthopedic surgery residency at the

University of Virginia, and then a Foot and Ankle Fellowship at the Hospital for Special Surgery in New York. In addition to his surgical expertise, which is why we have him here today, Dr. Hogan is very interested in healthcare policy and quality of care delivery. He currently serves as the Medical Director for Outcomes and Registries for UPMC Donald F. Wolf Jr Center for Quality Safety and Innovation. Last year at the Caucus, he talked about the importance of patient engagement and highlighted digital tools that can optimize the engagement process that are being incubated at UPMC. This year, he is on a panel asking the question, "Is access to care threatened by new payment models?" Before we get into our conversation, first, I would like to say welcome to Dr. Hogan.

Dr. Hogan: Thank you, Dr. Mason, it is great to be here and to be having a conversation with you and this topic, and it is always enjoyable to be in DC.

Dr. Mason: Well, you know, I consider you to be a source of inspiration because here you are. And I want you to tell us a little bit of about your history and the evolution of how you found yourself from growing up as a young man in Alabama, who found his way to medical school and now in leadership, at one of the more prestigious universities in our country. So, tell us a little bit about your background and what inspired you or maybe who.

Dr. Hogan: So, I won't take all the time for that no, thanks again this as you mentioned, I grew up in Alabama, a small place called Muscle Shoals, Alabama. And my parents are still there. And from there, I went to New Orleans to undergrad at Xavier University, Louisiana, and then to Howard Med School where you and I met and where you were as sort of my first orthopedic mentor and you and Dr. Grant at that time and others and Dr. Reagan really inspired me and really gave me an opportunity, just an open door and access as we have this discussion regarding access and access to care, you guys really gave me access to opportunity, and I think that is at the core of what this means of this discussion and what we've been talking about today and what we had in our panel discussion.

And from there during that time in DC I really was just gaining more knowledge of policy healthcare delivery. And that rolled right into my time at the University of Virginia and during the latter parts of my residency that was during the time of the debates and passing and evolution of the ACA. And from that, a lot of exposure, a lot of opportunities to just kind of listen and understand and I think that really gave me a foundation of, you know, there's more that we can do beyond even just being orthopedic surgeons and I have been fortunate. I mean, from my time at the University of Virginia, for my chairman who recruited me there, Dr. Lorensen and other faculty members there who really gave me the opportunity to really spread my wings and look into other things and particularly in policy, and even

having the chance to lobby here in DC with our Academy during the National Orthopedic Leadership Conference. Then from there just maintaining a partnership with the National Medical Association, with the Gladden Society and having the opportunity now through Movement Is Life over the last several years to keep this conversation going, which is an important conversation. I have made it this way, you know, to this point on the shoulders and backs of a number of people who come before me and people who tolerate me and inspired me through their tolerance of my interests and the many things I enjoyed doing, but I believe healthcare is dynamic in our country. And if we don't approach it dynamically, we won't be able to continue to evolve in the right direction to ensure that everyone has access to appropriate care.

So, at UPMC it's been a great environment and foundation because everything that really is happening in healthcare is happening at the University of Pittsburgh Medical Center from a standpoint of being a payer provider being in a very competitive marketplace and being in an academic institution but also a community with a number of variable needs. And so, it's given a good opportunity to really explore my different interests and really build upon those things.

Dr. Mason: How could you describe some of the innovative approaches that UPMC has taken to maybe even addressing healthcare disparities, if in fact that's

part of the mission that you all are tackling, or are you looking at this more from a quality payment reform perspective where healthcare disparities may or may not be at the top of the agenda?

Dr. Hogan: No, that was a great question and point. So, at the UPMC from our clinical perspective and just our delivery model, I believe it gives a lot of opportunity because as a payer provider there are incentives on both sides of the ledger and in the beginning and the end, it should be about the patients. How do we provide care to all of the patients and all the members, and how do we provide care to our communities? And what I have found in a very short amount of time is that it becomes complex once the answer becomes complex and when it is not simple.

Dr. Mason: Right.

Dr. Hogan: And as soon as it's not easy, it's like, "Oh, that's going to be hard work." "And how do we look that deep?" "It's not possible?" And then you say, "Well, it is possible. You just have to be intentful about your actions." And so, for us, a lot of our bundle work, joints replacement bundle work, did come out of the mandate, was with CJR and the CMS mandate. However, prior to that, UPMC has always, I think they built a strong academic institution and clinical care model because with a lot of the volume of surgery, being with the pretty much the largest provider in Western

Pennsylvania, there's always been a lot of focus on how can we deliver the highest quality care at the most competitive and affordable cost, and that has really been at the foundation of UPMC since its birth. And when you combine that with the collaboration with the University of Pittsburgh and our School of Medicine there's always been this opportunity to have synergy and two forces colliding to try to propel that theory forward. And so, that's a positive. When we really look at from a standpoint of access, when we look at it from the standpoint of our health plan, our health plan has a large population, they have 3.5 million members and only growing. A large percentage of their population is Medicaid based or needs based planning. And so, it incentivizes our health plan as well to really take good care of that population, and when you put those two together it really forces you to look at things a little bit differently. Even with that though, the cost containment pieces are always the first thing that many people want to talk about. I mean, that is what we're talking about a healthcare now. If healthcare was affordable for everyone, truly, we wouldn't be having this conversation with these podcasts.

Dr. Mason: Right.

Dr. Hogan: We would be doing something else, but our current model in our country it's not a sustainable affordability. So, I think what our challenges are for UPMC going forward, are how do we continue to provide the highest

quality appropriate costs, but how do we ensure the wellness and access to care for everyone and that when they actually do need care, how can we prevent them from needing care? How can we keep them well, when they actually do need care that they have access to that care with the best providers, and that they are not going to find themselves kind of homeless from a standpoint of a medical home and a treatment home, because we know that that actually leads to poor outcomes for everyone. So, that's the approach we're taking. We're constantly learning and trying to self-learn and evolve with that.

Dr. Mason: So, we've learned over time that, you know, the bundle payment system has actually increased some of our healthcare disparities in the form of cherry picking. Choosing patients who have potentially better outcomes from the very start and not choosing to offer certain treatments to patients even pre-surgically have additional comorbidities that may contribute to a poor outcome, and we call that lemon dropping. So, with some of the reform measures that UPMC is putting in place, you know, how are you addressing that particular, concern as we look to decrease healthcare disparities, but we know that has not happened.

Dr. Hogan: So, those are great questions. In our environment, one of the first things we put together with our joint, pathway and program was really a modifiable risk, as well as non-modifiable risk stratification. You know, the

patients who have chronic disease that is uncontrolled but also different lifestyle factors that usually do not result or have a higher chance of them resulting in a untoward outcome, following a joint replacement or any type of orthopedic elective, orthopedic intervention. And I found relief in that a majority of my partners and colleagues in helping build and manage this program from a surgeon standpoint, agreed that if we can really help patients modify their risk, the outcomes will be better now with modifying the risk, some people may say, well, your modification is, well, I am just going to cherry pick out of that population.

Dr. Mason: Sure.

Dr. Hogan: And that is my modification. I just won't see those patients. And so, I think it is important as these programs are built that we speak about the challenge first and that's one thing I do believe we did a good job of. We said, okay, we have risks. How do we manage these risks? Right. So, you are not going to change the hemodynamic status of a transplant patient, whose already post-transplant, but really needs a joint replacement, and all of a sudden, they have Avastin necrosis of their hip because they were on longstanding steroids because of a chronic renal disease that was genetic. So, all of a sudden, now, how do you manage that patient? I mean, in theory, medicine helps save their lives, but medicine also gave them an arthritic hip.

And so, do you close your doors on that individual? So that was one of the first challenges and with our group of surgeons agreeing on our modifiable risk approach that has helped us. And so, we essentially have patients go through a pre-habilitation program that really looks into what is your functional status prior to needing a joint replacement? What is your functional status prior to getting on the pathway towards joint replacement and understanding what are the different opportunities we have to optimize you prior to surgery. And that works across a number of chronic comorbidities, such as hemoglobin A1C with diabetics. How do we help with weight loss? How do we work with smoking cessation and nicotine replacement therapies to really help patients have the best chance and opportunity to receive a joint replacement, but also how can we help you just be mobile and be functional? Everybody kind of enters that pathway toward Care, at a different entry point. And so, we've done our best to take the approach of regardless of when or how they enter, how do we get them through? I think that’s very important and I was relieved, we never leave, but I guess the better statement to make is it was a heartfelt receipt of an email this week of our large center of excellence work group, which has about 80 people on it, and individuals other than myself or those who are running, they're managing the program, sending out emails talking about a lot of the recent literature around the risk of heart stops and diversion on heart-stop medical measures, such as BMI and smoking and

how they can be barriers to care. And I think it speaks to, again, we do not have the answer. We are not a utopia, but at least speaks to, this is something that a population of individuals providing this care thinking about on a larger scale. If you don’t speak about it, you will not do anything about it cool.

Dr. Mason: Yeah, that is risky in and of itself even having the conversation. So, you all are to be lauded from that perspective. So, I'd like to shift just briefly in our conversation. I want to move back to you because I regard you as someone I admire, but also as a role model for other young African American men who may want to go into medicine, but who may also want to be an orthopedic surgeon. You know, what advice would you give, you know, someone in high school or that person in college, who wants to follow your footsteps? I mean, it may be even based off of, and you and I have tons of conversations about what it takes to traverse this path successfully, but given, you know, the landscape and the climate of what we're enduring today and given that there were more African American males in medical school in 1979 than there are today, what type of advice or support or encouragement can you give these young people from a realistic perspective? Cause you and I talk about that often.

Dr. Hogan: No, it’s a great question at point. And, you know, I never thought I would be the person that someone would ask that question. Let me start with

this, my perception of my path, I tell people all the time and my wife, who you introduced me to I say regularly, you know, I am just the person who I feel so blessed and fortunate that I've come across so many mentors, people who are willing to help. A lot of it is really I know its faith and hope for, you know, just the opportunities. And when I look back on it in a very short career, like a lifetime I have been fortunate. And so, and then others say that, I think about when I give advice to others, how can you take advantage of just a crack in the door and being able to recognize those different encounters and taking advantage. So, when you say high school, I give my story. I mean, in high school, I was fortunate, my brother is an engineer. So, he is 10 years older than me. So, he was like a father and, you know, brother. My parents were very supportive and a football player in Alabama. That is what I did. I mean, everybody played football, but you had to have good grades too, otherwise I could not come home safely to my parents. I was interested in medicine. I thought I wanted to do family practice or pediatrics because that's all I really knew and great fields. And then I literally, once I broke my ankle, the guy who fixed my ankle told me, I should think about orthopedic surgery. And so, the reason I bring that up is because it was a gap in the door, right? It's someone who leaves a door open, open-ended statement and you know, sometimes people are trying to close the door behind you after the statement. They really don't want you to come in, but it was just an open-door statement, and if they are trying to close the door on you, open-door statement you take advantage

of it, explore it. You never know what you may find out. You may like it, you may not but at least you have another experience, another skillset you can build on. And then with those, you can start learning to appreciate when someone's welcoming you in and taking advantage of that. So, I just started shadowing that individual and white guy in Alabama, and he tells me, we talk about this all the time. He is still one of my mentors and he still helps take care of my family and his sons now an orthopedic surgeon. He came to do research with me last year. So, it's a great thing to watch. At the same time, you have to be present, you have to be active and you have to be engaging and you have to be willing to go out of your comfort zone to kind of meet people where they are, and I think that is what's really helped me over the course of my career, and up to now because I've never been really afraid to go where people don't know my name or where in theory, it's an environment where, okay, am I supposed to be here or not. And I think that is important to do, and you don't gain courage to do that until you actually take some of those open-door offers, so you can see what a closed-door offer looks like. I think that helps you move through the challenges that are going to come as you move forward. And it also gives you the cue of when you do need to stick your kind of foot at the bottom of the door and say, "Whoa, hold on a minute. I really want to have an opportunity to be here and get exposure and learn from you. I won't get in your way, and I won't be a nuisance," and you'd be surprised how often, sometimes the support you may have, may be very passive,

and they just are willing to let you be in the environment, but you need to soak all that up. And with that, I think that's really what helped me once I got to UPMC, just the environments where I just soaked up knowledge, observing and being willing to be places that are outside your own comfort zone. And all of a sudden people want you in their zone. And so, I think that's important.

Dr. Mason: This entire conversation is relevant to our discussion on healthcare disparities because we know diversifying the physician workforce is one of the keys to eliminating healthcare disparities and increasing health equity. So, I think when we have the opportunity to learn from you so that we can imbue that spirit of stick-to-itiveness and endurance and courage, right, that young people know that is what they need. Be willing to walk through that door when it is opened and be willing to take that risk. So, from your perspective, and maybe even from what you have seen growing up in terms of healthcare disparities, maybe in your own community, given the disparities that you may see in Pittsburgh in your surrounding areas now, what do you see the orthopedic surgeon's role as being in helping to address some of these healthcare disparities? We've talked about it from a system level, but when we talk about it from the individual surgeon's level or even physician's level, what do you think some of the things are that we can do to address these disparities?

Dr. Hogan: So, I think orthopedics, as whole, we could do a better job of, and we are working toward it, but a better job of really taking command and helping steer and drive the delivery of musculoskeletal care overall. I mean, some of the challenges that we are dealing with come at the root of permitting over time, as we kind of worked our way in the hospitals. Being busy, delivering, you know, high volume care, high quality care, we have left behind some of the core teachings of musculoskeletal medicine. And so, what that has done is actually put our entire population at risk across the board. What is appropriate? What is not appropriate? When should you really be thinking about a certain type of intervention for a knee replacement, hip replacement, or what joint pain actually is, real pain that you should be paying attention to? So, that's one piece. As surgeon, I think it is very important that we partner more and more closely with primary care because the value of what we do can deliver for patients in regard to the mitigation of joint pain and the optimization of mobility is one of the greatest gifts you can give in medicine. I mean, our patients are happy. So why not work harder to share that with the whole? And a lot of times that is not going to be evident without partnering with primary care, which are the true gatekeepers to that care. When you have that in mind, and maybe we do evolve how we think. More primary care doctors are thinking about panel size and the patients who represented them as a part of their panel. And as more primary care physicians and practices, are in partnership with health plans, they're going to essentially receive a panel

that is associated with where their practice may be located or who has been designated to them. So, once they actually start having to partner with us more on. I want my patients to get the best quality care. And I am following how they do, whether they get surgery or not, I think that is going to change. Hopefully, it will change more how we look at it as orthopedic surgeons. But from a standpoint of access to care. and as I spoke about it in my panel discussion over time and with the expansion of Medicaid. You know, at the state level with expansion of Medicare advantage and different payment models. There is going to be a blending of where. We are not going to be able to recognize who has what insurance, and I think that is the part that a lot of people are running from. It is the devil you know; versus the devil you do not know. I believe as surgeons; we need to have it as musculoskeletal care providers. We need to have a broader understanding of that and how we really help take care of a population. And otherwise our ability to maintain a system in a sustainable manner, there is no corner of the world to hide in with this anymore. There are no environments in America, where you can say healthcare has done perfectly here, and everyone who crosses this line shall not be scathed by any negative aspects of care. And so, I think that is what we just really have to think together and more but partnering with primary care and asking, why are patients not doing well? I think that is important, and if we do that more, at least ask the question again, coming out of our comfort zone, meeting people where they are, I think we can get there. But it's

going to take some time, it will be challenging, and we will have to have some difficult discussions. But it is very important.

Dr. Mason: Well, I think with your kind of leadership demonstrating that the discussions can lead to effective outcomes, and then you are talking about it in forums like this, that more leaders might be willing to have some of those difficult outcomes. And as you spoke about the gift, the greatest gift that orthopedist provide is the gift of movement. I think that underscores, while we have you here as one of our distinguished panelists today not to mention that you have been voted by your peers as the best doctor in America in 2016, 17, and 18 proud mentor moment bragging. But I really appreciate your time today, as you were able to share with us a little bit about, some of the health system innovations and payment reform that UPMC is leading the way on.

In addition to, like you said, having conversations around managing risk and those modifiable risks, the modifiable risk program that you are talking about and the pre-habilitation program as well. I think those are types of innovations that more hospital systems could benefit from. And then more importantly, in my mind, as the master mentor at the table with the junior mentor encouraging our young people to go ahead and walk through that door. Whether someone who looks like you is opening it or not, when that door is open, take a risk, walk through, see what is on the other side. And

there lies your opportunity to grow and follow in your footsteps. So, Dr. Hogan, thank you so much for being here today.

Dr. Hogan: Thanks for having me.

Dr. Mason: Thank you listeners for joining us once again for the Health Disparities Podcast. Join us again at movementislifecaucus.com or you can subscribe to the podcast at iTunes, Google, Spotify, and Stitcher. New episodes post every two weeks. So, look out for our special series featuring such thought leaders as Dr. Hogan from our partner organizations. Until next time, this is Dr. Bonnie Simpson Mason, thank you so much.

(End of recording)