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COMMUNITY

Dr. Jeffrey Norris of Father Joe's Villages: "Get physicians out of doing unnecessary administrative work"

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By Luke Kervin, **Co-Founder and Co-CEO at PatientPop**

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The COVID-19 Pandemic taught all of us many things. One of the sectors that the pandemic put a spotlight on was the healthcare industry. The pandemic showed the resilience of the US healthcare system, but it also pointed out some important areas in need of improvement.

In our interview series called "In Light Of The Pandemic, Here Are The 5 Things We Need To Do To Improve The US Healthcare System", we are interviewing doctors, hospital administrators, nursing home administrators, and healthcare leaders who can share lessons they learned from the pandemic about how we need to improve the US Healthcare System.

As a part of this series, I had the pleasure to interview Dr. Jeffrey Norris.

Dr. Norris was raised in Houston, TX and Salt Lake City, UT, and he received a BS in Biology from the University of Wisconsin–Madison. He completed medical school at the University of Utah, a year-long epidemiology fellowship at the Centers for Disease Control and Prevention, and residency (including being Chief Resident) in Family and Community Medicine at the University of New Mexico in Albuquerque. His passion to service those most affected by social inequities led him to become the Chief Medical Officer at Father Joe's Villages, a large homeless service agency in San Diego, CA.

Thank you so much for joining us in this interview series! Before we dive into our interview, our readers would like to get to know you a bit. Can you tell us a bit about your backstory and a bit about what brought you to this specific career path?

Having bounced around the United States throughout the course of my life, I was exposed to many diverse experiences that helped me see all people as having inherent value and worth. This was underscored by being raised Unitarian Universalist, which instilled in me a focus on social justice. Further, because my father is half-Japanese and half-American (born to a first-generation immigrant from Japan) and was raised in the rural Midwest, he experienced significant racism while growing up. All of this led me to seek out a career where I could use my privilege in life to give back to the community.

Can you share the most interesting story that happened to you since you began your career?

When I first came to San Diego in 2015, very few clinics were providing Medication Assisted Treatment (MAT) (specifically buprenorphine/naloxone, also known as Suboxone). There was a general hesitation and resistance to the idea, either because it was "too hard to do" or it "enabled people". Because I was trained in New Mexico, where MAT was a normal part of primary care, I was baffled by this. The data on MAT was so compelling: it can reduce mortality rates by up to 70%.

I became determined to bring MAT not just to my organization, but to the community at large. By 2017, our organization had built one of the first low-barrier MAT programs in the county. Low-barrier means people can walk-in and get started on MAT the same day in almost all cases. Our operating mentality became "if someone walks in the door and says they want to stop using heroin, then we should do everything in our power to get them medication and treatment that same day."

This program began just before there was a surge of fentanyl in our community and a large amount of funding for MAT programs. I like to say that we got into MAT before people realized we needed MAT in San Diego. Then when things got bad, we were suddenly positioned as experts in the community and we were better able to push others to provide low-barrier MAT. Now there are robust and thriving networks of clinics doing MAT, and that means thousands of lives have been saved across the county.

Can you share a story about the funniest mistake you made when you were first starting? Can you tell us what lesson you learned from that?

My first HRSA site visit was when I was only a few months into the job. HRSA site visits are required every three years for Federally Qualified Health Centers (FQHCs) to maintain their status with the federal government. Thus, the site visits are very, very important and mission critical. There is a "site visit guide" that describes the requirements of clinics like ours, but as I was so new to the job, no one had told me this document excited (so I had not reviewed it). When working with our auditors, that made for some very awkward interactions, as they asked me whether we were following x, y, and z requirements and "are you aware of these requirements?" Since then, I have become very familiar with the requirements. The learning lesson here is that you don't know what you don't know—so always ask a lot of questions!

Can you please give us your favorite "Life Lesson Quote"? Can you share how that was relevant to you in your life?

"A true leader is one who is humble enough to admit their mistakes". -John C. Maxwell

I truly believe that leaders who cannot take responsibility for their own mistakes are dangerous. While it is not easy to own mistakes (and I cannot claim I always do it), this is the way to maximize trust and psychological safety. Contrary to what some people may believe, admitting mistakes will make you seem stronger to the people you work with.

Homelessness is one of those "wicked problems" in society that is incredibly hard to solve. As such, working on solutions means that inevitably there will be failures along the way. Leaders owning their mistakes becomes even more important when working on homelessness. Owning mistakes allows us to truly look at what worked, and what did not work. When working on a social issue like homelessness, that ability to reflect honestly is essential.

Are you working on any exciting new projects now? How do you think that will help people?

If anything, we are working on too many projects. My biggest challenge as a health care leader is not overextending the organization and people I work with. Homelessness presents so many challenges: to health, to wellbeing, to communities, to the economy, etc. It is very easy to get pulled into trying to "fix it all". But no single person or entity can do everything. For that reason, most of our new projects are focused on integration and collaboration within our organization, with governmental agencies, and with other service providers. The goal is not to do more as a single entity, but to do more as an entire community.

An example of that is how we provide healthcare on the streets (our Street Health team). Historically, health care and social services teams operate in silos, even within our own organization. But health and social issues *never* operate in silos. One of our big pushes right now is to better integrate our street medicine—health care directly on the streets—with what others are doing.

How would you define an "excellent healthcare provider"?

An excellent health care provider does two things: (1) they readily acknowledge what they do not know, and (2) they do not provide care in the exact same way to every patient.

Acknowledging what you do not know helps you to not hurt people. It ensures that you know your limits and it allows you to look for support, if and when you need it. Support can mean many things: looking things up, getting a consult, or sometimes asking the patient themselves! Often patients know more than we, as clinicians, give them credit for. And that actually takes me to the next point: each patient has a different story, a different background, and different needs. Patients thus need care delivered to them in a way that works for them. The only way we can do that effectively is by asking patients and considering what's going on in their lives. Doing the same thing, in the same way, for every patient simply does not work. In my work,

people who are unsheltered on the streets often have very different health care needs than someone who is housed. If someone who is living on the streets needs a colonoscopy, it is not as simple as ordering a colonoscopy. Anyone who has done colonoscopy prep could tell you that doing that prep on the streets, without proper bathroom access, is not going to go well.

Ok, thank you for that. Let's now jump to the main focus of our interview. The COVID-19 pandemic has put intense pressure on the American healthcare system. Some healthcare systems were at a complete loss as to how to handle this crisis. Can you share with our readers a few examples of where we've seen the U.S. healthcare system struggle? How do you think we can correct these specific issues moving forward?

One of the biggest crises in health care related to "big data". As with most industries, there has been an explosion in the quantity of data in health care over the past few decades. But the conundrum of that data is that it sits in silos that do not talk to one another. There is little "interoperability"—the ability to securely exchange and share electronic data. We have been working for decades to address these issues through things like "exchanges", but those efforts are usually county by county or state by state. As a result, there has been varying degrees of success and most of these systems leave a lot to be desired. Because of this, health care still relies on very old technologies like fax machines to transmit data.

During the pandemic, communities had to act quickly to understand what was going on and respond. Lack of rapid access to health care data meant that communities were less responsive and agile. That meant more death.

The solution? We need more data standards in health care and those standards must be "required" at some level (by either governmental bodies or accreditation agencies). If data is collected and stored in different ways by different systems, interoperability becomes a nightmare. You end up having to decide how to map data fields that often do not line up nicely. I cannot tell you how many hours I have personally spent on mapping health care data fields because there are so few standards in the industry.

Of course, the story was not entirely negative. Healthcare professionals were true heroes on the front lines of the crisis. The COVID vaccines are saving millions of lives. Can you share a few ways that our healthcare system really did well? If you can, please share a story or example.

The biggest win in so many communities around the country, and San Diego is no exception, was organizations' ability to put aside their own interests and figure out what was needed for the community. It was heartwarming (and exhausting) to see stakeholders on calls at all hours and on the weekend early in the pandemic, hashing out what needed to be done. We were all in it together, and we were all seeking the same goal: less disease and less death.

Here is the primary question of our discussion. As a healthcare leader can you share 5 changes that need to be made to improve the overall US healthcare system? Please share a story or example for each.

1. Break down health care and social services silos. For too long, health care and social services systems have operated as two totally separate systems. Much of the time, they do not talk to one another, do not work together, or do not share resources. As a result, community members end up confused and unable to get what they need. The services delivered are not "person-centered". This has massive negative implications for health, wellbeing, and economic performance of communities around the country. We must break down the walls between these two systems. In some cases, that means health care systems doing more social service work (e.g., building or funding housing) or it may sometimes mean building true collaboration. The best example of movement toward success, *en masse*, is here in California. Medi-Cal, our State Medicaid system, is working on an entire redesign called CalAIM. This initiative will move Medi-Cal and the companies that administer it directly into the space of providing things like rental subsidies, true case management, etc.
2. Value-based care. Much of health care is paid for by "fee for service". That means the more you do, the more you get paid, even if the services do not make people healthier. Health care is slowly marching away from this system, and for good reason: it does not work for people and their communities. It is a wasteful and inefficient system. What we must work toward is paying for "value". We must incentivize health care systems and providers to do the right thing for patients. I am glad to be part of the leadership team in an organization that is doing just that in Southern California. Integrated Health Partners (IHP) is a network of nine FQHCs, which provide care to over 270,000 people in Southern California. As FQHCs, we are all currently paid by Medi-Cal at a flat rate per visit, regardless of the services we provide. If I see a patient for five minutes for a cold or spend an hour with a patient who is suicidal, we get paid the same amount. That payment system incentivizes seeing more patients for shorter periods of time. IHP recognizes that we can do better by moving toward getting paid for the value we provide to our communities, not just the number of visits we provide. We are actively working on value-based care contracts with Medi-Cal and Medicare health plans.
3. Create functional data sharing systems and standards. As I mentioned above, health care data is incredibly siloed. If we cannot address this issue, our ability to respond to crises and meet the needs of our communities will be severely hampered.

4. Address social inequities head on. Over the last few years, our country has (belatedly) come to the recognition that we are not doing enough to address or meet the needs of the inequities faced by people of color and other minority groups. Health equity means that all people have the opportunity to be as healthy as possible. How is that possible when people experience homelessness, poverty, violence, endless discrimination, low quality schools, etc.? The answer is that it is not possible. Health equity can only occur when social *in*equities are addressed head on.
5. Get physicians out of doing unnecessary administrative work. Being a physician now is harder than ever. The amount of time spent on administrative tasks has skyrocketed, while the amount of time we have with patients has gone down. Few of us got into medicine to do data entry, stare at a screen all day, and feel we do not have the proper amount of time to talk to patients. Further, because physicians are among the most expensive workers in any health care system, having physicians do unnecessary administrative work does not make sense financially. We must ensure that physicians have the tools and support they need so they can spend more time doing what they do best: caring for patients.

Let's zoom in on this a bit deeper. How do you think we can address the problem of physician shortages?

Over the last decade, the number of medical school slots has risen, but the number of residency slots has not kept pace. That means we do not have the proper capacity to train all the budding doctors. Running a residency program is expensive and time consuming, and it requires substantial financial investment. The billing and revenue generated by residents never make up the cost. That means that governmental entities and foundations have to fund residency programs. Right now, the amount of funding out there is not sufficient to keep pace with the need. The big change needed here is more federal funding for things like Teaching Health Centers, which fund residency programs in primary care, in areas with the most need.

How do you think we can address the issue of physician diversity?

Within health care facilities, front-line staff are often very diverse. The custodial staff, medical assistants, certified nursing assistants, etc. are often a quite diverse group of people, while the physician workforce itself is often much less so. In order to fix this, health care organizations need to create better internal mentoring and support systems and establish more pipelines to get folks into medical school.

How do you think we can address the issue of physician burnout?

The biggest issue is one I've already mentioned. If we cannot reduce the administrative burden of being a physician, not only will we have fewer physicians than we need, but we will also have physicians who are less happy and more burned out. Burned out physicians will not be very good at listening to their patients and their communities, and they will be less able to meet the needs of those they serve.

What concrete steps would have to be done to actually manifest all of the changes you mentioned? What can a) individuals, b) corporations, c) communities and d) leaders do to help?

The first step is having frank conversations about what is not working. You cannot solve a problem you are not willing to name. Just as being a good leader means owning your mistakes, it also means owning your part in what is not working in your community. Working on the above issues means we each must be able to acknowledge our part in broken systems. It does not mean we can fix things on our own, but if we get together, own our piece of it, then we can start to work on real solutions.

You are a person of great influence. If you could inspire a movement that would bring the most amount of good to the most amount of people, what would that be? You never know what your idea can trigger. 🙂

In the late 1970s, our country began drastically reducing the amount of money invested in affordable housing. Around the same time, we reformed our mental health system to release people who were institutionalized for many years, but we did not build enough outpatient mental health capacity to deliver the care those folks needed. These two factors together have caused much of the homeless crisis we see today.

Part of fixing that is a drastic reinvestment in affordable housing. Data shows that in most urban areas, rent costs have gone up decade after decade, while renters' income is stagnant or has fallen (adjusted for inflation). If, at an absolute minimum, we do not put a massive amount of money into subsidizing rents, there is no way we will climb out of the hole we are in. Efforts are building in local and state governments across the country to do just this, but I truly think it will take a definitive act of Congress to invest the type of money we need.

How can our readers further follow your work online?

https://www.linkedin.com/in/jeffreyn/

Thank you so much for these insights! This was very inspirational and we wish you continued success in your great work.

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