HEALTHLEADERS MEDIA
POPULATION HEALTH EXCHANGE

Insights Report

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PRODUCTS: THREATS AND OPPORTUNITIES IN A NEW MARKET

Analysis and in-depth discussion from healthcare leaders at the HealthLeaders Media Population Health Exchange in April 2016

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Analysis

Innovation Beckons, but Comes With Risks and Tricky Choices

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What kind of healthcare systems do executives want to be running once the move from volume to value happens? The many strategic choices, including business or care models driven by various technological innovations, were a hot topic at the HealthLeaders Media Population Health Exchange in Austin, Texas, held April 27–29.

Much talk at the Exchange was about reinventing the process of care delivery, but in order to truly transform healthcare, the outcomes of that process must change as well. Whether it's engaging patients to be more active participants in their care, or whether it's a new technology that makes the gathering of healthcare data easier or more actionable, each healthcare system faces both the challenge and the opportunity to make its own distinctive mark on what is effectively a national laboratory of innovative ideas.

Here is a breakdown of some of the innovations underway:

- **Consider moving as much care away from the hospital as possible.** Care needs to follow patients and employees to where they are, including workplaces and schools. Telemedicine and remote monitoring are pivotal enablers.
- **Rebuild care offerings around the patient.** Regardless of whether care includes new offerings such as health insurance, make sure care coordinators follow patients to provide care continuity, which will also align nicely with changing payment incentives from Medicare and Medicaid.
- **Consider partnership options carefully.** Startups, venture backers, and even crosstown rivals provide intriguing opportunities, but the failure rate for any such venture is systemically high, so communication between stakeholders is essential.

Discussion

Products: Threats and Opportunities in a New Market

SCOTT MACE

As health systems implement population health, they are faced with many choices of direction. Assuming various levels of risk, some are trying to emulate lower-cost competitors moving into their areas, or beginning to resemble payer-provider systems such as Kaiser or UPMC. Still others are launching ventures that make them look more like high-tech startups, or the money behind such startups. Such was the range of answers to the innovate-or-die challenge at the Exchange.

Innovate they must, but strategies vary wildly

"We're building an urgent care just down the road from our own ER to try and keep people going to an urgent care, rather than to the ED," says Linda Butler, MD, vice president of medical affairs, chief medical officer, and chief medical information officer at UNC REX Healthcare, a 660-bed facility based in Raleigh, North Carolina. "And we've partnered with a local ER group to provide a virtual coworker clinic through RelyMD. Since this is not the group that is staffing our ER, this was a little controversial."

On the technology front, UNC REX is dabbling in virtual care, including sending patients—and employees—home with the Skype messaging application, called TouchCare, installed on their phones for follow-up video visits with cardiologists. "A lot of things can be handled just by that Skype visit," Butler says.

TAKEAWAYS

- **Innovate they must, but strategies vary wildly**
- **Proliferating partnerships**

Meanwhile, certain cardiac patients are sent home with the CardioMEMS device implant, which measures pulmonary artery pressures, Butler says. "You can see changes via the CardioMEMS before a patient will actually start having symptoms or gaining weight. So for those real recalcitrant heart failure patients that we're having a difficult time managing, it gives you a heads up and you can intervene and change their diuretic."

Moving from volume to value inevitably means slowing or stopping the rate of adding hospital beds. "Our operating income has been shifting very rapidly into outpatient," says Frank C. Astor, MD, MBA, FACS, chief medical officer of NCH Healthcare System, an alliance of more than 700 independent physicians and medical facilities in dozens of locations throughout Collier County and elsewhere in southwest Florida. "So we're not investing in as many beds. We think the hospital should be an ED, an OR, and an ICU, and everything else in the whole system should be out elsewhere. We are trying to focus on outcomes and not on process data."

Northwell Health, a 22-hospital healthcare system based in Long Island, New York, is focusing on patient experience, says Chief Applications Officer and Vice President Tina Christopher.

"Our new branding for Northwell is really to look at patients cohesively across all of our sites so that when you come in, you feel like you're connected," Christopher says. "We're doing a lot of programs in pop health where we have to pull out data that's appropriate for our Medicare and Medicaid patients. We have a development group, so we're creating our own care tool, and we're working very closely with the business to create a tool that works best for the care coordinators. We've also invested in our own insurance company, CareConnect, to see how that will benefit our patients, and we allow

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PEER INSIGHTS: Members of the Population Health Exchange enjoy the peer discussion. From left, Matthew Chambers, CHCIO, chief information officer at Baylor Scott & White Health in Dallas, and Helen Macfie, PharmD, FABC, chief transformation officer at MemorialCare Health System in Fountain Valley, California.

our employees also to be insured by CareConnect."

Much of Northwell's Medicaid efforts arise from New York State's Delivery System Reform Incentive Payment (DSRIP), the main mechanism by which New York will implement the Medicaid Redesign Team Waiver Amendment. DSRIP's purpose is to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Avoidable hospital use encompasses not only avoidable readmissions, but also inpatient admissions that could have been avoided through proper preventive care services, according to the FAQ on the DSRIP website.

"DSRIP is one of the programs that we're really focusing on, and that's all related to data," Christopher says. "We're working with IBM and Explorys to create some data repositories to be able to pull out that information in easy dashboards for our pop health people, our pay-for-performance, and also for our research folks to see that data for specific types of patients, so we can help them throughout the care continuum before they come to us and then when they leave our organization. We're developing mobile apps to help our patients feel more connected and be able to pick the specialists they're interested in. But [we're] trying to confine it to Northwell so we can stop leakage and keep our patients coming to our systems. We've developed some joint ventures for urgent care centers

> "Our operating income has been shifting very rapidly into outpatient."
>
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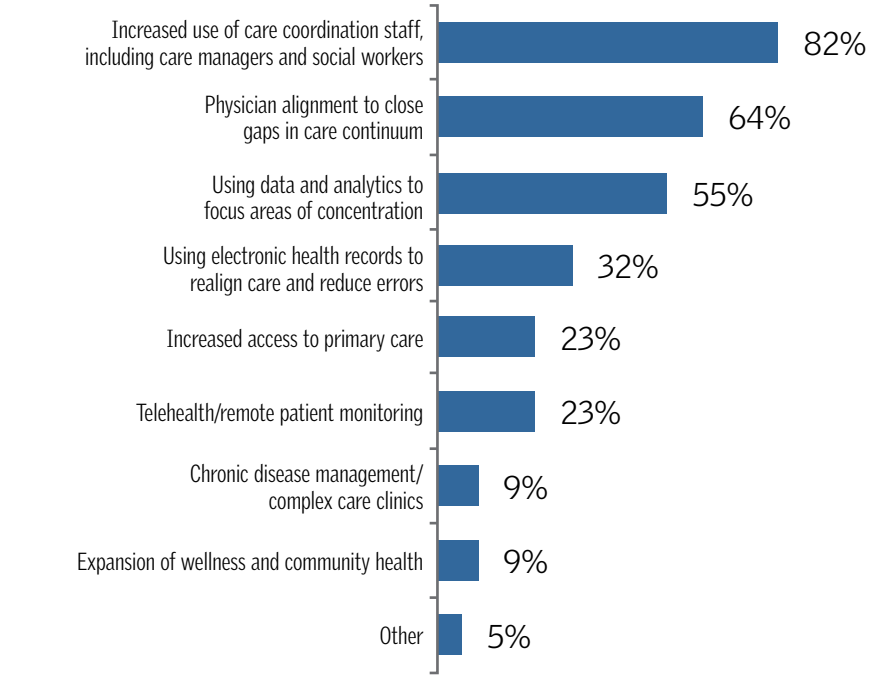
What are the top three strategies that have been the most effective for your health system in population health?



SOURCE: HealthLeaders Media Population Health Exchange Pre-Event Survey. Multi-response. Base = 22

and ambulatory surgery centers, all in the idea of keeping our patients contained with our physicians."

Another participant voiced a similar theme about transformation. "We've redesigned our case management so that it is patient-centric and practice-centric as opposed to being regionally deployed across the hospital," says Lee Duke II, MD, MBA, senior vice president and chief executive physician at Lancaster General Health/ Penn Medicine, a 631-licensed-bed nonprofit health system encompassing Lancaster General Hospital, Women & Babies Hospital, and the Lancaster Rehabilitation Hospital in partnership with Kindred Healthcare. "The case managers now follow patients if they're admitted, and then hopefully not readmitted, but if they come in another time, then they're followed by the same case manager who relates directly to the primary care."

"The expansion of telemedicine is very big for us," says William Phillips, CPHIMS, CISM, senior vice president and chief information officer for information services at University Health System, headquartered in San Antonio and anchored by the 716-bed medical center. "And the fact is that we're doing things and partnering with other hospitals or other physician practices outside of our county—we're the local county hospital district—yet we're partnering in reading and doing telemedicine for stroke and neurosurgery and some other things for rural areas and other areas across Texas, which is very dynamic in its growth."

In other cases, care is being tailored to the patient population's schedules. "We've got a number of direct

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In which patient engagement areas is your organization investing with the intent of supporting population health management?

Patient portals	85%
Wellness- or condition-related outreach programs	70%
Patient access to medical record	69%
Telemedicine for clinician-patient consults	50%
Systems to assess patient engagement levels	43%
Remote monitoring	31%
Telehealth to track patient health status	29%
None	1%

Multi-response
SOURCE: HealthLeaders Media Intelligence Report, *Population Health: Investing in a Risk-Based Future,* October 2015; *http://hlm.tc/1OR3JWI.*

employer products, and we found two things that have really shifted the cost," says David L. Dull, MD, chief medical officer of Penrose-St. Francis Health Services, a 522-bed acute care facility in Colorado Springs, Colorado, that includes Penrose Hospital and St. Francis Medical Center. "One, for many of our employers, we've started doing employee clinics, but focused around their hours in the vicinity. Two, in one of the school districts, we have a clinic that's open before school hours, and then minimally staffed during school hours, and then open again afterwards for both the teachers and their families so they can bring the kids in before and after."

Proliferating partnerships

Another innovation at Penrose-St. Francis: a mobile stroke unit, the result of a partnership between the healthcare organization and a competitor in Colorado Springs. "It's essentially an ambulance that is dedicated specifically to stroke patients; it can communicate with both facilities and can send some things via telemetry to the facilities," Dull says. "And then triage is where the patient goes based on the symptom."

Interestingly enough, the collaboration was initiated by the competitor, says Dull. "The competitor pushed this. They were the ones that wanted to do it. They're associated with the University of Colorado. They have a little bit deeper pockets than we do. They initiated the project with grant funding, and then we jumped on board, obviously because we have the neurointerventionalist and we

"We're developing mobile apps to help our patients feel more connected and be able to pick the specialists they're interested in."

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CHIEF APPLICATIONS OFFICER AND VICE PRESIDENT
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DAVID HARTIG

didn't want them bypassing us to Denver with those cases."

The demands of innovation are spawning partnerships across healthcare, something that Carolinas HealthCare System has given a great deal of thought. One of the most innovative approaches to clinical care is improving care experiences before they happen, says Pamela M. Beckwith, FACHE, system vice president of quality. Carolinas HealthCare, an integrated delivery network with 900-plus care locations, has a simulation strategy for doing exactly that, says Beckwith. Carolinas Simulation Center is accredited by multiple agencies and areas, including by the American College of Surgeons as a comprehensive education institute, and by the Society for Simulation in Healthcare in four areas: assessment, research, teaching/education, and systems integration.

Carolinas Simulation Center lets system physicians, clinicians, and care teams use innovative clinical content and curriculums to advance care practices in multiple clinical domains, she says. Medical error disclosure and delivering bad news are two of the simulated situational scenarios. In addition, the Center was mobile to 16 Carolinas hospitals and their respective obstetric clinical teams for managing and practicing obstetric hemorrhage protocol implementation.

The systems testing component helped Carolinas reduce variation and maximize tool utilization, as well as strengthen patient safety and clinical outcomes. "Improving clinical effectiveness is a core business fundamental for us, and this approach and focus has helped us innovatively solve common issues and challenges," Beckwith says.

Within three years, in which areas does your organization expect to have redesigned the delivery of care with the intent of supporting population health management?

Care management with risk-based patient panels	67%
Clinical programs organized by disease state	63%
Systems to identify gaps in care	61%
Team-based care in patient-centered medical home	61%
Care goals, incentives aligned across continuum	59%
Care registries organized by disease state	51%
None	5%

Multi-response

SOURCE: HealthLeaders Media Intelligence Report, *Population Health: Investing in a Risk-Based Future,* October 2015; *http://hlm.tc/1OR3JWl.*

Dull sounds a cautionary note about centers of innovation, however.

"I was at a medium-sized health system that had an innovation center that was launched with great fanfare that was supposed to take all of the intellectual capital that was freely flowing out of our institution and into vendors, and to my knowledge, they brought one or two products to market, and I think it was an abject failure," he says. "The last I heard, they were not focusing on innovation in their innovation center any longer. So I think it's a real struggle for health systems, and I wonder if you're best off partnering with or identifying venture capital companies to do your innovation for you."

Instead, Dull suggests "new ways of thinking about care and using what you've got."

Innovation is unlikely to reside solely within any healthcare organization, says Alan Pitt, MD, physician and professor of neuroradiology at Dignity Health, a 17-state network of 10,000 physicians and 56,000 employees who provide care at more than 300 care centers, including hospitals, urgent and occupational care, home health, and primary care clinics.

"There's a really interesting book by Lisa Suennen, a venture capitalist, and David Shaywitz, who writes for *Forbes,* called *Tech Tonics,*" Pitt says. "They talk about how innovation has really three parts to it. It has the investor group. It has the innovator who usually doesn't know much about healthcare—usually it's some gearhead that had a personal problem and they think they can do it better, and they come up with some innovation. And then there's healthcare. And really to create innovation, all three of those have to come together and have a common working knowledge of how are we going to take this forward."

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