ROUNDTABLE

Getting Serious About Population Health Management

Healthcare provider organizations have increased their embrace of population health management, according to HealthLeaders Media research. How they approach population health is strongly connected to leaders' strategic vision. One route is a clinical integration strategy, another to receive funding from federal programs, such as Delivery System Reform Incentive Payment. The choice of strategic pathways determines how a provider organization builds and executes a population health strategy, and is tightly bound with the governance process. Organizations are at different levels of sophistication in understanding what a PHM strategy requires, so leaders must think clearly about their strategy and ensure that tactics follow suit, or their efforts may flounder.

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Roundtable Highlights

HEALTHLEADERS: *What are the prerequisites for deploying an effective population health management strategy, as opposed to a strategy based on volume?*

ROBERT A. GREENE, MD: First, you really have to have incentives aligned from the top down to the people seeing the patients. For example, if they're paying people for volume based on RVU bonuses, it'll fail. They'll generate volume and they won't do the population health management things they need to do, which generally include a lot of nonbillable services. Second, you have to have actionable information. You have to be able to identify your target patients and your target initiatives. That then has to be translated into what can be done by each practice. Third is clinical operations. If somebody is being discharged from the hospital, there has to be a mechanism that gets them follow-up at the primary care office. The last one is leadership and communication. You have to be able to have not only a hierarchy that supports this, but also a lot of communication, change management, and culture management.

CHRIS STANLEY, MD: One prerequisite is simply willingness to change culturally. Population health principles are very disruptive to how care is being provided, whether you're a physician, a nurse, in a hospital, or in an ambulatory setting. Second, historically we have been a hospital-centric system. Hospitals tend to be risk averse, relatively slow to change—many times because the traditional ways of doing things have worked really quite well from a business perspective. You have to think tactically about operations and clinical integration. A fair amount of care is provided to our attributed members through facilities that are nonaligned and nonaffiliated, so we need to understand not how the network fits together for us as providers but how it fits together on the journey of a patient or a consumer. Another key is care management. Successful care management is going to evolve around patient empowerment and supporting them. They're their own best caregiver. The final core pillar is around data and analytics, and that's very complex. That is where we've had some learnings, some missteps; it's a real challenge to pull information from multiple sources and, in as real time as possible, analyze it for your needs and get it into the hands of the end user.

STEVE LONG: Hospital centric is what we were, and we were very successful. We employed most of the primary care physicians in our county. In the past, we had looked at them as the necessary loss leader to drive volume to the hospital, so you held down that expense as much as you could while still driving volume. But now we are coming to the realization that volume in the hospital will be unhelpful to future success, and that in fact we need to take care of patients at the place where it's most appropriate and where it has the biggest impact—and that is in the primary care clinics. So we are undergoing a transformation. We don't think of ourselves as Hancock Regional Hospital, but as Hancock Health. We understand chronic disease needs to be a major area of focus and that most of the determinants of chronic disease are social variables. Very little of that can be addressed at hospitals. So we needed this fundamental change.

MICHAEL SIMPSON: Leadership, as these colleagues have demonstrated, is paramount. Without the right leadership, you're not going to move very far. Incentive programs are also a key component, as well as actionable information. Without these three elements, population health programs never get off the ground. One new idea we've had is the creation of a preventive care service line where your incentives are very different. You're aligning clinicians based on the number of incidents that they prevent, or the gaps of care that have been identified. That's an alternative to saying we're just going to put population health across the entire environment, which is very difficult.

Chris Stanley, MD
Vice President
Catholic Health Initiatives

STANLEY: I don't know that it would work well for our organization to set up a preventive service line—partly because it feels to me like it would be switching out one population health concept that is not clearly understood for something else that would probably still not be quite what we're trying to get to. Our organization has struggled to some degree with trying to understand population health, being a very procedure-based, specialist-oriented organization historically. There is concern we are biting off too much. Where we've had a lot more traction over the past couple of years is around bundles or episodes of care that are very discrete. If you put enough bundles together, after a while you've got 30%, 50%, 75% of healthcare services bundled together, and it's sort of a stepwise move toward population health that works well for us.

LONG: I believe the reason our industry started down this population health road in the first place is because,

fundamentally, we're driving our country into bankruptcy. The problem is that until we change how providers are paid and incentivize the move from volume to value, it's going to be very difficult because those old models are very sticky and we're all in them. My organization is 95% to 98% fee-for-service volume based, and I can't just step away from that overnight. It would be very attractive for me to develop a preventive health service line because I can get my arms around that. Limiting the concept in this way may limit our ability to make the dramatic changes that are needed nationally, plus we have a finite window to get things done. Care management and data analytics will be key approaches, but true population health extends outside of what we do within the health system. You have to proactively reach out to the populations that don't come to you until they hit the ER, and that means delving into areas usually associated with social service agencies and not-for-profits.

GREENE: We're in an early stage of resolving this question of the relationship between specialty care and primary care. An example of how we're trying to address that is with our primary care service line, which is where preventive medicine is based. We're building a granular model based on team-based care. Within a primary care office, a team might be one or two doctors, one or two nurse practitioners, three or four nurses, and six medical assistants. A lot of the basic preventive services can be done at a more basic level. Building really strong primary care like this requires a culture shift for the team members and for the patients, because it's not like the patient is always going to see Dr. Smith; they might see someone on Dr. Smith's team. When we onboard the patients, we have to tell them about that. Behavioral health has to be in there because of its effect on everything. We've split our health system management up: Another physician leader is leading the medical specialties and surgical specialties, and my division will be where the primary care and elements of behavioral health sit.

Robert A. Greene, MD
Executive Vice President
Dartmouth-Hitchcock

LONG: At Dartmouth, do you employ the physicians, or are they partners?

GREENE: They're all salaried.

SIMPSON: That's one of the holy grail questions. In the '90s, every hospital bought practices; in the early 2000s they unloaded them all; and now they're acquiring again. So is salary-based care for GPs the right answer?

LONG: Great question. We have recently begun changing the employment contracts for all of our physicians and made them at least 50% quality and value based and 50% RVU based. It is a step in the right direction. But when you begin to interview new physicians, they're not sure about using nurse practitioners because it takes the "easy" patients leaving the physician with the "hard" ones. It's going to be that way everywhere because we need everyone practicing at the top of their license to succeed in the new environment.

SIMPSON: We all understand exactly what providers can and cannot do relative to their license, but does the American public? How do you get the consumer involved? How do we educate the American public that an LPN can do X, a physician assistant can do Y? You do not need to see your doctor as often.

STANLEY: We as an industry are largely to blame for that. In fee-for-service, the only way you get paid is a doctor-patient relationship in the office. We've done a very good job of educating the physician as the only one who can provide care. So I think we need to own part of that message back as well. And it's definitely going to take time; it may even take a generation. To some degree, younger generations are much less focused on their particular doctor. They're more focused on access, on availability.

LONG: I've seen this in practice, and not only with the young. The hospital I was with in Iowa is more rural than where I am now. We had a number of rural health clinics staffed by nurse practitioners. To the people in those communities, that was their doctor—in fact, they didn't know it was a nurse practitioner. To them it was natural. Over time, patients will get used to that. Even in the much more urban environment where I work now, when we incorporate nurse practitioners into primary care practices and they practice alongside the primary care physician, doing many of the same things, it often becomes indistinguishable to the patients.

HEALTHLEADERS: *Is making yourself attractive to consumers or patients a top priority in a strategic shift to population health? It seems like an obvious question, but really it's not. Patients still tend to go where their doctors refer them.*

LONG: It is imperative. If at the end of the day the patients do not love you, you will not be successful. We understand that, and we're going down that road. Access is a requirement. We have looked at that very carefully because we have a MinuteClinic in the CVS down the street, and people can walk in there for about 18 hours a day and be seen immediately. If we cannot provide a level of service that's like that, they're not going to pick us. As important as volume is today, the number of covered lives is that

important or more important in the future. That will be highly associated with access and with reputation.

GREENE: That's exactly right. We're also thinking about how we can transform ourselves into a consumer-focused health system as opposed to having an inside-out point of view. So it's important strategically, but also in most of our ACO contracts. The CMS models are a good example—people are still free to go wherever they want. So if you don't have a good brand image, and you don't have a good reputation and good access, you get leakage out of the system, and then costs can ramp up and you can't coordinate care as much. So it is a strategic imperative.

STANLEY: In a Medicare Shared Savings Program or some other programs, we're getting claims information. With that, we look at how patients remain with us throughout the care process or receive care outside of our network. The percentage of patients who seek or receive care outside of the clinically integrated network is a real-time measure that touches on how patients see your brand. To use an Apple example, people who have a very strong view of the Apple brand would never think about an alternative. It's not because they're forced to. It's because it taps into the consumer experience.

SIMPSON: Do you believe your leakage stems from brand, or do you believe it is access?

STANLEY: I still see the two of those connected. Meeting consumers' needs is part of the brand image that the consumer has with respect to your organization or your system. Access is a huge issue and has very positive or negative implications on the brand. What's been fun over the past couple of years is we started managing our own employees through our own population health activities. Some of our real weak spots are showing up. For example, do we have all of the right docs for the right size population? Are they geographically located to where they are easy to get to? Do they have open panels? We're still relatively early on in this.

SIMPSON: There are practice lines that absolutely understand how to deliver on this. But just not broadly across all the practice lines.

GREENE: What we're touching on now is how many things are interrelated. The product design, the components of the network—both from a provider side and from a payer side—and the actual medical management, the community health, all of it. One of the hard parts about this work is that you have to move a lot of those pieces in coordination.

LONG: Access is so important to us that we have substantially increased the size of our primary care workforce. We needed to be in more places, and we needed to have more availability. We have invested in primary care access because we realize that it is fundamentally important to everything else that we're doing, but it takes a big investment up front and the support of the board to understand why it is so important.

HEALTHLEADERS: *With much of this, you are betting on the outcome—that is, you're not getting paid for a lot of it. So how do you evaluate where to make investments based on value principles?*

LONG: We live primarily in a volume-based environment right now, but we're not going to be there forever. There are opportunities to do both during this transitional period. When we look at our ACO data and we see the leakage, there's an opportunity not only for us to learn care management and apply those techniques, but to identify where these patients are going and try to pull them back. So we can increase the volume while we're also making the shift into value-based care.

Steve Long
President and CEO
Hancock Health

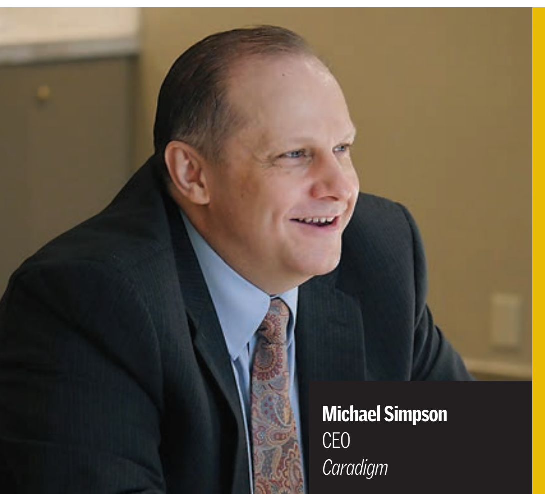
GREENE: One of the things that's become apparent to us about making the shift to value-based care came from a cost accounting system Dartmouth-Hitchcock uses that's patient focused. It tells us what costs are from the patient's point of view. If they see a primary care doctor and that generates an EKG and chest x-ray, that's part of the cost accounting. And that's been very useful because it lets us focus on problem areas. Medicare, for example, generally does not cover our costs. New Hampshire Medicaid really doesn't cover our costs. So for those patients, the business model is already upside down. We still want to keep them healthy and out of the hospital so we don't lose as much money. Then we have our employee population, which is about 15,000, including dependents. And there we're just transferring money from one pocket to another, minus their copays. So when we look at that whole population, really our business is about half government and 10%–15% employees. So at 60%, we're already there.

SIMPSON: Another point to keep in mind is that we keep saying we're all moving to value when in reality there are service lines that must be focused on fee-for-service. If you are a GP and you've got a diabetic patient and they need to go see a podiatrist, you want them in tomorrow. You want that podiatry service line to be based on volume, and you want them to have great access. You have to manage that

service line that way. If you manage both service lines the same, you're going to end up with a mess. So one of the keys as we really move toward how we balance population health is that there are service lines that are very population health–type focused, very value-based focused. But if we try to manage everyone the same way, we will lose.

LONG: You make a very good point. We understand that if we do population health well, we will out of necessity reduce the need for the inpatient capacity. However, to really reduce inpatient capacity is a structural transformation that is difficult to accomplish. So how do we bring in more patients to drive that acute care piece that will always be there? How do we increase our market share to the point where we can maintain the inpatient capacity that we have while still doing the population health piece? If we are unsuccessful at that, we will have to manage our costs down to the point where I'm not sure we can provide the inpatient piece very well.

GREENE: Managing inpatient capacity is a fascinating subject. Building new beds is probably not the best strategy right now. One of the things Dartmouth-Hitchcock started doing a number of years back is affiliating with smaller hospitals—as opposed to merging—so the hospitals retain their local board and local identity. That enables us to do volume shifting with a number of critical access hospitals that are paid on a cost-plus basis by Medicare. Through the affiliation, we are able to shift some lower-acuity inpatient admissions to that hospital so those patients can stay local, and that opens up a bed for the heart attack patient or the neurosurgical patient that we need for the right care at the right place. So those hospitals are financially better off, and we didn't have to build a dozen extra beds at ours. We've done that with three hospitals, and a fourth is in the works.

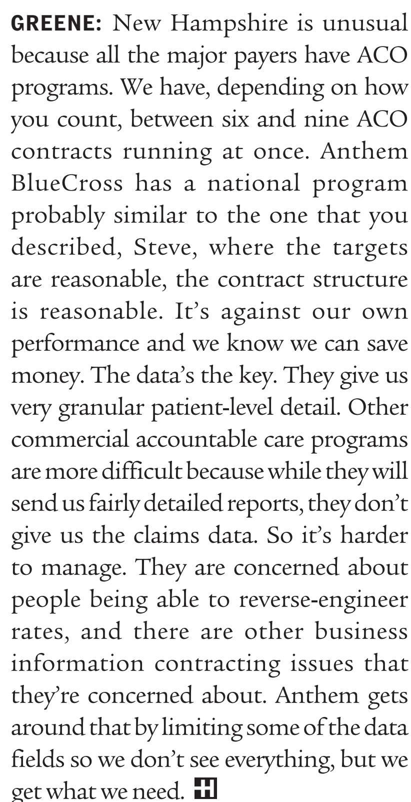

Michael Simpson
CEO
Caradigm

STANLEY: I love that approach. In fact, it may be in some cases a much better experience to be in a smaller location because of a number of convenience factors for the patient. That can be a great solution. From an investment viewpoint, we've decided to focus a lot on bundles or episodes of care—whether it's around process improvement, infrastructure capabilities, or data analytics. Before we were trying to do a lot of things as sort of total population health. That can become very cost prohibitive. It also becomes very personnel and bandwidth prohibitive, and it can be at times distracting. So in our current phase, it resonates as we try to prioritize it based upon our financial risk ratio. So we're putting a lot of effort now on bundled analytics and care.

HEALTHLEADERS: *We haven't discussed the payer component of this. Do they want to play in value-based care, or are they just giving it lip service in most geographic areas?*

STANLEY: Every market is different. But we certainly have some markets where on the commercial payer side, there's significant market dominance of a particular payer, and in some of those circumstances there's not a burning platform for payers to shift risk, to develop new alignment incentives or programs to move to value, because they have for the most part been able to drive up premiums based upon fee-for-service methodology and even high utilization—sometimes inappropriate utilization. In other circumstances, they certainly do have a desire to change, whether it's because they have competition or because their hand is being forced by employers. We are not ready to take full global payment or capitation in any one of our markets. That doesn't mean we're not interested in doing pay-per-performance and upside gainshare and up- and downside risk. Aetna has partnered with us in some locations quite well, Cigna to some degree, United to some degree. But it's been sort of a challenge on the commercial side.

LONG: Our experience has been very similar. When we look at some of the big payers in our area, one in particular, Anthem, does a great job with a value-based program that we have participated in, and it is substantially based on metrics on the primary care side. We do very well with that. That said, I've come to discover that most of the big insurance companies are just as addicted to fee-for-service as we are. Their current systems are built around that concept, and they are undergoing a transformation just like we are.



GREENE: New Hampshire is unusual because all the major payers have ACO programs. We have, depending on how you count, between six and nine ACO contracts running at once. Anthem BlueCross has a national program probably similar to the one that you described, Steve, where the targets are reasonable, the contract structure is reasonable. It's against our own performance and we know we can save money. The data's the key. They give us very granular patient-level detail. Other commercial accountable care programs are more difficult because while they will send us fairly detailed reports, they don't give us the claims data. So it's harder to manage. They are concerned about people being able to reverse-engineer rates, and there are other business information contracting issues that they're concerned about. Anthem gets around that by limiting some of the data fields so we don't see everything, but we get what we need.

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