ROUNDTABLE

Energizing Patient Engagement to Drive Loyalty, Wellness, and Appropriate Utilization

What does *patient engagement* really mean today? As patients take a more active role in managing their own health, healthcare organizations are challenged to enact strategies that improve customer loyalty. Increasingly, that challenge can be met with an infrastructure that encourages wellness and appropriate utilization built from sharing transparent information with patients about your organization's outcomes and expertise. Patients want a partner in their healthcare decision-making that is focused on what's right for them. At the same time, healthcare organizations are conflicted. With a population health–based strategic emphasis, they can't afford to have profitable procedures go to retail competitors while footing the bill for expensive acute care interventions on the same patients. As healthcare strategists, marketing chiefs, and experience officers plot the next few years for their organizations, they must think expansively about transparency, consumerism, digital engagement, and other trends that are changing how patients choose where they get their healthcare. In a world full of choices, developing a patient's trust in a partnership to improve their health may be the bond that endures.

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Roundtable Highlights

HEALTHLEADERS: *Many hospitals and health systems aren't used to having to breed loyalty with patients. Why is it now necessary?*

BRET GALLAWAY: Compared with other industries, the consumer has been relatively invisible to healthcare economics for the last 70 or 80 years, but now that's shifting. There's a lot more transparency, there's a lot more consumer involvement, and people are looking harder at prices, so health systems are paying more attention to the consumer outside of the clinical environment.

DAN MCGINTY: The rise of consumerism is driving a lot of this change. There are more and more options for individuals to seek and receive healthcare. The move toward value-based payment models—especially as we move to total cost of care management—really is driving us to find ways to engage with patients in a different way over a longer period of time, moving from an episodic partner to a partner on your path to better health.

GREG POULSEN: I take a little issue with the premise. As an industry, we have tried to engage consumers for a long time, but we have been trying to engage them with the opportunity to treat rather than engaging them in being a guide and a counselor in managing health. We're facing an uphill battle because historically the industry tried to persuade people to receive more healthcare, and that was probably an incorrect thing to do from the patient's perspective. Repeatedly, data suggests that overtreatment is as harmful as undertreatment, so though we've been engaged with the consumer, I'm not sure we've been engaged with them correctly.

BEN LOOP: If you're used to engaging with consumers to treat patients in a transactional way at a point of service, now, smart hospitals are taking a more longitudinal view. Today, hospitals need to think about health and outcomes and wellness, and that requires a relationship. It requires trust, it requires loyalty, and it requires working with and through all of the parts of the care network. As we start to think about the consumer as an individual in a holistic way, hospitals and health systems are smart to build relationships and engage in a conversation or dialogue that ties all the pieces of their care together.

HEALTHLEADERS: *In an ACO structure, getting patients to receive care at your institution and not to go outside the ecosystem is a big challenge to value-based care. How do you mitigate that variable?*

POULSEN: We've had an insurance organization for north of 30 years now, so for us, it was engaging the consumer upstream, when they were making a decision about their insurance plan. Once that happened, then we had an opportunity to retain that relationship as long as we met their expectations and needs, because we had a relatively focused network that provided care to people that have insurance from us.

MCGINTY: We're fighting a bit of an uphill battle there. Choice is an American concept. We like choice, and our physicians and other providers are not really motivated to spend a lot of time keeping a patient in the ecosystem. We have to work with our teams to educate and help them understand continuity of care as our specialty services have become more disconnected from primary care. We're working hard to try to build bridges there and bring those people together in different ways—for example, through our clinically integrated network.

GALLAWAY: Also, we're seeing much more and different choice drivers than we've seen before. For a long time it was mostly about the quality of care, but now those factors seem to be more like table stakes because people assume they'll receive excellent care. Now people are also looking more at price and convenience factors, too. That's a new dynamic for an industry that is used to being judged more on quality of care.

Dan McGinty
Executive Vice President
Allina Health

POULSEN: There's an additional interesting dynamic: The evidence is compelling that high-quality, high-value, and high-service care all depends on the team, and it's far from being an individual game anymore. That's incredibly important.

LOOP: There's an educational opportunity because if referring physicians don't really see themselves as being part of that ecosystem, then the outcomes are going to be inconsistent. What's interesting is that in creating integrated networks and in narrow network development, there's rising consumerism and demand for choice—maybe even driven by factors that aren't clinically related, strictly speaking. Are those contradictory trends?

MCGINTY: They're competing trends. We need to err on the side of keeping folks within our network of care. Where folks are leaving that network of care, we've really not done a very good job of understanding why they're making that choice, and we need more information about that.

POULSEN: For us, that's changed quite a lot recently, and the reason is if they don't stay in the system, you lose the information about them, and quality and efficiency is highly dependent on that continuity of information. So having all of that information, we think, is a quality-of-care issue, and we've pushed that really hard with our docs to basically agree that they're not doing their patient a service if they go out of network unless there is a very compelling reason for it.

HEALTHLEADERS: *Do you think the consumers understand there's an advantage to staying in your ecosystem?*

POULSEN: Absolutely. We've tried to make sure they get it by pointing that out to them.

MCGINTY: We're attempting to do the same thing. You can't sell this on keeping them in the network because it's better for us financially. You have to sell it on higher-quality patient care—we've got continuity of record.

GALLAWAY: Many systems are going through a lot of transformation and trying to find the synergies and efficiencies in healthcare. And that's the right approach to serve consumers because the fact of the matter is high-quality care usually costs less, so it is, in the end, best for the patient.

HEALTHLEADERS: *How is patient experience or patient engagement as we try to practice it nowadays different from the past?*

LOOP: This is somewhat controversial, but I would argue the lines are getting awfully blurry between engagement and communication from a marketing perspective and a clinical perspective. Where does the one stop and the other start? Does the patient even know there is a network? Do they care? Are their needs being met? It has to be an ongoing conversation with the patient to build loyalty and trust, meet their needs, and achieve the best outcomes.

MCGINTY: I like your use of the word *conversation*. Traditional healthcare marketing was a one-way message. For example, we've got a CyberKnife. Great. It applies to less than 1% of the population. But we put it on the side of buses and let everybody know we have one—that's a communication that probably doesn't even get received by most people, but it sounds cool. When we're talking about patient engagement, we need to be in two-way conversations. We're using some technology to accomplish that, but most importantly it's that face-to-face interaction with the physician, the provider, the care navigator nurse.

HEALTHLEADERS: *What role are customer or patient ratings playing in healthcare decision-making now and in the future?*

LOOP: We started a new project called Health Stories, and it's the opportunity for patients in the community to share their personal experience and story with one another on a provider profile. We routinely test to see what influence that kind of content has over consumer choice and preference for one provider over another. Turns out, it's one of the most powerful and compelling pieces of content. Consumers are passionate about their care experience and want to share their stories. In combination with the objective information that's available at Healthgrades—a provider's experience, patient satisfaction, and the quality of the hospital where he or she practices—this subjective information helps drive provider decisions.

POULSEN: Those stories, as you put it, approach being data rather than just being anecdotal because you now have—if you have 30 or 50 or 70 people who are on there with a rating and descriptions about what they liked and what they didn't like—that starts to be like Amazon.

LOOP: I agree. Once the numbers get large enough, it's a way of dimensionalizing a professional as an individual so that it creates a pattern that you can understand and interpret in a way that's more than just anecdotal.

GALLAWAY: It is really interesting to see some systems taking their HCAHPS star ratings and posting them online in physician profiles, along with the related comments from their HCAHPS surveys. Significantly, the star ratings driven by HCAHPS often are much higher than the ratings physicians were getting on their own site—which can be appealing to physicians.

POULSEN: The ancillary benefit is it helps the docs. They actually become better at what they're doing.

MCGINTY: We've seen that, but we also use coaches—physician leaders who have been trained to be coaches to improve patient interaction.

HEALTHLEADERS: *So how do you assign a coach to a physician? Is that seen as a negative?*

MCGINTY: No, it's done in a very sensitive way. The data is all very transparent within our system. So Dr. A knows he's third from the bottom, and Dr. A really doesn't want to be there because most doctors want to be on the top of the list. And so one of our physician leaders, who is well respected, will just schedule a one-on-one meeting and talk about things. And maybe he can just observe a patient care interaction, give some feedback. There are a few who get uncomfortable with that, but the majority really appreciate it.

HEALTHLEADERS: *We've got some large organizations around this table. How are the challenges of smaller organizations in generating patient loyalty different?*

MCGINTY: Well, we actually don't do everything. We don't have a role in post-acute care, for example. Like anyone else trying to figure this out, we've developed partnerships with who we believe are the best in class because the care that's received postdischarge is very important to the health of that patient. And some would say the driver is we don't want the readmissions because of the penalty, but that's really not our driver. We have some financial joint ventures with long-term care providers—two big ones

in the Minneapolis area. That's been one of our solutions. And I would suggest for smaller organizations, it is also going to be about partnering.

GALLAWAY: Strategic partnerships are a priority for us at Trinity Health. We're partnering at different levels because we recognize there are organizations out there that can do things better and faster than we can. We're a big system, we manage a broad spectrum of care, and by working with best-in-class partners, we can fill the gaps.

HEALTHLEADERS: *And how do you hold those organizations accountable?*

GALLAWAY: Clear agreements, milestones, and dashboards help ensure all parties are delivering on what they promise. More important, partners have the same goals we do—to deliver people-centered care and help people to be healthy and live better lives.

POULSEN: And if they're not delivering on it, you'll find a different partner.

GALLAWAY: Exactly.

LOOP: The idea of a physician group or a small hospital being completely independent is no longer possible. And I don't mean that financially. They can maintain financial independence, but if they're not working closely with others, they're not going to be able to meet the needs of the population of patients they have. So if you want to remain financially independent, you're going to have to develop the kind of partnerships that everybody around the table has been talking about. Otherwise, you will not be successful.

HEALTHLEADERS: *The general consensus seems to be that other industries have a better, more complete relationship with their customer than healthcare because they've had to for so much longer. How does healthcare catch up?*

GALLAWAY: I wish I could take credit for this analogy, but a friend of mine put it this way: Say you are a manager of a Nordstrom store, and your boss came up to you and asked you to manage a new store. In this store, every customer is going to check in with you when they walk in the door, and your best salespeople can interact with them throughout the day. Customers are going to wear your clothes, eat your food, and sleep in your beds, and they check in with you before they leave. How would you like to run that store? You'd love it, because you could get all the information you need about that customer to make sure that you're serving them exactly the way they want and need. In healthcare, we have access to the information, but we don't yet know how to collect it and analyze it and really use it to maximize that experience to give that person exactly what they need. But we're getting there.

HEALTHLEADERS: *What are most hospitals and health systems missing?*

LOOP: More than a million people a day come to Healthgrades to find the right doctor, the right hospital, and the right care. It's not just about finding the right orthopedic surgeon or surgery center. They're not just getting a knee replacement. There's rehab. There's all of the preop activity with their care team. So we're seeing an opportunity for healthcare providers to think more in terms of the patient or the consumer journey—the entire experience. It's really important for healthcare providers to think in that broad lateral way and to develop a communication infrastructure to follow the patient in that process. They're consuming content all the time from a lot of third parties. Healthcare providers need to be in the middle of this—to understand the consumer, meet them where they are, and build a real relationship.

GALLAWAY: That's why we call it consumer engagement and not consumer understanding.

POULSEN: The example you used of a knee replacement is a good one. What is the single most important characteristic of the knee replacement? Not an infection. Not the rehab time. The most important decision is whether you need a knee replacement. Was that the appropriate thing? And yet, historically, none of the metrics actually help you determine that. So you need to start upstream in knowing whether the decision to treat was being done in the patient's interest. That's a really difficult one to get at, but probably the most important in terms of the cost, quality, and service.

LOOP: Not just because you're trying to ration those services, but to achieve better outcomes.

POULSEN: Absolutely. The data suggests that the variation in the decision to treat is far higher than the variation in terms of the outcome once treatment is initiated. In the old HMO days, people were worried that appropriate care was being withheld for financial reasons. And some people may now get unnecessary care for financial reasons, so they're potentially both right. So we think it's incredibly important not to be rewarded dramatically for always providing the maximum services available. CMS data suggests that in terms of time, a physician is compensated six times more doing a procedure than they are doing a consultation—this is a perverse incentive.

LOOP: That creates a huge opportunity to earn trust and to open up the dialogue. That's when you proactively have the conversation. You reach out and engage with them to talk to them outside the encounter in an unexpected way.

Bret Gallaway
Senior Vice President
Trinity Health

HEALTHLEADERS: *The consumer doesn't always know what they're looking for. How does your organization help lead that conversation?*

LOOP: Consumers in healthcare are looking everywhere for support, and they want to have a choice—and to make the right choice. They're much more active in the decision process, and they have to navigate a really complex environment. We provide solutions to help the consumer find and connect with a care provider in an actionable way, no matter where they're looking. We also help the provider understand, reach, and engage with consumers in their communities, based on what is known about the consumer, their needs, where they're looking, and the content and channels that will get them engaged to make a choice and take an action.

GALLAWAY: When I started in financial services 20 years ago, we had very similar challenges. Brokers were like physicians. They had the information and they traditionally were at the center of everything by necessity. And then, suddenly, there was this explosion of transparency and information that reconfigured the whole industry, and that's what healthcare is going through right now.

LOOP: That's right. Providers are starting to use the power of predictive analytics and the Internet to understand who needs what service, how to guide them in the pathway, and how to create experiences that build relationships and influence choice. We see the same thing happening in healthcare that you experienced in financial services, Bret. We're not really inventing anything new. It's just applying it to the most important thing that you could possibly work on, which is people's health and lives.

HEALTHLEADERS: *Is healthcare moving to what we've known to this point as the integrated delivery system model to reduce the impact of these competing incentives in how we treat patients?*

POULSEN: Yes, yes, and yes.

HEALTHLEADERS: *So how quickly are we moving there?*

MCGINTY: At Allina, we thought we'd be there by now. Five years ago, we thought by now that greater than 50% of our payments were going to be value-based and we've got to get our physicians' compensation plans lined up to incentivize the right kind of behaviors. But now, about 7% of our net revenue is outcomes-based. We still pay all of our physicians on a work RVU basis. We haven't flipped yet, and we're not really in control of that. The timeline is the question mark, and I suspect it'll be different market to market.

POULSEN: I think the markets are hugely different, but it's hugely helpful if you've got it. We've talked repeatedly about the team idea. A truly integrated delivery system is just the next progression in the team concept, and certainly having all the clinicians, the hospital, and ideally the insurer engaged is beneficial. And to make it really interesting, add in the employer working together to be supportive with the patient.

LOOP: If you don't have the same economic incentives, how are you doing that? Are you laying that foundation in advance as the payment models are starting to shift? Or is it really struggling upstream?

POULSEN: For us at this table, we're defined as not-for-profit, so we should be willing to do what's right for the patient in spite of the fact that it's not currently financially remunerative. The organizations in this room have chosen to do that. We look at our shareholders as being the communities that we provide services for, and therefore we must maximize their value.

MCGINTY: I absolutely agree with what you said. We're motivated by our mission. For example, we redesigned our care of breast cancer patients. It went from two inpatient hospital stays and several outpatient visits and a bill of about $35,000 to no inpatient hospital stay, fewer visits, shorter timeline, about $8,500 total cost. One of our board members, not a healthcare person, raised her hand and said, "That $27,000 difference, where did that go?" Well, it probably went to an insurance company.

POULSEN: And, hopefully, to the employer itself.

MCGINTY: Exactly. Really, our stumbling block is our payers. They have no burning platform. The employers do, and we're doing some direct contracting with employers to try and get at that. One of our challenges is we have 17 Fortune 100 companies based in the Twin Cities, and they're all over the world. So designing a health solution for the Twin Cities doesn't really get their attention. They need a solution that works across the nation and across the globe.

POULSEN: The single largest benefit to move us in that direction is the creation of the exchanges—both the small employer and the individual exchanges—because there you've got people making individual value decisions and it's local. I think the local thing is key. It is impossible for a national or international employer to create a focus for each community in which they have employees because they're all over the world. But the individual employee can certainly make that decision for her or his family. And so to the extent that they're making the selections there, which a growing number of people are, you've got a real value proposition to make. We can help you stay healthier at a lower cost.

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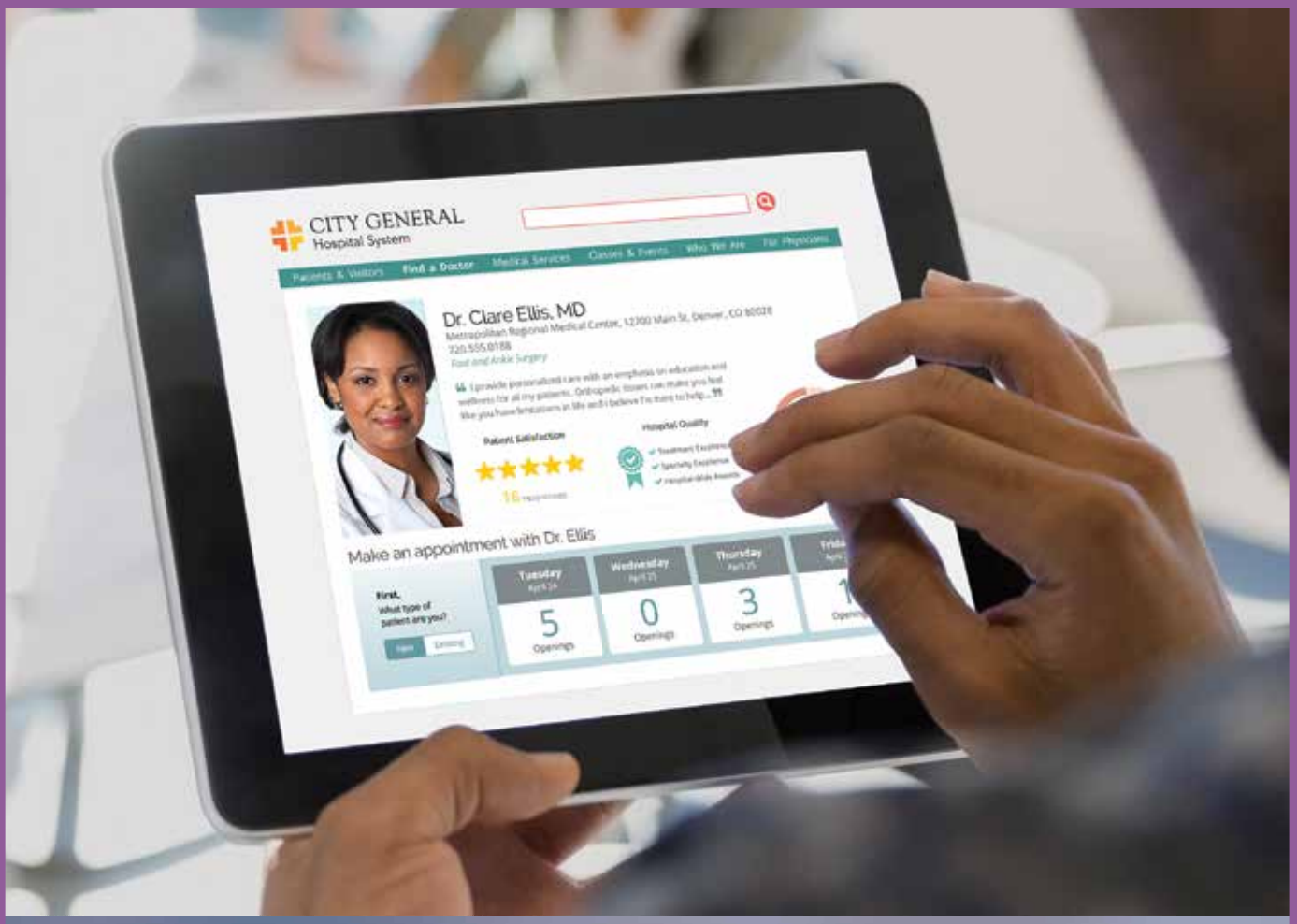

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