

The Transformation of Healthcare Delivery

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**EDWARD PREWITT**

Editorial Director
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Considering Healthcare's Transformation

The healthcare delivery system in the United States is under unsustainable stress. How can individual hospitals, health systems, and health plans adapt to current changes and prepare themselves for bigger shifts ahead?

This broad topic was the subject of an extraordinary gathering in January 2015 of healthcare executives representing leading organizations from around the country. In a series of conversations moderated by HealthLeaders Media editors, these experienced leaders shared their organizations' strategies, opened up about their anxieties for the future, and offered a range of perspectives that may be brought to bear on the big issues facing healthcare.

In the *2015 HealthLeaders Media Industry Survey*, members of our executive Council said the top industry hurdle (chosen by 32% of respondents) preventing their organizations from pursuing the transition to value-based care with more vigor was uncertainty

about revenue streams. Their second biggest concern (at 23%) was inadequate payer incentives. Another 14% of respondents said the industry needs to develop new care models. But Industry Survey respondents also cited the use of analytics for clinical decision support as the top challenge to improving clinical quality. Strategic partnerships with payers (chosen by 36% of respondents) and with provider organizations (35%) will help organizations meet their financial targets in the next few years.

All of these concerns came to the fore at our executive Roundtable, which was sponsored by PwC. Harold L. Paz, MD, MS, who is executive vice president and CMO of Aetna in Hartford,

Connecticut, and formerly CEO of Penn State Hershey Medical Center and Health System, spoke of the need for payer-provider partnerships to root out the huge amount of wasted effort and dollars that plague the healthcare system. Mohamed Diab, MD, principal in PwC's Health Industries Advisory group, outlined the range of strategies that provider organizations are pursuing, from sticking with fee-for-service as long as possible to learning how to take on risk as soon as possible.

Pam Nicholson, senior vice president for strategy at Centura Health in Englewood, Colorado, presented the logic of the goal pursued by many health systems, that of being all things to all people in their catchment area—and the difficulty of doing so as a hospital-centered organization rooted in acute care. LaVone Arthur, chief integration officer for Baylor Scott & White Health in Dallas, highlighted the difficulty of the timing of the shift to population health management even as health systems must cope with encroaching retail care. Lawrence Hanrahan, MD, principal in PwC's Health Industries Advisory group, emphasized the essential role that acute care hospitals will maintain in the care continuum.

Patrick Anderson, system vice president and CIO for Ochsner Health System in New Orleans, and Brent Lambert, MD, CMIO for Carolinas HealthCare System in Charlotte, North Carolina, both discussed the

critical role that information technology plays in healthcare today, and why so many barriers remain in the way of interoperable health records and actionable data analytics.

Davin Lundquist, MD, vice president and CMIO at Dignity Health, headquartered in San Francisco, and Kit Brekhus, MD, physician executive director for Colorado Health Neighborhoods, part of Centura Health in Englewood, Colorado, each talked about the strains that physicians face in the changing healthcare environment—even as their role retains its primacy—and the changes that healthcare organizations must make to accommodate physicians.


To better tackle these intertwined issues, the executives at the Roundtable broke into discussion groups on two transformation themes: technological disruption and opportunity, moderated by HealthLeaders Media Senior Technology Editor Scott Mace; and convergence and restructuring, which I moderated. The full group then came together for an incisive summary discussion about where the healthcare industry is going, the best ways to overcome the identified hurdles, and how to adapt their organizations for the best outcomes for patients and society as a whole. Read on to guide your thinking for your own organization. ❖



HEALTHLEADERS MEDIA
EXECUTIVE ROUNDTABLE

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Perspectives on Healthcare Technology and Innovation

At the HealthLeaders Media executive Roundtable in January 2015 on the Transformation of Healthcare Delivery, providers and payers came together for a lively discussion of how external forces—technological advances, demographic changes, government regulations, and financial constraints—promise to reshape the ways healthcare will be delivered in America in the coming years. The panel itself—bridging that payer/provider divide—presages how innovative new strategies, partnerships, and combinations will be part of the future landscape.

From our work with healthcare clients at PwC, one thing is abundantly clear: The transformation underway in the healthcare industry involves adaptation and advancement in both technology and strategy. These two forces together are changing care delivery in ways that promise to improve the lives of patients and their families, as well as the value the care delivery system provides to all stakeholders.

When doctors and nurses collected patient data 25 years ago, it was more often than not left buried in archaic, paper-based filing

systems, only to resurface if triggered by memory or identified during a quick page flip through a large stack of papers. Just as in banking and retail, one of the biggest developments in healthcare during the past quarter century has been the remarkable progress made in capturing patient, clinical, research, administrative, and cost data.

In 2009, the federal government put money behind the drive to go paperless and, as tallied in Centers for Medicare & Medicaid Services reports and data in 2014, has handed out more than \$25 billion in incentives for adopting electronic medical records.

At the same time, entrepreneurs have devised technologies aimed at increasing access, improving quality, and lowering cost—starting with e-prescribing to reduce medical errors and evolving to identify basic standards for sharing data to improve communication among caregivers often located in different settings. Industry leaders followed, devising new ways to connect patients and caregivers via secure websites, telehealth and remote monitoring modalities, and mobile health apps.

Today, we are entering a post-EMR world, a new connected and converged space that is enabled by cloud-based technologies. The original EMRs primarily focused on acute and ambulatory care. For physicians, the cloud will lead to an evolution of connected medical health records across the full continuum of care, enabling the new "health ecosystem." This new ecosystem demands connectivity 24/7/365 among all stakeholders—linking not only data generated within traditional healthcare settings but also input from sources as diverse as social media and wearables.

From the strategic standpoint, all healthcare stakeholders have come to realize they need each other; they need to be prepared to collaborate and innovate on a scale never before seen. In the emerging New Health Economy, the care management model for the future must have a consumer-centric focus because empowered consumers—starting with patients and their families—are taking more responsibility for health decisions and payment. At the same time, and reflecting that spirit of collaboration, it's important to appreciate how varied stakeholders, including not just patients and families but also insurers, employers, governments, and even at times providers, function as consumers in this new future of healthcare.

The November 2014 PwC Health Research Institute report, *Healthcare delivery of the future: How digital technology can bridge time and distance between clinicians and consumers*, contains survey

findings showing that caregivers and consumers share similar views on changes shaping care delivery:

- **Putting diagnostic testing of basic conditions into the hands of patients:** About 42% of physicians are comfortable relying on at-home test results to prescribe medication.
- **Increasing patient-clinician interaction:** Half of physicians said that e-visits could replace more than 10% of in-office patient visits, and nearly as many consumers indicated they would communicate with caregivers online.
- **Promoting self-management of chronic disease using health apps:** 28% of consumers said they have a healthcare, wellness, or medical app on their mobile device, up from 16% last year. Roughly two-thirds of physicians said they would prescribe an app to help patients manage chronic diseases such as diabetes.
- **Helping caregivers work more as a team:** Nearly half of consumers and 79% of physicians believe using mobile devices can help clinicians better coordinate care.

Innovation will be a key to that future. Technology is an enabler, but it is also clear that from a strategic standpoint, we need to adapt the care management model—tailor it, personalize it, make it a care delivery-focused model—if society is to realize the full potential of the transformation of healthcare delivery that we're undergoing and that we need. ❖



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SCOTT MACE
Senior Technology Editor
HealthLeaders Media

THEME 1: Technological Disruption

Technological disruption enables diagnoses to be delivered from anywhere, and allows patients access to ever-greater levels of self-monitoring and self-care.

These changes threaten to alter the hospital's traditional role as the locus of care, and remake the roles of physicians and other clinicians such as midlevels. Yet technology can also strengthen traditional providers' expertise, with opportunities for data sharing and the application of analytics for individuals and patient populations.

"In order to manage populations, in order to provide consumers with the kind of tools that they want in terms of self-service, we have to have good data," said Davin Lundquist, MD, vice president and chief medical information officer at Dignity Health in Camarillo, California. "We have to be able to trust that the data that's in front of them, the data that they're giving us, the data that we're using to make automated, logarithmic, or algorithmic decisions, is the right data."

Lundquist and other multidisciplinary health IT and quality leaders who gathered at HealthLeaders Media's Transformation of Healthcare Delivery roundtable shared ideas on how to turn tech-powered disruptions into opportunities to survive industry changes and thrive in new converged models of care.

New forms of healthcare delivery

Patients are demanding new forms of healthcare delivery reducing or eliminating the traditional time and distance between themselves and care.

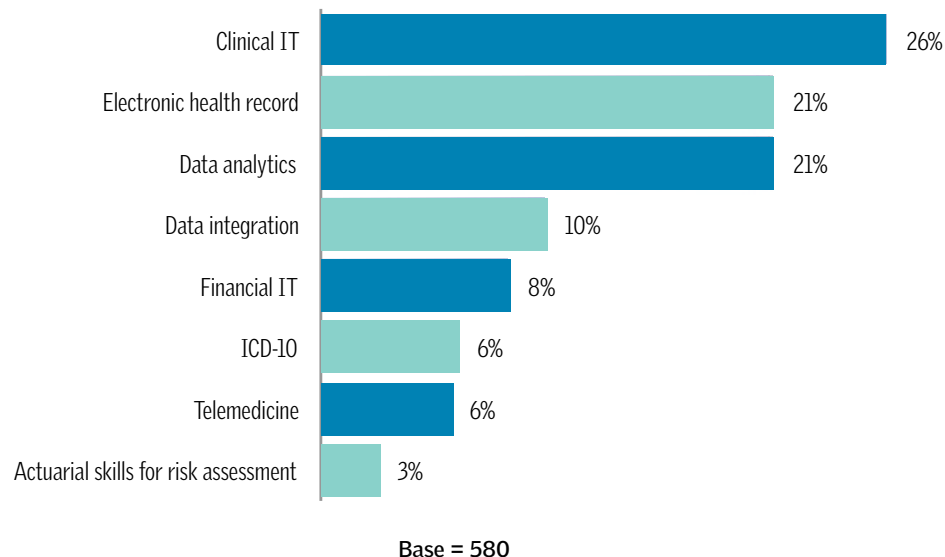
"Consumers are going to demand e-visits [in] real time at their convenience," said Patrick Anderson, system vice president and chief information officer at Ochsner Health System in New Orleans. "They're also going to want to be able to see a doctor same day. My organization actually provides that. Every time somebody calls we actually ask, 'Do you feel you need to see the doctor today?' We're trying to get ahead of that curve as an organization."

Patients generally want to take charge of their health in ways that have not been possible in traditional healthcare, and virtual care technology is enabling this, participants said.

"The consumer wants to be more in the driver's seat and less in the it's-being-done-to-them seat as we move forward,"

NO. 1 RANKED HEALTHCARE I.T. AREA IN STRATEGIC IMPORTANCE TO REACHING FINANCIAL TARGETS NEXT THREE YEARS

Q: Of the following areas of healthcare IT, please rank the top three according to their strategic importance in supporting your organization's efforts to reach its financial targets over the next three years.



SOURCE: *HealthLeaders Media Industry Survey 2015: Succeeding in the Risk Era: How to Accelerate Progress Toward a Value-Based Future*, January 2015

said Brent Lambert, MD, chief medical information officer at Carolinas HealthCare System in Charlotte, North Carolina. "That drives virtual care."

OpenNotes, a movement started at Beth Israel Deaconess Medical Center, Geisinger Health System, and UW Medicine several years ago, provides patients with unprecedented access to their electronic health records, and represents the kind of physician-patient collaboration and transparency being driven by technology.

"It's absolutely going to be the norm," Lambert said. "Almost every place that has done OpenNotes has found that when you talk to the patients about it, they will never let you go back. Providers are very nervous about this. We hold back things now because we think we are protecting our patients and, in fact, I think folks are going to demand that we no longer do that."

Traditional methods of contact from patients such as phone calls and voice mails won't stop with email, but will embrace photos and video, others said.

"If patients can pick up their iPhone and FaceTime with their doctor and ask a question, that's going to be very, very appealing," said LaVone Arthur, chief integration officer at Baylor Scott & White Health in Dallas. "If they can take a picture of the mole that they are concerned about and send it to a dermatologist and ask, 'Do I need to come in?' that's going to be very appealing."

Digital tools rise to the challenge

The answer to the question of whether today's digital tools are sufficient to meet the needs of value-seeking healthcare consumers

is yes in some places, no in others, maybe in still others. But as often is the case, technology's progress meets yesterday's solutions and needs to keep pace with what is possible tomorrow.

Aetna has a digital application called iTriage, and Harold L. Paz, MD, MS, executive vice president and chief medical officer of the Hartford, Connecticut-based insurer, described some of the app's capabilities.

"iTriage has taken steps to integrate into the app the estimated cost of procedures for Aetna members and members of other select carriers," Paz said. "But we're going to need a lot more technology and experience to really integrate the care experience for a patient, so they can touch all aspects of the healthcare system, understanding their reimbursement, their insurance benefit, [and] understanding where they can access care and medical information."

Standalone mobile apps such as iTriage are now being joined by mobile health-management apps from nontraditional participants, such as Apple.

"Apple's HealthKit allows the consumer to enter a lot of patient data into their iPhone," Anderson said. "It can pull [data] in from wearables, and will actually integrate right into the EMR, so that the physician or even care managers within the provider organization can leverage that information and potentially cause alerts for case management intervention."

Other providers are seeking alliances with organizations, including Aetna, to optimize their suite of digital tools.

"We've developed partnerships with numerous innovative companies to focus on the consumer with the goal being able to integrate the solutions together," said Pam Nicholson, senior vice president of strategy at Centura Health in Englewood, Colorado. "We have partnerships with iTriage, Walgreens, Emmi, and Welltok. We work to get them in a room together to build a solution based on the consumers' needs, and to integrate the best solution. And yes, we want to be able to get it into our EHR as well. It's going to happen fast, and we all are going to need to be ready for it."

More integration needs to be applied to patient portals, which all too often leave patients or plan members with multiple points of entry instead of simplicity.

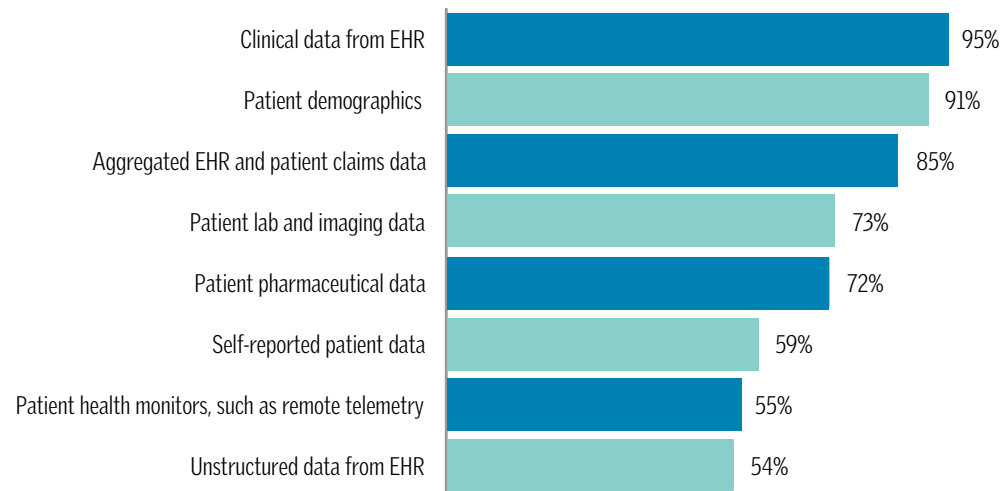
"If you're in a clinically integrated network and you have three or four different doctors, you have three or four different portals that you have to deal with," Lundquist said. "You go to the hospital and there's another one. Our ability to bring all that data together and create a seamless experience for the patients is a big challenge, but I think that's what consumers will expect. The systems that deliver that will have a big advantage when it comes to attracting market share, which we think is the only way you can really grow in the future pop health world."

All this integration will fall short unless the data is accurate and current, another participant noted.

"Real-time, primary source data is so essential," said Kit Brekhus,

TYPES OF PATIENT DATA TO DRAW ON FOR ANALYTICS WITHIN THREE YEARS

Q: Which of the following types of patient-related data do you expect to begin to draw on for your analytics activity within three years? Includes now and within three years (net).



Base = 367, Multi-Response

SOURCE: HealthLeaders Media Intelligence Report, *IT and the Analytics Advantage: Managing Data to Master Risk*, April 2015

MD, physician executive director of Colorado Health Neighborhoods, an integrated network of independent and employed physicians, along with other health professionals, partnering with Centura Health in Englewood, Colorado. "It's the rate-limiting step in many

ways. You can't get to transparency and you can't get to a lot of the important next steps until you have reliable data. It always comes back to that."

"I've been 25 years in Houston and so the energy industry surrounds us down there," said Lawrence Hanrahan, MD, MBA, principal in the Health Industries Advisory group at PricewaterhouseCoopers based in Houston. "We keep hearing, 'Data is the new oil.'"

Healthcare is in the midst of discovering the value of its own data, Hanrahan said. "We're in the infancy of trying to understand who owns the data of the patient," he said. "The patient thinks they own it, and each provider thinks they own it, and the aggregator thinks they own it. And then you've got upstream, midstream, and downstream, just like in the oil industry. Compared to 100 years of the petroleum industry, we're in our infancy around data on all those rights."

Other alliances pull in many stakeholders who play a role in keeping patients out of the hospital and at home, receiving an increasing amount of care there.

The Baylor Scott & White Quality Alliance, with more than 3,600 participating physicians, includes postacute facilities and home health agencies, Arthur said. "As the Quality Alliance develops preferred networks with third-party payers or our own health plan, we work with the payer and employer to develop benefit design that really incents patients to stay within the network, and everyone in the network has agreed to share data," she said.

56%

of healthcare leaders plan to begin or increase investment in care redesign over the next three years.

SOURCE: *HealthLeaders Media Industry Survey 2015: Succeeding in the Risk Era: How to Accelerate Progress Toward a Value-Based Future*, January 2015

Process follows technological change

Too often, traditional healthcare processes are playing catch-up to the data sharing and data utilization possibilities of electronic health records and digital health collection and dissemination.

"Documentation has been the bane of existence for many providers," Brekhus said. "I don't know if there was a promise with the advent of EHR that it would improve efficiency, but for most it has not done so. For many it has added to the burdens they face in documenting visits at the end of the day. Physicians are quitting jobs, moving, jumping ship, even getting out of medicine because of the hassle factors. If we can address those issues, and use technological innovations to streamline the processes, that would be a really great thing."

Order sets can present a tall challenge. "When you scale it to an entire system, maybe it makes more sense," Hanrahan said. "But I don't think anyone has really been realistic when you look at how big the task is. That's why it [hasn't] achieved its stated objective from the beginning."

Integrating payer and provider data for analytics

Value-based care hinges on agreed-upon measurements of quality that span payers and providers, which can then be subjected to a variety of analytical tools to reach consensus on initiatives for improvement. Reaching those agreements is more easily said than done, however.

"One of the issues we have though is [that] with every ACO there [are] different quality and service metrics, and they are not always aligned," Nicholson said. "This creates unique challenges and can cause problems for the physician. One thing we're trying to work with the payers on is to have standardized metrics across the board."

Aetna, which does not own its own hospitals nor employ its own physicians for delivering care, nevertheless partners with hospitals to manage financial risk, Paz said.

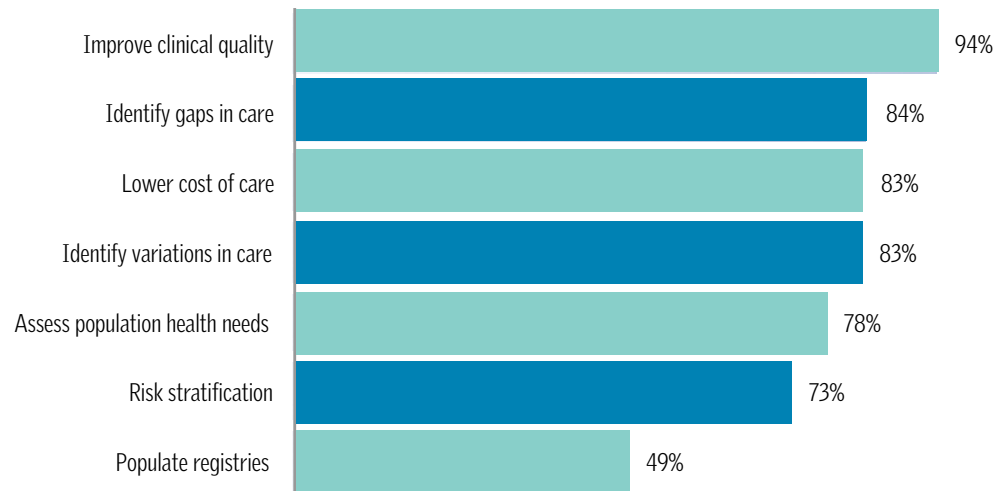
"We work with them, through our enablement tools, to move to population health in a new world order where payment structures will transition from fee-for-service healthcare to instead reward outcomes and value," Paz said. "For example, Medicity delivers health technology and analytics, and ActiveHealth delivers care management and clinical decision support. There's a long list of tools that we can bring to those organizations and help enable them to move toward population health."

More than 80 quality measures are in play across the different ACOs that Centura Health works with, Brekhus said. These measures "are different for each payer," he said. "We believe we can get to the point, as clinicians, where we define the measures that are most important. We can then apply those measures across all our populations to achieve optimal healthcare value."

Still, these many measures may map down to a smaller, more manageable set of measures, giving some providers optimism.

USE OF CLINICAL ANALYTICS WITHIN THREE YEARS

Q: What does your organization expect to begin using clinical analytics for within three years?
Includes now and within three years (net).



Base = 367, Multi-Response

SOURCE: HealthLeaders Media Intelligence Report, *IT and the Analytics Advantage: Managing Data to Master Risk*, April 2015

"The good news to me about moving to value is that while there are all kinds of different ways that we measure value and quality, particularly, I think that it all boils down to kind of the same thing,"

Lambert said. "That is, regardless of which metric it is you are looking at, if you've got things set up properly and are doing things in the best way and are using evidence to drive your treatments and your protocols and all of those things, the outcomes should be better than they were before. If we don't believe that, then we're designing things wrong."

Virtual care kicks into gear

The assembled executives agreed that virtual care technologies also give a technological shot in the arm to all the above efforts, ranging from seeing patients when they want to be seen, to keeping better tabs on them between visits.

"We're doing a lot with telemonitoring and home health monitoring now," Brekhus said. "It seems to appeal to all generations because everyone likes the convenience and support that the latest technology provides. The more care we can provide at home, the better."

"Sometimes the connection is not great, but that's going to get better and better," Lundquist said. "We did a pilot in my clinic of video visits over the last couple of months of last year. Even though it was a little clunky getting them set up—we had to help them download the app that we were using in a particular company, and took a little bit [for them to] get it—they still loved it. They love the fact that they didn't have to come to the office." ❖

**EDWARD PREWITT**

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HealthLeaders Media

THEME 2: Convergence, Competition, and Restructuring

The shift to value-based payment is upending healthcare providers' financial models, leading to massive consolidation and forcing many organizations to take on risk for the first time. Changes in insurance and reimbursements presage the growth of healthcare consumerism, in which patients will demand price transparency and value.

The mega-trend of convergence is creating unconventional partnerships and even calling into question the definition of a healthcare provider organization. Should healthcare focus on treating illnesses or be extended to monitoring and improving the health of a population—and how should populations be defined? Are provider organizations prudent in taking on financial risk, and is the movement toward integrated payer-provider hybrids a sustainable structure? Regardless, these shifts may be inadequate to fend off disruptive competitors—which may ultimately be a social gain.

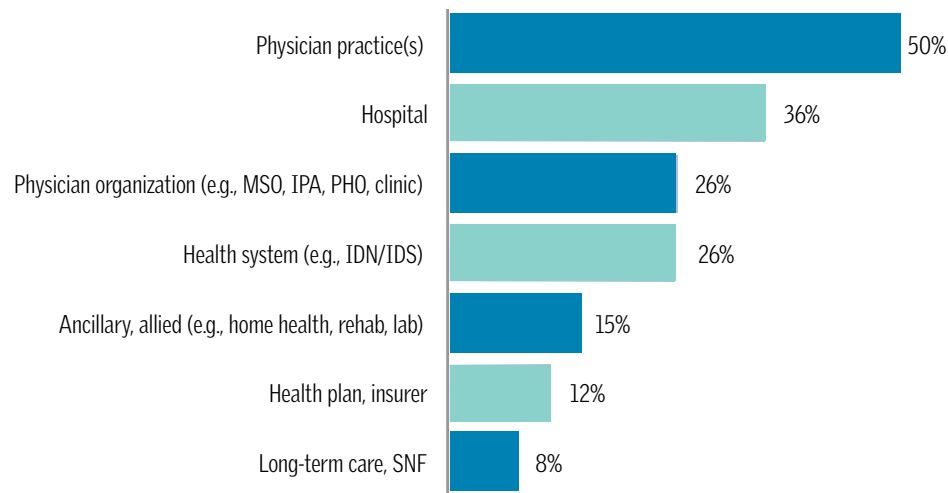
"Transformative changes are necessary and are going to require significant capital investments. ... Facilities are going to have to be designed to perform differently in the new world order of population

health. I think many institutions are going to be challenged," said Harold L. Paz, MD, MS, executive vice president and chief medical officer for Aetna, Inc., in Hartford, Connecticut, and the former CEO of Penn State Hershey Medical Center and Health System. "It's almost like you want to launch a rocket ship to the moon and you're going to do it by duct-taping together large helium balloons. Do they really have loft to get you to where you need to be, or do you need a different kind of an engine and a different kind of structure?"

Paz and other leaders with a broad range of perspectives on healthcare organizations gathered at HealthLeaders Media's Transformation of Healthcare Delivery roundtable to discuss the changing structure of the industry and how individual players can adjust.

TYPE OF ORGANIZATION INTERESTED IN PURSUING

Q: Which of the following would you say your organization has a high interest in pursuing through a merger, acquisition, or partnership within the next year?



Base = 315, Multi-Response

SOURCE: HealthLeaders Media Intelligence Report, *The M&A and Partnership Mega-Trend: Deals for Growth and Survival*, February 2015

New market strategies

Baylor Scott & White Health, the 46-hospital system based in Dallas, was formed in October 2013 from the merger of the Baylor Health Care System and Scott & White Healthcare. LaVone Arthur became chief integration officer for the new

system. "There's a whole different definition of health network now. We have, historically, like most systems, been a system of hospitals with inpatient and outpatient services—a lot of bricks and mortar," she said. In addition to retail partnerships, the merged entity has focused on growing the Scott & White Health Plan. "We now have a health plan within our system, and that allows a lot of growth opportunity and flexibility about how you get into new markets and how you develop products. We can take it direct to employers in some cases and add value to those employers. It's exciting."

Around the United States, leaders of healthcare organizations "are trying to see what the best model is to respond to the regulatory changes and the changes happening in the healthcare economy," said Mohamed Diab, MD, a principal with PwC's Health Industries Advisory service who is based in New York City. "The continuum is from people who are still trying to resist that change and stay with the fee-for-service, to some folks who are doing fee-for-service with some incentives like pay-for-performance, to shared savings, to bundled payment, to capitation, to full risk and building insurance plans. ... In many instances, people are doing all of these at the same time and trying to see which models work and which models don't work."

Kit Brekhus, MD, is physician executive director of Colorado Health Neighborhoods (CHN), an integrated network of independent and employed physicians, along with other health professionals,

partnering with Centura Health in Englewood, Colorado, with the goal of optimizing healthcare value for consumers. CHN exists to bring together physicians and other healthcare professionals operating under different models, such as independent physicians associations (IPAs). "We have more than 2,800 providers, and about 2,000 or more of those providers are independent. So by nature, we are finding ways that we can interact with different entities and trying to figure out how we can come together and begin to row with the same energy and going in the same direction," he said.

CHN targets six populations in the greater Denver area, three of which are organized as commercial ACOs. Its model allows provider members to partner with Centura Health's 15 hospitals and multiple payers in a flexible arrangement that accommodates different operating structures and reimbursement situations, he said.

Affiliating with other healthcare provider organizations is a key strategy for Ochsner Health System, said Patrick Anderson, system vice president and CIO for the 10-hospital system headquartered in New Orleans. "It seems like every four or five months we have another affiliation with a hospital or large physicians group that wants to partner with us. For example, we just signed a 20-year deal with a medical center where we have a clinic in that geography. The deal is that we will not build a hospital there and they won't build any clinics, and we'll share our P&L 50-50. So we're going in and building ambulatory surgical centers

and standalone EDs in that geography with some limited radiology and labs. ... Longer-term, we want to be a referral center for the Gulf South. If we partner locally across the Gulf South and help sustain those independent medical centers, we can all coexist in harmony. ... Where they don't have advanced specialties, we can then be a referral center for their toughest cases."

Partnerships across the country are being driven by the financial necessity, Arthur said. "Much of the partnering is driven by the notion that while healthcare is local—people still want healthcare close to them—healthcare financing is quickly becoming regional and national. And that's driving these partnership expansions to build a network. ... You have to be able to either be part of a network or take [patients] to a network that's going to meet their needs, and that's challenging in a lot of markets."

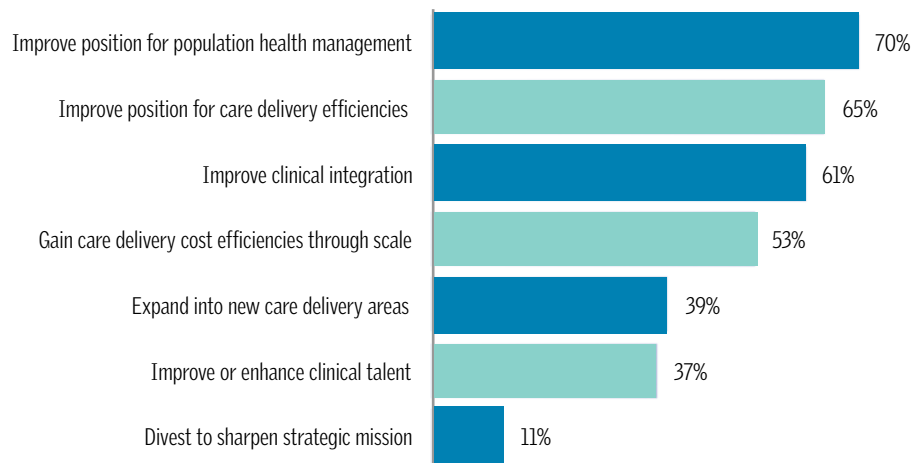
The path to population health management

Many provider organizations are committed to population health management as their future care model. It's a logical strategy for value-based reimbursement that matches the mission of providers: to improve health for all people.

"One of the exciting things for us is this whole new era of healthcare, which is the ability for us to really fulfill our mission. We've always been focused on caring for those who are ill, but we haven't really gotten to focus on nurturing the health of the communities that we serve," said Pam Nicholson, senior vice president for strategy

MERGER/ACQUISITION/PARTNERSHIP CARE DELIVERY OBJECTIVES

Q: Which of the following are among the care delivery objectives of your overall merger, acquisition, and/or partnership planning or activity?



Base = 315, Multi-Response

SOURCE: HealthLeaders Media Intelligence Report, *The M&A and Partnership Mega-Trend: Deals for Growth and Survival*, February 2015

at Centura Health. "That means going into those communities and finding out what they have for health resources and then being able to fill in the gaps."

Davin Lundquist, MD, vice president and chief medical information officer for Dignity Health, the 42-hospital health system

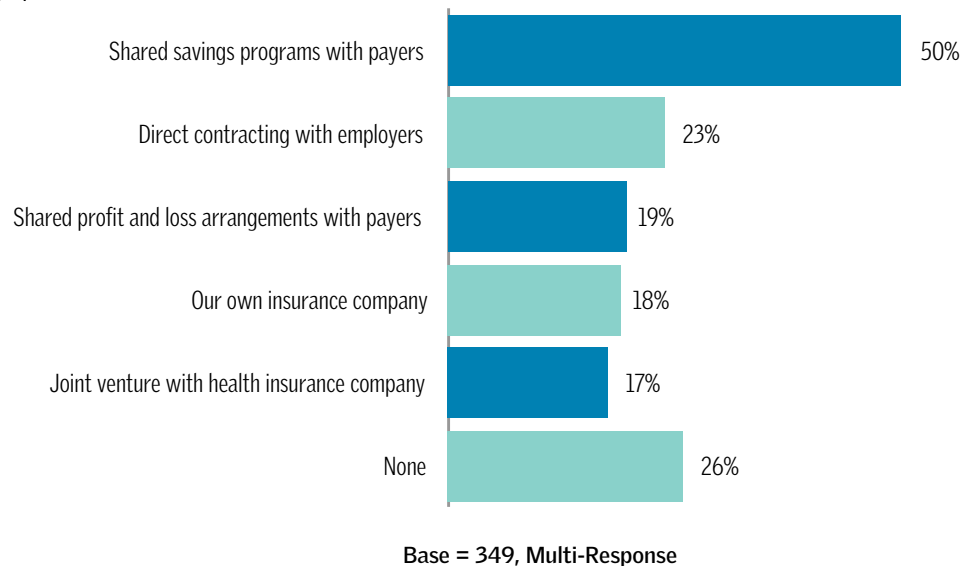
headquartered in San Francisco, observed that, "If you have an uninsured population or a Medicaid population, the principles of population health work really well. The ability to deliver care to a population is possible maybe in ways that it wasn't when we were operating with ever-declining federally funded dollars."

Diab echoed the point, saying, "Payment reforms are making a significant improvement in the way we deliver care today. We are now focusing on the 80% of people who are healthy, who we never paid attention to before. In the past, nobody cared if a member is healthy, because as long as there is no cost and he is not sick, it's not important. But now, because we are going to be accountable for the total cost of our population, we want to keep these folks healthy, which means we can attack the obesity problems to prevent people from getting sick and getting diabetes. That's important."

Changing the image of an acute care-focused health system can be difficult, however. At Charlotte, North Carolina-based Carolinas HealthCare System, which has more than 900 care locations, "We still want to be the traditional healthcare provider in our area; we want to have hospitals and doctors' offices and all of those other things," said Brent Lambert, MD, the system's chief medical information officer. "But more and more we also want to focus on the health of the community, more so than treating the ill. How do we change our image [to say], 'We're here if you need surgery, but we're also here to help promote your health?'"

FINANCIAL RISK STRUCTURES USED NOW FOR POPULATION HEALTH

Q: What financial risk structures does your organization currently use in caring for an identified population?



SOURCE: HealthLeaders Media Intelligence Report, *Population Health: Are You as Ready as You Think You Are?*, October 2014

Getting comfortable with risk

Along with population health management will come the risk-based payment. Even organizations holding onto fee-for-service care in future years will probably have to take on some level of risk. While some health systems incorporate a health plan—such as Baylor Scott & White—others are averse to that move. “You have to define

risk,” said Centura’s Nicholson. “If you’re talking about bringing down the total cost of care, improving quality, adding convenience, and basically optimizing healthcare value, we’ll take risk for that. As far as taking insurance risk, though, we’re not so excited about getting into the insurance company business. Been there, done that. That’s not what our competencies are all about.”

But risk has become endemic to the healthcare business, said Paz. “I would argue as a former hospital CEO that there’s enormous risk in the traditional fee-for-service world, where each year you’re seeing effective reductions in your reimbursement. The last place I ran, we were looking at a world where we had to live on Medicare, not because Medicare was our single payer, but that’s what the rates effectively would have meant for us. So how do you find enough efficiency and how do you reduce enough waste in the system to be able to live in that world? That’s enormously risky. And how do you generate adequate margin to cover the capital costs that are necessary not only to maintain your existing operations but also transform them to remain competitive across your region? Enormous risk there.”

Combat or cooperation with new competitors

New entrants such as Walmart are opening retail clinics that threaten to undercut traditional health systems. “The Walmarts in central Texas announced, ‘We are going to have a clinic, and we’re going to provide \$4 visits,’” said Baylor Scott & White’s Arthur. “Our folks in that particular market approached Walmart and said,

FUELING FINANCIAL GROWTH NEXT FIVE YEARS

Q: How will your organization fuel financial growth over the next five years?

Expand outpatient services	63%
Strategic marketing campaign for existing market	43%
Develop or join an ACO or PCMH	39%
Acquire or merge with physician organizations	36%
Strategic marketing campaign for new market	34%
Acquire or merge with hospitals	27%
Develop or partner with convenient care facility	22%
Acquire or develop a health plan business unit	18%
Increase inpatient bed capacity	9%

Base = 580

SOURCE: HealthLeaders Media Intelligence Report, *Succeeding in the Risk Era: How to Accelerate Progress Toward a Value-Based Future*, January 2015

'Let's talk, because you still need physician oversight for this clinic.' So we're working with Walmart, but it's in the early stages."

Baylor Scott & White has a longer-standing collaboration with 13 Walgreens clinics, where the health system's employed primary care group provides the clinical oversight. "That seems to be going well because it's a partnership and not competitive," Arthur said.

"But in the Dallas–Fort Worth market, the Walgreens is across the street from CVS, which has the Minute Clinic, which is down the street from the Walmart, which is near CareNow, which has now been purchased by HCA. On every corner is either an urgent care or a freestanding emergency room, which is very confusing to consumers."

Similarly, Colorado Health Neighborhoods signed an agreement with Walgreens in January 2014 to collaborate on several retail clinics in the Denver metro area. "We see retail collaboration ... as another arrow in the quiver of our population health strategy," said Brekhus. "Those clinics meet a specific need; it's a low-cost point of access that enhances our ability to serve our populations. We believe the best strategy is to bring these retail partners into our network and fully integrate them into our continuum of care. The collaborating physicians who oversee the clinics are CHN physicians. ... The Healthcare Clinics at Walgreens have agreed to cooperate with our quality initiatives, our costs, and with communicating on patient care."

Health system executives are acutely aware of the threat of new competitors. Yet the attendees at HealthLeaders Media's Transformation of Healthcare Delivery roundtable remain sanguine about their organizations' role in the new order.

As Lambert of Carolinas HealthCare noted, "One thing about these disrupters: I haven't seen one yet that wants to be a large integrated delivery network. They're after a little niche." ❖



Harnessing Healthcare Transformation

Many forces are reshaping healthcare in America today. Digital tools offer improvements in patient care, patient engagement, and clinician workflow, and also allow disruptive new entrants. An aging population afflicted by stubborn chronic ailments requires an overhaul in approaches to care, extending across the care continuum and requiring new competencies from and different roles for physicians and other clinicians. The government-driven shift to value-based payment is upending healthcare providers'

financial models, leading to massive consolidation and forcing many organizations to take on risk for the first time. Changes in insurance and reimbursements presage the growth of healthcare consumerism, in which patients will demand price transparency and value. In response, executives at hospitals, health systems, and health plans are plotting their market positions for the future. The transformation of healthcare on a large scale will require a transformed identity for many organizations.

HealthLeaders Media: What does the consumer- or patient-oriented healthcare delivery system look like 10, 20 years from now?



The lines between what has traditionally been considered healthcare and social determinants are going to blur, in that the challenges people go through in their day-to-day lives that impact their health and well-being are becoming more important.

KIT BREKHUS, MD
Physician Executive Director
Colorado Health Neighborhoods
Centura Health
Englewood, Colorado

Kit Brekhus: The lines between what has traditionally been considered healthcare and social determinants are going to blur, in that the challenges people go through in their day-to-day lives that impact their health and well-being are becoming more important. We see this occurring specifically within the Medicaid population, and we're finding more and more that our emphasis needs to be on helping this population of patients

manage and maintain their health and wellness. We're going to have to redefine the scope of what we do in healthcare.

Harold L. Paz: We wouldn't call that person a consumer, we'd call that person a member. We view our responsibility to create a health universe for that individual, to curate resources so that they remain well and healthy. Social determinants are extraordinarily important. We know that poor people don't have the same health status as wealthy people. They die sooner. But social circumstances, including

financial status, accounts for 15% of health status, while 40% is determined by social choices. Do you choose to overeat? Do you choose to not exercise? Are you obese? Do you practice unsafe sex? Do you use drugs? And, of course, one of the biggest determinants is smoking. What do we do to make sure that each individual is in an environment that creates the greatest level of health and wellness? Because that is important obviously for them and their families and the workforce but also for the country.

Mohamed Diab: I'll take the consumer view. As a consumer of healthcare—because we all are, right?—I would like to be treated as a consumer. Now that I have more financial burden in this equation because I have a high-deductible plan, I want the system to be transparent for me. I want high quality. I want easy access and convenience. I want my information to be available to me on my iPhone or iPad where I can see my results. I don't want to run with my kids to the ER because the doctor doesn't work extended hours. I want to be able to do a virtual visit with him over Skype or whatever. So I want it to be fully digitized. ... I also want centers of excellence where I can go. It should be a one-stop shop for me. I can see my endocrinologist, I see my primary care physician, I do my lab, I do my imaging. ... There is a correlation between volume and efficiency and advanced medicine, because these folks see a lot of cases.

Pam Nicholson: I think what you're saying is you want optimized healthcare value, which comes back to the personalization that's going

to need to occur for every single one of these consumers going forward.

HealthLeaders Media: How close are the organizations around the table to be able to provide personalization?



Medications and technologies are going to continue to evolve and reshape the way care is delivered. So our goal is to help shape it into something that can be managed cost-effectively and improve outcomes. That's our job.

PATRICK ANDERSON
System Vice President and Chief Information Officer
Ochsner Health System
New Orleans

Patrick Anderson: Not in the next couple of years. A lot of it is going to depend on the consumerization of a lot of products. Does anybody here think that people are going to be doing EKGs at home on their iPhone without the direction of a physician? I don't see that in the near future.

Brent Lambert: Physicians probably don't read EKGs as well as machines read them today.

Paz: We may not need EKGs in the future. There may be another way to get that information based on technologies that we can't even imagine today.

Anderson: Right now, Xerox has cameras that they're implementing in Parkland in Texas in the ED to diagnose patients potentially with Ebola. This camera goes into the deeper layers of the skin and can

diagnose six or seven different diseases. This is the kind of thing that is being developed in the labs right now, which means it's going to be completely unknown what the technology impact is going to be on healthcare. The unknowns are going to be coming fast and furious. Medications and technologies are going to continue to evolve and reshape the way care is delivered. So our goal is to help shape it into something that can be managed cost-effectively and improve outcomes. That's our job.

Lambert: Another thing to understand as things evolve and new technologies come along is: Who are the healthcare providers of the future? If we go back not that long ago, the typical physician went to medical school and did one year of internship and treated 90% of what was going on out there, including doing surgery. ... But complexity changes so rapidly with all of these new things that now human beings can't do it all. There's no way that a human being can sort through 15 different labs, a multitude of different possible conditions, interactions between four drugs, and so on and so on. It may be that the iPhone will be better than any physician could possibly be.

Lawrence Hanrahan: I don't feel that hospitals are going to go away. I don't think we're going to be doing appendectomies at home. We're going to continue to need a venue for tertiary and quaternary care to be delivered. On top of that ... there's an emerging practice of medicine: over 20 conditions where the patient typically did not

survive to adulthood in the past but are now living into their 20s, 30s, 40s, even into their 60s and 70s; patients with spina bifida, congenital heart disease, cystic fibrosis, and so on. They're unique and challenging patients, which demands a new type of caregiver with new types of training and new types of technical resources. We have created new clinical challenges that didn't exist 20, 30, 40 years ago.

HealthLeaders Media: How do reimbursements and the financial system need to change in order to arrive at the right healthcare delivery system?



We'll have the ability to measure outcomes and performance in areas that make sense to payers, that make sense to patients, that make sense to overall health. If we start to get paid based on that, then that alone moves us in a very good direction.

DAVIN LUNDQUIST, MD
Vice President and Chief Medical Information Officer
Dignity Health
Camarillo, California

this concept of actually getting paid for the quality of care that you deliver. We have an opportunity as providers to actually show

we are better. We'll have the ability to measure outcomes and performance in areas that make sense to payers, that make sense to patients, that make sense to overall health. If we start to get paid based on that, then that alone moves us in a very good direction.

LaVone Arthur: At the end of the day, the goals and the incentives between the providers and the payers have to be aligned, and that's not where we've been traditionally. There is movement toward that but probably not as quickly as all of the changes in medicine and the changes in technology. ... There have to be significant changes in the financing mechanism to allow [alignment] to happen. The organizations that are going to be out in front, creative, and partnering with the providers are the ones that are going to win. But if those incentives don't get aligned all the way through, then we're not going to get where we need to be.

Lundquist: I think those incentives will, in a way, guide these disruptive solutions. If the incentive is to provide a lower-cost, higher-quality solution—whatever that may be, technology or some new process or some new thought—if it's getting the right outcome, then people will migrate to that solution. So then it doesn't really matter where it comes from. Some health systems are saying we need to try to be that solution. We need to figure it out as fast as these disruptive companies are so that we can stay viable and we don't get misplaced. We want to be part of that solution as opposed to getting displaced.



Now that you're going to be responsible for the total cost, you have to reward the people who are doing the right thing. That's how you can make profit.

MOHAMED DIAB, MD
Principal, Health Industries Advisory
PricewaterhouseCoopers
New York City

the population health management approach is that we are able to bring the cost down so the financial burden is not significant on the consumer. Because otherwise we can be doing everything good but the patient is not willing to comply.

Lundquist: The piece we haven't mentioned is that consumers, patients, members—whatever we're going to call them—they have to be aligned as well. I can totally see that a futuristic app says, "Here are recommendations for you. These are lifestyle recommendations, these are prescriptions, these are labs we think you should be getting if you're diabetic." And as you do these things, you get healthy rewards or something like that. Maybe it lowers your deductible or maybe it gives you money back in your pocket.

Diab: But because of ... the shifting of cost to consumers now, you have people who have to buy products that have a very high deductible. The doctor might be doing everything right but the patient cannot afford the medication, or they don't see the value. ... We all know about the thousand-dollar pill for hep C that creates a challenge for the population to be able to afford them. My hope with

There are ways to align incentives with patients that we just haven't had the technology to do before.

Diab: That's a very good point. Now that you're going to be responsible for the total cost, you have to reward the people who are doing the right thing. That's how you can make profit.

Hanrahan: One of the big critical milestones we've achieved is this convergence that's happening among payer and provider. I think it's real.

Arthur: What level of convergence do you see between providers and our largest payer, CMS? We can do great, innovative, creative things with Aetna, with Cigna, with the Blues, with United ... but our largest payer is still sitting in D.C. writing regulations and laws that in many ways are controversial, contradictory, and prevent us from doing some of the things that we need to be doing together.

Paz: That takes a lot of different paths. For example, Medicare Advantage—yes, Medicare is the funding source, but how that funding is conveyed and then the role that payer organizations and providers play in that environment is very different from traditional Medicare. ... There will still be traditional Medicare, but even there, don't forget that some of the earliest pilots for ACOs came out of the Medicare pilot program. ... Federal payments are not going away ... but those dollars will take, I think, a different number of routes.

Arthur: My concern is timing. The technologies are changing so quickly, medical advances are changing so quickly, the convergence between payers and providers is changing quickly. We have to have the ability to be innovative, to create some things, pilot it, test it, and if it works, let's go. While a lot of advances have maybe started in a CMS environment, like ACOs, that was 10 years ago. Is that mechanism of government-funded traditional Medicare a hindrance to the providers to move the rest of their organizations along, when you still have 40% [of volume] that's under this old model?

Anderson: If value-based reimbursement grows, outcomes will improve and everybody should win. That's the concept.

whole question of how patients really judge with accuracy quality outcomes, even with good data.

Diab: The high deductible helps a little bit because I question everything I pay for because I'm paying the first \$6,000. That helps from a consumer standpoint, but the issue is much bigger than that.

Lundquist: I think this goes back to the incentives again. When the incentives are strong enough for us as an industry to provide that level of transparency, we will. It's building now ... but it's not proven. There's a hesitancy to invest a lot.

Paz: If you talk to many physicians and you ask them what the cost is of a certain service, what the cost is of a certain device or procedure, they're not clear on it. Having run a health system, I talked to our CFO about our chargemaster ... and how those are charges are derived. It's amazing when you start drilling down into it and understanding where it came from. It's a system that's grown over many decades. Unraveling it is going to be challenging, but I think as long as we still have the current methodologies in place for reimbursement, having the patient understand the actual cost of care is extraordinarily important. I think it's important for the providers as well. And that [also] involves the cost of devices and the cost of drugs. There's been a lot of discussion around hep C recently but there are many, many examples of that.



Something else that needs to take place is a change in culture in the country, so that people can live a healthier lifestyle.

PAM NICHOLSON
Senior Vice President for Strategy
Centura Health
Englewood, Colorado

Nicholson: Something else that needs to take place is a change in culture in the country, so that people can live a healthier lifestyle. That's still totally misaligned. It's very expensive to eat healthy.

HealthLeaders Media: Another barrier is cost transparency ... which is a long way off from actually happening. Then there's the

Brekhus: Cost and pricing transparency is important, but there's also quality and outcomes transparency for our providers. Part of that depends on the data received. ... You can't start being transparent about your quality if you are given substandard and incomplete data.

HealthLeaders Media: That was just forced on providers in the state of North Carolina with the recent release of partial quality data required by the legislature.

Lambert: We don't even know how to do it. It is extremely complex and it will be interesting to see how that [transparency] comes about.

and we benchmarked it against our historical success and against other providers across the region to see how they were doing. For example, hospital-acquired infection rates are X at our institution versus others, and what are the steps that we can take to reduce that? That's invaluable.

Hanrahan: To stay a step ahead of that, there are health systems engaging in social listening and just seeing what the chatter is about their health system out there, and responding to that on a daily and weekly basis.

Arthur: You have to these days. If you're not plugged into social media, you've got your head in the sand.

HealthLeaders Media: In a fragmented healthcare system with multiple health systems that compete ... as soon as the patient goes outside your system, you lose sight of them. The key is communication. How can that be enabled?

Anderson: CMS was trying to drive interoperability through HIEs and through meaningful use, but it has fallen short.

Lambert: If you look at who wrote the meaningful use rules—largely vendors—their greatest value is their install base. If we truly have interoperability, they become much more of a commodity than anything else.



I think as long as we still have the current methodologies in place for reimbursement, having the patient understand the actual cost of care is extraordinarily important.

HAROLD L. PAZ, MD, MS
Executive Vice President
and Chief Medical Officer
Aetna
Hartford, Connecticut

Paz: Pennsylvania had publicly available quality data for years. I think the greatest value of that data is for process improvement. I don't know how much each individual patient really looked at it or how much it really determined their decision about where to get their care. But I do know that we [at a health system] looked at it very carefully each year,

Anderson: There's going to be a new edition of interoperability coming out of Washington. But I wonder about the conflict and the timing and the realistic practicality of it.

Lundquist: I get excited as a primary care provider when I think about tools that will give me my entire panel, that will analyze that population, that will risk-stratify them, that will put them in categories or segments or whatever you want to call it that will help me know how to manage these patients, and that will give me a team of people that will help me focus on the most important ones. Even though I may not have data about when [patients] go outside my system (that would be nice someday but we have so much work in front of us right now), if we just can start ... to apply some actual

evidence-based protocols, that will make a difference. We just haven't had the means to really effectively apply [these tools].

Diab: But these tools exist today. The data exist today in the same way you're talking about. The problem is, it is not trickling down to you, because there is no incentive. Again, back to the financial incentive.

Lundquist: Yes, but we are very close. There are contracts right around the corner. Like us, every other health system on the planet is looking at these tools. They're trying to figure out how to fund them and how to install them. They don't want to overcommit until those contracts are there. But it's all coming together and it's exciting, as many challenges as there are.

HealthLeaders Media: We've talked a lot about the importance of incentives. Who's going to align those incentives in order to get the healthcare delivery system where it needs to go in the future? Is it the invisible hand? CMS is doing it, though there doesn't seem to be a lot of excitement here. Is it your healthcare organizations? Is it going to be driven by disruptors?

Paz: All of the above.

Lambert: The free market.

Anderson: The closer partnership with payers and providers may create some new and innovative reimbursement models.

Hanrahan: Is influencing CMS unachievable? How do we address that issue?

Nicholson: I don't believe CMS is going to do something that's too progressive. ... But if we can show that we're reducing the total cost of care, improving quality, increasing value, and improving health



One of the big critical milestones we've achieved is this convergence that's happening among payer and provider. I think it's real.

LAWRENCE HANRAHAN, MD
Principal, Health Industries Advisory
PricewaterhouseCoopers
Houston

status, they're going to come along with that and get behind that. It's a timing issue. In our state, we have 20% [of residents] now on Medicaid, and the state wants us to move as quickly as we can to be more at risk.

Diab: We can't say that CMS didn't do anything because the government has pushed for change by reducing payments. That's what got everybody to think differently about value-based care. The same thing with [health insurance] exchanges; that drove the thinking about how can we deliver care differently.

Lambert: I think CMS will be slow, but if it is clear that there are models out there that promote the triple aim and are going to be

to the benefit of CMS and the Medicare beneficiary, they'll come along. They'll be the last one to get there, but I think they'll be there.

Nicholson: Don't you think that the baby boomers will help drive change, too? They are very healthcare-savvy and they know that incentives have to change.

HealthLeaders Media:
What are ways in which the

healthcare delivery system of the future could be one that people really regret? Interoperability might never arrive. How could the system go awry?

Paz: I think the biggest challenge we have is that because many of the healthcare institutions in this country are not-for-profit hospitals, due to the lack of capital to make the necessary investments and transformation, we may wind up losing a number of invaluable parts of our communities. ... All these changes in healthcare today are very exciting, and I think there'll be a better world as a result of them, but they don't come for free. When most of the institutions that are involved in care today are operating on single-digit margins, not-for-profit institutions can't go out and sell stock. The best they can do is maybe sell some bonds or do some fund-raising. We have to be very worried about that precious resource.

Nicholson: But don't you think that can be an opportunity, too? Critical access hospitals can't stay the way that they are today. There needs to be private healthcare delivered in that community close to home. So in what form? We have to be willing to change what it looks like in those communities. It doesn't mean shutting the hospital doors. That's what's going on in some places, but other states are looking at new models. Georgia is looking at something. Kansas is looking at what can they do differently with critical access hospitals, and so is Colorado.



... But complexity changes so rapidly with all of these new things that now human beings can't do it all.

BRENT LAMBERT, MD
Chief Medical Information Officer
Carolinas HealthCare System
Charlotte, North Carolina

Arthur: All it takes is a new, highly contagious disease that gets out and enters into our system. Look at what happened at Presbyterian in Dallas for a short period of time—and that was one man. If

[Ebola] had not been contained then. ... Look at the expense that now has been triggered at healthcare systems across the country: hundreds of thousands of dollars of PBE equipment in reserve and new protocols, new training. While we've got great advances in cures, there are also new diseases and new things coming up that could end up on our soil that could completely disrupt American healthcare.

Brekhus: A number of catastrophic events could turn things upside down. Cyberattacks could potentially cause major technology disruptions.

Hanrahan: We need to be worried about creating a brain drain in healthcare. These are challenging issues, and the financial challenges get more and more difficult every day. As young individuals decide what they're going to do for a living, if this industry gets too challenging, they're going to pick something different, and we're going to lose that brain power that we've always had ... in healthcare. ❖



There have to be significant changes in the financing mechanism to allow [alignment] to happen. The organizations that are going to be out in front, creative, and partnering with the providers are the ones that are going to win.

LAVONE ARTHUR
Chief Integration Officer
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