



ROUNDTABLE

Preparing for Population Health Management

Healthcare leaders are preparing for the shift away from volume-based reimbursement by experimenting with different structures for population health. Organizations must learn how to collaborate with new partners, including erstwhile competitors. Population health management also requires internal bridge building; executive and physician leaders must work together to create networks. Primary care physicians could be in short supply, while specialists are likely to see their payment, work mode, and degree of control turned upside down. Good data and analysis of the patient population is absolutely necessary, but not sufficient. The most important determinants of success or failure will be so-called soft factors: trust, culture, and leadership.



PANELIST PROFILES



FRANK MARSHALL
President
MedSynergies, Inc.
Dallas



TIM PETRIKIN
Executive Vice President of
Ambulatory Care Services
Vanguard Health Systems
Nashville



CHRIS STANLEY
Vice President of Care
Management
Catholic Health Initiatives
Englewood, Colo.



EARL STEINBERG, MD
Executive Vice President of
Innovation and Dissemination
Geisinger Health System,
and CEO, xG Health Solutions
Danville, Pa.



**EDWARD PREWITT
(MODERATOR)**
Editorial Director
HealthLeaders Media
Danvers, Mass.

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Roundtable Highlights

HEALTHLEADERS MEDIA: *Let's begin by talking about what population health management is at a working level. How do you define it, how do your organizations think about it?*

TIM PETRIKIN: We are all [in this Roundtable] a little unique. [Vanguard is] an urban healthcare provider, building integrated delivery networks in large urban settings. When we think about our population, it is very diverse, and we think about them in populations of half a million to a million lives within an urban community. That often means that we have to take into account the market segmentation because that is not a homogenous population. I think that's one of our challenges. ... Are we going to define that population by health status, or are we going to segment that population differently? Traditionally we've done it by some health status.

How we connect to the rest of the population we think [will be] less about health status and more about their personal relationships, whether it be demographic, psychographic information, however we start to segment that—how we connect with them really more as customers. That population does not connect with *healthcare* as much as it connects with *health*. So we have to design something fundamentally different.

CHRIS STANLEY: With Catholic Health Initiatives being in 17 states—historically more of a hospital-based, nonprofit, faith-based organization now emerging more into a larger health system approach—we've always been very focused on the communities that we serve. One could define a population as a particular geography or ZIP code. ... With our legacy and our history with the Sisters, starting up healthcare services in the late 1800s, they had a very strict definition of population: It was whoever was in

their particular community. So we try to bring that forward into our current way of thinking of population health. ...

While it's about the community, while it's about a broader population, frequently [population health management] ends up being around a particular program or a particular funding source or initiative or pilot, and that's where we try to focus then with our data analytics, our deployment of case managers and other services, to try to improve care.

EARL STEINBERG: I'd like to step back and take a little more basic perspective on it, because I agree with everything that has been said, but I think what we've heard is more the “how” than the “what.” And the “what” in my view is taking responsibility for the care of the health of a population. Segmentation and relationship management, those are all part and parcel of how you would go about doing it, but it isn't the “what.” The key issue in my mind is how population health management contrasts with typical healthcare. Typical healthcare from a provider perspective is delivered one patient at a time. You are focused on that particular patient. You had really no reason or method by which you could look at what was going on in terms of either the health or the care of a population. The game has changed.

And then to your point about data analytics, you can't do population health management well without data analytics. Just like you can't manage anything without measuring what's going on. When you move out of the need to understand everything that's known about a specific patient and you start targeting people for outreach, personalizing how that outreach is delivered, and trying to proactively make sure that certain things are done in a much more systematic way, data analytics is at the heart of all of that. So whether you call it segmentation by financial risk, clinical risk, sociology,

etc., those are all part of how one goes about delivering population health management. The better you are at that data analytics component, I believe the better you will be at population health management. Providers that get into this game without having that are in for rough sledding.



FRANK MARSHALL: From our perspective, population health is going to be defined differently in the different geographies, from urban healthcare to rural healthcare. ... But you have to have the infrastructure to be able to get to the individual patient and be able to treat and interact and have a relationship with that individual patient, and then be able to roll up those data analytics so you can look to make sure that you are doing the things you set out to do: increasing the wellness or the healthcare in those communities, no matter how you segment them. So from our perspective, you need the data analytics, but you also have to be able to get from a relationship perspective into that individual patient, and you have to be able to have those systems where you can help direct the individual patient to be in the right spot, see the right provider, and be able to track that along that continuum, and then be able to roll up those results and the costs.

ROUNDTABLE: PREPARING FOR POPULATION HEALTH MANAGEMENT

HEALTHLEADERS: *Who convenes the population health discussion? Is it always a healthcare system? Is it payers? Does it vary from place to place?*

STEINBERG: I think it will vary. I think it can be driven ... by whichever entity has the financial risk and they say, "Okay, I'm bearing the risk. I need now to take responsibility for managing that risk." So that's one possibility. The other is mission orientation, where I believe in the provider world more than in the payer world; part of the institutional mission is to perform population health management and take care of the community by preventing disease, etc. Having been in a number of different cultures, the differences between those cultures is striking, and it matters and it plays out in the actions taken by those different parties. So I don't think there's a single entity that can assume responsibility. I think it's much more likely that the mission aspect emerges from the provider's side and the financial responsibility can be assumed by many different entities.



Tim Petrikin
Executive Vice President of
Ambulatory Care Services
Vanguard Health Systems

PETRIKIN: You could step back and [ask] who ideally should convene. In every one of our communities someone else is, and multiple parties are convening the conversation around population health and driving that. We certainly see it where payers are driving that. We have experience where physicians are driving that, and then you

have health systems and certainly large integrated systems or hospitals. And then you have governments who are trying to do it through policy. But what's very interesting is who's not convening: the communities and the members of the communities themselves.

STANLEY: So often the convener ... is focused around a particular opportunity, around a particular program, an application or something like that—which makes a lot of sense. I also think of the convening process around operations. Once we figure out what it is that we want to do, how do we bring all the right stakeholders to the table and move things forward? ... A question for me and my organization and similar organizations in our communities is: Who is the change agent that is going to be able to move us from where we are now to where we need to be in the future? Again, you can think about it convening operationally. How do we become an affordable or accountable care organization under CMS rules, how do we truly start taking responsibility for the triple aim type of goals, and how do we become change agents? Who are the various stakeholders that need to drive that? I would suggest it really should be from the provider's side, that that's where the incentives should all align. That's where the connections are to the community.

I feel really strongly about my organization's faith-based type of approach to being in the community. We're the ones that were there five years ago and 20 years ago and a hundred years ago, when our facilities first started. Health plans will come and go. Accountable care organizations may come and go. The Affordable Care Act will come and go. But we're in the community, and it's really that provider side that should be the change agent.

STEINBERG: One point that I think might be interesting just to think about going forward is to look at the extent to which the outcome of these experiments varies with who the

convener has been. I don't think we know how that is going to turn out. I have my views about it, but we may guess wrong as to what turns out to be most successful.

MARSHALL: When you think about it, the largest entity financing healthcare is corporations. Being able to partner with a Walmart or something like that could be a change agent, could be an aggregator. But a lot of times it comes down to the financial risk and responsibility, because the mission is on the provider's side. [Physicians are] the most disparate group within the whole ecosystem. Individual physicians are all coming together more in alignment, but still a health system is probably only going to employ, what, 20% of the physicians in a geography, maybe more? You've got another 80% that you have to interact with, and they're disparate. How do you pull that together and what's the aggregation point?

HEALTHLEADERS: *The elephant in the room is the physician take on population health management ... primary care is going to be an issue, primary care shortages. The specialist world is going to be turned upside down.*

MARSHALL: It's a question that people have been asking: Do you align the primary care physicians into an employment model and then you'll be able to work with the specialists, or do you get the specialists and then the primary care guys? We believe that the primary care model—where you align those and then create extenders to help with the need for more primary care physicians—is the right model. But no matter what you look at, you're not going to be able to employ or align 100% of the physicians in a geography. So how do you extend your reach with the folks that you're not going to employ? What are the tools, what are the things you're going to do? What are the governance models? How are you going to be transparent with your information so

you can interact with those folks to be able to move patients through? ... How is that all going to work so you can try to get the patient to the right facility, right provider, at the right time to help manage that population? Those are the things that we're trying to figure out.

STANLEY: It's going to be a big challenge for us to align the physician side. If you look to other countries that have both a population health-based approach as well as lower cost and still very high quality of care, they have maybe 50% less hospital beds than what the United States has on a per capita basis. As a downstream driver of that, there is a different mix and content of specialty care. The reality that I think we're all facing is that the future for specialists, specialty care, and especially preference-sensitive types of care or supply-sensitive types of care is going to be significantly changing. We are almost certainly overstaffed with certain types of specialists. There are certainly geographic access issues, even within certain specialist bases. We are understaffed and underresourced but also underconnected on the primary care side as well. So all of us need to realize that our future is very different than our past. We're all going to have to change.

As clinician leaders, we can either be a part of that change or we can try to hold that back, but the tsunami is coming. ... A lot of what keeps me up at night in my organization is, how do we bring along physicians in general but specialists in particular to see the future, and for them to be a part of and design a system with the right incentives and disincentives so that a patient-centered, patient-appropriate community and population-focused care is being delivered.

PETRIKIN: I'll be a little bold and kind of go out there a little bit. I would say there's a primary care physician shortage only to the extent that they are unable to practice at the top

of their license the majority of the time. I would argue that a shortage of advanced practitioners is the real shortage, whether it's nurse practitioners, PAs, etc., and that we should start to encourage the primary care physician—family practice, internal medicine, pediatrics—to practice at the top of their license. We have to change the business model and the delivery model. That's really what I think the key factor is. ... It drives me crazy when I see that we're supposedly 80,000 primary care physicians short. No, the majority, or however many it is, are unable, for a multitude of reasons, to adjust to a changing business model. That's the critical factor.

There will have to be a redistribution of specialists, but I don't think the specialist model is doom and gloom. As I talk to the physicians who work in more of a population health model—the plans we work with that are solely Medicare Advantage populations—they have better lifestyles. They have better incomes. And they're practicing medicine the way they wanted to practice it, because we've changed the fundamental business model.

HEALTHLEADERS: *Brown University's Alpert Medical School is planning a population health degree program for physicians in training. If you were to design that curriculum, what would be in it?*

STEINBERG: I actually am very happy to hear that a medical school is putting into place a program for population health management, because medical schools are not turning out people trained to do what we are ultimately looking for them to do over the next decade, everything that we have talked about: team-based care, operating at the top of your license, delegation, automation of tasks. Medical schools are not your most efficient primary care-oriented institutions. They certainly historically have not been in a position where they've done population health data analytics, either clinical or actuarial, because

they've never had the data to do it. So I think this is excellent, and I think students should be doing rotations in settings where they are doing population health management, just as a couple of decades ago training people to operate in managed care settings was important.

I spent 12 years of my post-training professional career in an academic medical setting and have returned there recently, and was told that they want to excel in how to train people for this new environment. I'm skeptical about their ability to do that given all the other components of their mission, but I applaud them for their desire.



MARSHALL: Our chairman emeritus, Dr. Hutton, explained it this way when we were discussing something similar at one point: When a physician is trained, they're trained in an episodic method. So you go in and you diagnose, you treat, and then you move on to the next thing. You don't ever think about the whole approach, especially with the specialists. That needs to change to get to that team-based approach. ... He also likened those residency programs to the television program *House*, where everybody is trying to be the smartest person in the room and trying to figure out if they can diagnose something more substantial than the next guy. It doesn't create that consistency in a team.

ROUNDTABLE: PREPARING FOR POPULATION HEALTH MANAGEMENT

HEALTHLEADERS: *Population health management [will require] competencies that you don't necessarily have in-house. So you're going to have to look elsewhere. How great of a concern is this?*

STEINBERG: I think it's significant for a couple of reasons. One is that if you think about population health management as opposed to focusing on a subset of care and you look at episodes of care related to procedures, for example, and you look out 90 days postdischarge, half of the cost for many of those episodes is postacute discharge. Hospitals have never given much thought to that period of time, whether the patient is going to this skilled nursing facility or this rehab facility or home. They just want to get them out of the hospital. I think that we will likely see more attention paid to the performance of these different options and preferred partners to whom patients should be referred.



Earl Steinberg, MD
Executive Vice President
Geisinger Health System
CEO
xG Health Solutions

The other area besides managing the costs—and I think there is huge opportunity here—is substantial variation in quality and readmission rates after case-mix adjustment. That means there is substantial opportunity.

STANLEY: If whoever is responsible for population health is not addressing this, they're missing the boat wildly. They're going to be incredibly unsuccessful from a cost and a quality viewpoint. Just think about our earlier discussion, where we

were talking about accuracy and reliability on consistent process flow. If you're doing that with a thousand or ten thousand doctors versus doing that with a smaller subset who get it ... and you can set up the right incentives or disincentives better, just from a managerial viewpoint it makes sense to do that. But from a cost and quality viewpoint, it's paramount.

PETRIKIN: I think partnerships are critical. As a matter of fact we cannot do population health solely on [Vanguard's] footprint. In the populations we serve, the six geographies that we serve today, there are 23 million people. If we extend our acute care service market share into population health management, we could essentially take care of 1% of the U.S. population; we'd have 3.5 million lives in a population health model. There's no way we can do that without effective partnerships.

We're spending probably the majority of our time not on what we can acquire, but on who can we partner with and what the criteria are for a partnership. That's tough because we've all been in our silos and we're all on these discrete P&Ls, and now we're taking the margin and putting it at a network level or a partnership level. So we're really spending most of our time on how do we form networks, how do we govern those, what's the participation criteria to be in the network, and how that's going to evolve. It's the only way we can successfully enter the world of population health management because of our scale. There's just not enough capital available to develop the entire continuum of care beyond merely acute care services. ... For instance, in acute care, we're no longer in the four-day stay business; we're in the 90-day acute episode business. That's going to require a partnership across that 90-day continuum.

MARSHALL: And then you look at if the organizations are a fit culturally and

they match from a mission perspective on what they're trying to accomplish. I think those things have to happen also.

STEINBERG: I agree totally. Every issue that people have raised I think is critically important, but culture may trump a lot of other things. If you can get culture right, I think a lot of other things will flow from it. One other thing that hasn't

"If you can get culture right, I think a lot of other things will flow from it."


been mentioned is leadership. If there isn't the right leadership and that leadership hasn't bought in, then it ain't going to happen. Or you may have buy-in from the administrative leadership but not the medical leadership, and vice versa. That's another aspect that's very important in choosing a dance partner.

HEALTHLEADERS: *Alignment, trust, culture, leadership; those are kind of soft factors. What about shared risk and incentives?*

PETRIKIN: I think that's secondary to a strong partnership. Partnerships are about getting the softer things right. The rest of it actually is easier. It really is.

STEINBERG: That's not to say that the incentives aren't important, that the incentives have to be aligned, but without the other things, the incentives won't drive behavior.

MARSHALL: You could do that in a spreadsheet. Everybody can figure those things out—the returns and all those kinds of things.

STANLEY: And you can set up the right legal structures. You can say, "In this place we're going to buy, and this place we're going to rent, and this place we're going to do all those things." It's just tactics if you've got the culture right. 

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