ROUNDTABLE

How to Integrate Population Health Strategies to Build Market Share

Hospitals and health systems are transitioning from a reimbursement system based on volume to one based on quality of care and outcomes. While these changes are still developing, they are disruptive enough that senior leaders must make preparations for the transition now. That means making investments in population health management. Treating patients in an effort to keep them well takes much more information and data-processing capability than most hospitals and health systems currently possess, and the penalties for poor or uncoordinated care are such that investment in these capabilities is a must. But the choices and information technology solutions from which to choose are overwhelming. How does a senior leader determine what's most important when long-term viability is at stake?

PANELIST PROFILES

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Roundtable Highlights

HEALTHLEADERS: *At what stage of evolution are your population health management strategies now?*

BARCLAY BERDAN: The key issue is that all of our efforts have to be physician-directed. A lot of the early disease management focus worked around the physician and demonstrated minimal success. Enabling physicians, particularly primary care physicians, to use tools to better manage the health of their patient populations will allow them to be much more efficient and create longer-lasting behavioral changes in patients.

JAMES SAMS: In our employed primary care group, we have a collaborative with Cigna. The mere fact that you start defining populations is a real mindset change for physicians—that is, when you start telling them how many patients and certain groups and disease states they have. Our care coordinators are contacting these patients on behalf of their primary care physician. We're not making extra work for the doc by working around him. We're working through his existing work flow to try to make it as seamless as possible.

C.R. BURKE: Population health is a softer phrase for managed care or HMOs, as HMOs are often thought of as a four-letter word. Questions to consider are: What's the business case to move toward population health? Where are the payers? Where are your competitors? Is there an advantage to being first in? What are the payers doing to try to incentivize the move? We have an accountable care contract with Blue Shield of California that is built off of an HMO model. My bias is that capitated or risk-oriented contracts are the endgame because that's ultimately where you can get the right returns for doing the right thing clinically.

J.R. THOMAS: Most people know population health is the right thing to do. What we're seeing is that most of the systems don't have the basic infrastructure. The short nature of some of these managed care contracts is a hindrance. We need to see three-year or five-year contracts, which will allow organizations—health systems, payers, integrated affiliated physicians—to normalize how the economics is going to work. The executive suites of hospitals today are a very tough place to be. They know they need to do it, and many of them are moving forward, but the pace is slow and getting the necessary attention span is pretty tough.

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HEALTHLEADERS: *What about the fact that your contracts and the incentives in them are all so different?*

BURKE: That's where this whole conflict is. If a third of your population has a new payment system that begins to reward population health and two thirds is still volume-based, if you start to treat everybody across the payer grid the same way, you could very well go out of business in the process.

BERDAN: That's a big topic of debate in health systems and with physicians. Should we be treating one population one way and another population another, or should everybody be treated the same way? At a recent leadership retreat we were showing some primary care physicians tools they could use to help organize their panel in a way that they could change their work processes. I asked a primary care physician who has 4,000 patients in his panel how many were diabetics. He said, "Probably about 600." I said, "Do you know who they are? I mean, could you give me a list?" And he said, "Well, not really." I asked, "How would you change your practice if you had tools and help rearranging work flows that allowed you to understand some of the broad brushstrokes of your population and to drill down to individual patients? With these tools you could determine who hasn't been in for a physical who should have been rather than coming in every day and trying to figure out how you're going to see 35 patients in a series of 10-minute interventions." It was a big eye-opener for him that these kinds of tools are available.

C.R. Burke
President and CEO
St. Joseph Heritage Healthcare

SAMS: There are ways to build that bridge. In the value-based part of the contracts, there's value for not seeing them if you don't have to. So that means a lot of phone and nurse time. But it's not payer-agnostic. You've got to look at who's paying you on value. At the same time, good care is good care. A controlled diabetic is a controlled diabetic. How you get there and how it's paid for can be different, and that's what we have to do in the office setting.

HEALTHLEADERS: *How difficult is it to segment that population and have different rules for how you treat those patients?*

SAMS: We try to look for the common denominators. You can be a better doctor. You can take better care of your patients. Here's your list and this is how many diabetics you have. If you start giving physicians that kind of data, they start wanting to engage.

John R. Thomas
President and CEO
MedSynergies

BURKE: Beyond the financial part of it, there's the competitive nature of physicians. One of the key tools is a disease registry. Having an EMR is great, but having a disease registry is what we're really talking about.

HEALTHLEADERS: *There's clearly some paralysis because we don't have the endgame resolved. Where do you get started?*

SAMS: There is no endgame. It will continue to be an evolving market. If we get good at population management, there will be a tweak. But for God's sake, do something. It does not have to be hard or complicated.

THOMAS: How do you reconcile the economics?

SAMS: You can do both. I want to see us lead with the care and support it with the money. We've gotten away from that in healthcare. We lead with the money and expect the care to follow. Let's take this opportunity to reset the dynamic. Here's the care and the money's right behind it. If we're taking better care of patients, physicians are going to like being doctors again.

HEALTHLEADERS: *But what investments need to be made? How do you make a strategic decision that doesn't break you financially in the process?*

BURKE: If there wasn't a business case to invest in a disease registry in 2004 in Southern California, I don't think we would have invested in it. As long as we're dealing with the third-party payer system, their incentives drive the investments. We made the heavier investments in the mid-2000s because of pay for performance. You've got to have three- to five-year contracts and payers who will help fund these investments.

THOMAS: There are health systems that—call them lucky or smart—have made significant investments in the last 24 months. This is not an overnight issue. Your physician alignment strategy may determine the future fate of the health system. A lot of secondary market hospitals are going to have to align with well-capitalized health systems with better skill sets who already have the model working because they can't do it themselves.

HEALTHLEADERS: *Is that a function of the fact that third-party payers want narrower networks?*

THOMAS: Employers want narrow networks. We're self-insured and we would love to have the ability to prepay office visits, physicals, and breast screening for women. That takes it out of your health insurance costs. It would make health insurance really health "insurance," which is for things I can't predict.

"Your **physician alignment strategy** may determine the future fate of the health system."

BERDAN: I don't think employers want narrow networks. They are forced to create narrow networks. They've already gone down the road of redesigning benefit plans and increasing deductibles and trying to put incentives in place to make patients make better choices. Now they're at the point where they're trying narrow networks. Employers will begin to channel their business to organizations that can help them manage not only the cost, but the quality of care. We've got to engage in dialogue with those payers as direct customers. We're searching for who's on the cutting edge of taking information that's available in the marketplace and predicting who's going to be high cost so we can channel scarce resources to those patients who can most directly impact cost and quality.

BURKE: In this population with Blue Shield in CalPERS [California Public Employees Retirement System], we found that 14% of the patients retrospectively drove 70% of the cost. We recently previewed a predictive modeling tool that says for a certain doc's population, for example, there are 43 patients and these 20 have a 60% probability of admission in the next 12 months. It's pretty powerful.

BERDAN: Because that's the patient population you want the system to interface with. And maybe for those cases, it would be worthwhile for a physician to even make house calls.

SAMS: It's going to have to go to that. Every one of these patients is going to require a little different tweak. You can take your analytics down to a certain point, but then it's got to move toward boots on the ground and that physician has to own the rest of the process. That's where docs are going to have to engage in a different way, and that's different for them because now they're managers.

BERDAN: You have to figure out how to move through that shift in your panel over time. Otherwise you're going to be spending time and energy on patients that don't really need it.

HEALTHLEADERS: *That's a good segue into labor costs. How are you avoiding investing in areas that aren't likely to give you a good return in population health?*

SAMS: The competencies and the technology around population health can be a tremendous alignment tool, and it can be a very strategic thing for systems and physician groups. That's where the real opportunity here is. And what do we come together around? We come together around better patient care. Who in the hell can argue against that? So we drive that as the common denominator. You're going to have systems—maybe payers, too—that are willing to help invest. The relationship with payers is going to continue to be tricky. Are you going to wait for them to come in and afford you the opportunity, or are you going to start building some competencies so that you can drive them? Quit waiting for them to open the door and put yourself in a position to engage the payers and start pushing the market a little.

THOMAS: But to do that, don't you have to make the long-term commitment to this patient market-share strategy?

SAMS: You either have to build or align those pieces. And alignment means that they're exclusive.

BERDAN: I don't know that they all have to be exclusive. I do think we will see physicians choose sides. Some of the providers in the postacute care world aren't going to necessarily have exclusive arrangements, but systems will start to organize themselves and determine whether those providers will be willing to link processes together so we don't let patients fall through the cracks. Let's face it, not many of our systems have spent time thinking about the likelihood of a patient coming back into the hospital because his or her nursing home isn't doing something they should be doing. You could say the same for home health, rehab, and the rest of the postacute environment.

THOMAS: There will be winners and losers, and that is going to be more rapidly determined than it has been in history. And the financial requirements to make the bets and lay the infrastructure for several years from now is significant, especially when a lot of people really don't understand what the rules will be four years from now with what looks like a 50% Medicare/Medicaid population around the country.

HEALTHLEADERS: *Back to the point about driving the change, what can you show the payer or employer to demonstrate your value to them?*

BERDAN: The first thing the employer is going to ask is whether you have done this work with your employees. We've been doing this for more than a decade now, employing strategies that motivate patients to change. Let's face it: Healthcare workers are not always the healthiest people in the world. We can show that our benefit costs have flattened while others are seeing a steep rate of increase.

BURKE: The employer has to push the button in terms of the health risk assessment on the front end so you get a picture of employees. Otherwise, how do you really begin to have a picture of the population you are accountable for? A lot of employers still won't do that.

HEALTHLEADERS: *How do you manage internal disagreements, especially with the finance suite, given the anticipated long-term payoff scenarios for these investments and changes in incentives?*

SAMS: I had this discussion with our CFO when I showed him our Cigna data and how we've gotten things moving. He's wondering how much of this he wants. He told me, "You're taking volume out of my hospital." Yes, I am, but the reality is that the only people who should be in those beds are the appropriate people, so we'd better have a backfill strategy. So I would be taking tertiary services out of outlying hospitals and I'd be building those referral lines.

BERDAN: That's a hard move though.

BURKE: And it's an expensive one. We've got three hospitals in Orange County. The same cardiovascular surgical group covers all three. No one wants to have their hospital be the one that doesn't do heart surgery.

SAMS: We're a certificate-of-need state, so that's an easier play.

Barclay Berdan
Senior Executive Vice President
Texas Health Resources

BERDAN: The state of Texas does not require a certificate of need. It's a free market, peppered with a lot of physician-hospital joint ventures that incent patients to move around. There are three large viable systems that dominate the marketplace, and on top of that, at least a quarter of the population is uninsured. We've got to change the system or we're basically going to find ourselves in an environment where the only way that people deal with the problem is through narrow networks slashing costs under a traditional reimbursement model.

BURKE: On the commercial book of business, hospitals need to think about accepting risk contracts or capitated

agreements. As long as you have these competing economic alignment models, you're going to have that tension.

BERDAN: For the smaller markets or markets that are not in growth mode, that's a real challenge. One of our blessings is a growing market. So as you destroy traditional demand, you have the ability to at least continue to provide new services on an inpatient basis to a growing marketplace. If you're in a marketplace that's stagnant in terms of growth—it's just aging or shrinking—the challenge is bigger. The truth is, people are innovating right and left. There's a lot of capital coming into the marketplace in ways that are completely outside traditional networks and delivery systems.

James Sams, MD
Medical Director
Piedmont Healthcare

BURKE: There's overutilization around the country. I worry that once it's squeezed out, the aging boom is still going to drive the cost curve higher. We're still going to end up with this frustration that we haven't adequately bent the curve. That sometimes keeps me up at night.

BERDAN: Well, I think it keeps a lot of people in our field up at night, but it's really exciting to think that we as leaders in healthcare can affect the shape the future takes and actually play a part in saving the country's economy, because that's really what we're talking about. Reform has to happen locally. We all have a completely different set of inputs, providers, and populations, and we have to figure out how we can begin to influence change and get people focused on the long term. Our society likes to focus quarter to quarter and year to year. But today, if you don't focus on the long run, you won't be here in the long run.

THOMAS: The other part is maybe there's not a financial win here. One of the challenges that most people face is if we don't change our business model, then our economics are going to be a lot worse than if we do. It's hard to put a financial number on what it means to avoid a worse healthcare outcome. So if you employ 50 primary care physicians in your marketplace and it costs you $50,000 per doc per year to do that, all you've done is add cost to your infrastructure—and in a short-term world, that's true. But it's a good bet that 12, 18, or 24 months from now you'll be really glad you had those 50 primary care docs at that cost structure because without them you may have lost everything. It's hard for the finance people to get their arms around that.

BERDAN: It's not just the finance people. We have a governing board that's composed of community members. They've listened to the senior management team talk about options, and they are taking the long view. We absorbed a large physician group a little over a year ago and there are losses associated with it. But they understand why we're doing that in the long run from the strategic point of view, and they have confidence in the senior leadership that we'll keep focused on the long run and we'll do all the things on a day-to-day basis and a month-to-month basis and a year-to-year basis to keep the organization healthy at the same time.

THOMAS: Barclay's group has gone from 66 physicians to 834 in three years. And when you look at those dynamics, acquiring a practice in a good market that has the right mentality in terms of physician alignment with patients many times is much better financially than trying to start from scratch.

BURKE: Still, I'm guessing, Barclay, even with 800 employed docs, the independent medical staff is still the significant driver.

BERDAN: The medical staff is a significant driver, but we've actually gone to great lengths to try and create an environment where the independent physicians know that we are not interested in employing everyone. We recognize that in the long run, our employed physicians will make up maybe 25% of the physicians who use our facilities. There's value in that, but it also begins to create tension and divisiveness. So we're purposefully talking about physicians broadly because employment doesn't mean that they're aligned or integrated. Whether you're employed or independent is mostly a financial relationship and it shouldn't be how we think about physicians up front.

SAMS: Autonomy is an illusion anyway. We've got an employed model and there are resources and things you can do only inside an employment model, but our PHO is the bigger piece and that's the independent and the employed physicians, clinically integrated, contracting with the hospitals. That way, we have a mechanism to develop population health, clinical integration, and closer alignment, and we don't care whether you're employed or not.

BERDAN: I think there's a real subtle point to be made here. A lot of organizations call themselves health systems when in fact they're really hospital-centric organizations because that's where the capital is. Whether you're an executive leader, a board member, or a physician, if you're coming at it from the mind-set that's still stuck in that hospital-centric world, you're going to have a really hard time. Being patient-centric is what brings us all together.

BURKE: If you work for the patient, everything else falls in place.

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