HEALTHLEADERS MEDIA
POPULATION HEALTH EXCHANGE

# Insights Report

JULY 2016


# PROCESS: DATA, TRANSFORMATION, AND CULTURE FOR THE MODERN CLINICAL ENTERPRISE

*Analysis and in-depth discussion from healthcare leaders at the HealthLeaders Media Population Health Exchange in April 2016*

*An independent HealthLeaders Media report*

Analysis

# Population Health: One Goal, Too Many Choices

**JIM MOLPUS**
Leadership Programs Director
HealthLeaders Media
*jmolpus@healthleadersmedia.com*

The goal of population health is to take better care of the people in your community. Simple enough. That goal may have a different name like "volume to value," or get cut into several pieces like the Triple Aim, but the basic movement forward isn't in question. It's the strategies behind the movement that are variable, sometimes to the point of chaos.

Health systems are on a group trajectory to the same end goal, but they still struggle to focus on which new processes will not only make a difference, but make the most difference. Likewise, they strive to wade through a flood of data in search of information that is not just illuminating, but also actionable.

More than two dozen senior clinical, information technology, and population health leaders, representing small community hospitals and urban health systems alike, joined HealthLeaders Media's third annual Population Health Exchange in Austin, Texas, in April to compare their experiments that worked, their discussions that led to new understanding, and their lessons learned about focus.

## A few of the most notable takeaways:

**Governance first:** A new system of care will not work with an old system of governance. Defining which enterprises among many have specific responsibility for driving change can be a challenge, especially in health systems where prior roles may overlap (such as ones with an existing health plan and a new ACO). Being firm but not rigid in defining which units are accountable for progress will avoid wasted time and conflict later.

**Don't chase squirrels:** Setting measurable points along a path of continuous improvement will help avoid the tendency to chase the latest shiny trick or fancy tool. And while public and media discussion may dwell on more novel aspects of population health such as wellness, the greatest opportunity for gains and cost savings will remain in high-risk populations and individuals.

**Remember clinician workflow:** For every population health goal, there is a process. For every process, there is a measure. For every measure, there is a data point that must be entered. For every data point that must be entered, there is a provider who is supposed to be taking care of patients. For every physician on a tablet or keyboard, there is a patient waiting to be seen. Start from the end and work the process backwards.

# Process: Data, Transformation, and Culture for the Modern Clinical Enterprise

JIM MOLPUS

The real conflict in the move toward population health is a reimbursement one, not a clinical one. The hospitals and health systems represented at the Population Health Exchange are generally past the startup stages of population health, having reached the stage of development where real clinical progress butts up against fiscal reality.

Gina Anderson, RN, BSN, MPPM, chief integration and quality officer at four-hospital, 771-bed St. Vincent's Health System in Birmingham, Alabama, a part of Ascension, says the challenge is knowing when—and whether—to move on from fee-for-service, either partially or completely.

"So in one meeting we're talking about population health and what a great job everyone is doing, and asking about our next move," Anderson says. "And then the next meeting we're talking about the best strategies to serve patients in the inpatient setting, and asking, 'How we can live in both worlds when reimbursement models say inpatient now and ambulatory soon?' "

Anderson says the question that resonates across the health system and its ministry leaders is when to go "all in" for risk-bearing contracts, knowing that fee-for-service is still the primary reimbursement model, at least until 2018 when at least 50% of Medicare payments are set to be value-based.

**TAKEAWAYS**

- **Divorce innovation from reimbursement, for now**
- **At first, follow the high risk**
- **Much data, little information**

Matt Chambers, CHCIO, chief information officer for Baylor Scott & White Health, which has 48 hospitals spread across central and north Texas, says one of the challenges in moving forward is understanding the complexity of governance and accountability.

"We are all trying to get to the right place, but we're all using different methods," Chambers says. "I don't know if we have questions around ownership so much as clearly defining roles and responsibilities. So we have a health plan and we have an ACO; they are both doing very similar things, and the challenge is to figure out how we create value for the patient from both organizations while marketing their distinctions in the marketplace."

## Divorce innovation from reimbursement, for now

Driving toward population health puts considerable pressure to change on the clinical team, which is already beset by new regulations, IT systems, and team members. Before all else, creating a sense of reinvention will help focus the team, says Vivek Reddy, MD, chief medical information officer for Pittsburgh's UPMC, an integrated delivery system with 20 hospitals and 2.9 million health plan members.

"We've been focused on primary care and trying to create what primary care in 2025 looks like," Reddy says. "We've electrified the provider arm to actually be interested in this by asking them, 'What would it look like if we never had a face-to-face visit for a blood pressure check? What would it look like if we did telehealth for X problem and Y problem?' We are not trying to freak people out that we're going to do it tomorrow, but to be creative and see where this might all go and then build backwards. That's been one of the fun parts of this journey: It gave us an opportunity to tap into a different way of thinking about medicine."

## THE PARTICIPANTS

**Gina Anderson, RN, BSN, MPPM**
Chief Integration and Quality Officer
St. Vincent's Health System
Birmingham, Alabama

**Julia Andrieni, MD, FACP**
Vice President, Population Health & Primary Care,
Houston Methodist President and CEO,
Houston Methodist Physicians' Alliance for Quality

**Tanya Arthur**
Vice President, Information Technology Services
Business Operations
Catholic Health Initiatives
Englewood, Colorado

**Frank Astor, MD, MBA, FACS**
Chief Medical Officer
NCH Healthcare System
Naples, Florida

**Sameer Badlani, MD, FACP**
Chief Health Informatics Officer
and Vice President
Sutter Health
Sacramento, California

**Pamela Beckwith, FACHE**
System Vice President, Quality
Carolinas HealthCare System
Charlotte, North Carolina

**Joe Boyce, MD**
Chief Technology Officer/
Chief Medical Information Officer
Mosaic Life Care
St. Joseph, Missouri

**Linda Butler, MD**
Vice President of Medical Affairs/Chief Medical Officer/Chief Medical Information Officer
UNC Rex Healthcare
Raleigh, North Carolina

**Matthew Chambers, CHCIO**
Chief Information Officer
Baylor Scott & White Health
Dallas

**Tina Christopher**
Chief Applications Officer, Vice President
Northwell Health
Long Island, New York

PEER INSIGHTS: Members of the Population Health Exchange listen to ideas shared at the discussion table. From left, Casey Meza, MHA, executive director, affiliated health services at Kootenai Health in Coeur d'Alene, Idaho, and Pamela Beckwith, FACHE, system vice president of quality at Carolinas HealthCare System in Charlotte, North Carolina.

Helen Macfie, PharmD, FABC, chief transformation officer for MemorialCare Health System, a six-hospital, 1,600-bed not-for-profit health system in Long Beach, California, says one strategy has been to "innovate in space" so as not to disrupt the workflow of the 30 medical groups they work with.

"We have a Lean innovation shop where we're sequentially redesigning to make it easier for the physicians and the support staff to have a better day, to bring that joy back to the workplace," Macfie says. "The more you pile on, the more people just get buried. So we are trying to unpeel that and get to single-piece workflow, moving the physician closer to the patient and doing work at the top of their license."

Cliff Fullerton, MD, MS, president of the Baylor Scott & White Quality Alliance, an ACO comprising more than 4,000 physicians, says the health system initially targeted population health programs at a population it was already at risk for: the uninsured who show up in Baylor emergency rooms. The lessons and care coordination structure learned from that population


> "We have a lot of data, but we don't have a lot of information."
>
> **TANYA ARTHUR**
> VICE PRESIDENT OF INFORMATION TECHNOLOGY SERVICES BUSINESS OPERATIONS CATHOLIC HEALTH INITIATIVES
> ENGLEWOOD, COLORADO

What is your organization's status in regard to managing the overall health of a defined population?

| | |
|---|---|
| Fully committed and underway | 41% |
| Experimental or pilot program(s) underway | 28% |
| Will pursue but have not yet begun | 12% |
| Examining how or whether to pursue | 13% |
| Do not plan to pursue | 3% |
| Other | 2% |

SOURCE: HealthLeaders Media Intelligence Report, *Population Health: Investing in a Risk-Based Future,* October 2015; *hlm.tc/1OR3JWI.*

**Deborah Dahl, BSA, MBA, FACHE**
Vice President, Patient Care Innovation
Banner Health
Phoenix

**Lee Duke, MD, MBA**
Senior Vice President
and Chief Executive Physician
Lancaster General Health
Lancaster, Pennsylvania

**David Dull, MD**
Chief Medical Officer
Penrose-St. Francis Health Services
Colorado Springs, Colorado

**Mike Fletcher, MD, MBA, FHM, FACP**
Internist and Chief Medical Officer
Hancock Regional Hospital
Greenfield, Indiana

**James M. Frazier, MD**
Vice President, Medical Affairs
Norton Healthcare, Inc.
Louisville, Kentucky

**Cliff Fullerton, MD, MS**
President
Baylor Scott & White Quality Alliance,
Chief Population Health Officer
Baylor Scott & White Health
Dallas

**Helen Macfie, PharmD, FABC**
Chief Transformation Officer
MemorialCare Health System
Fountain Valley, California

were taken into the ACO, which has commercial agreements with Aetna, as well as Medicare Advantage programs and its own Medicare Shared Savings Program.

"So we are trying to marry together the risk-based contracts that are the typical part of what an ACO does, and then this other broader population health effort that is unfunded and doesn't create direct revenue, but does save money in multiple different places," Fullerton says. "We can take the expertise from one side and the funding from the other side and begin to synergize both those efforts."

Fullerton agrees that transforming primary care is a major focus, and says there are at least 10 pilots across the Baylor system looking at elements of redesign. None of the pilots are focused on current reimbursement, and that ties them all together.

"What we're doing is we're trying to take some practices and divorce them from this reality of the current incentives," he says. "We're going to take those practices and we're going to manage them just like their patients are all in one of our population health or risk contracts. At the system level, we'll manage the money so the practice doesn't even have to worry about that."

## At first, follow the high risk

One obvious place to focus effort is in patient populations that are among the highest cost centers. Phoenix-based Banner Health, which operates 29 hospitals in seven states, began a considerable investment in telemedicine with a focus on intensive care, says Deborah Dahl, BSA, MBA, FACHE, vice president of patient care innovation.

"We started in intensive care even before our population health

> "Optimization is about the people and process side of it; we often tend to make it about the technology piece of it."
>
> **LUIS SALDANA, MD, MBA, FACEP**
> CHIEF MEDICAL INFORMATICS OFFICER
> TEXAS HEALTH RESOURCES
> ARLINGTON, TEXAS


DAVID HARTIG

**Casey Meza, MHA**
Executive Director, Affiliated Health Services
Kootenai Health
Coeur d'Alene, Idaho

**Michael Meza, MD**
Physician Consultant
Kootenai Health
Coeur d'Alene, Idaho

**Pam Nenaber, FACHE**
CEO, Banner Pharmacy Services
Banner Health
Phoenix

**Bill Phillips, CPHIMS, CISM**
Senior Vice President and Chief Information Officer, Information Services
University Health System
San Antonio, Texas

**Alan Pitt, MD**
Physician and Professor of Neuroradiology
Dignity Health
Phoenix

**Shafiq Rab, MD**
Vice President and Chief Information Officer
Hackensack University Medical Center
Hackensack, New Jersey

**Vivek Reddy, MD**
Chief Medical Information Officer, Health Services Division Assistant Professor, University of Pittsburgh Department of Neurology
UPMC, Health Services Division
Pittsburgh, Pennsylvania

**Luis Saldana, MD, MBA, FACEP**
Chief Medical Informatics Officer
Texas Health Resources
Arlington, Texas

**Christopher Stanley, MD, MBA**
System Vice President, Population Health
Catholic Health Initiatives
Englewood, Colorado

**David Stowers, RN, MSN, PhD**
Vice President, Enterprise Care Management
Covenant Health System
Lubbock, Texas

What strategic initiatives is your organization engaged in or exploring to improve the health of a defined population?

| | |
|---|---|
| Clinically integrated networks | 64% |
| Patient-centered medical home–related | 57% |
| Alliance of providers | 49% |
| Health system–led ACO | 42% |
| Merger with or acquisition of providers | 42% |
| Expansion of ACO to nonhospital providers | 24% |
| Not examining or underway with such arrangements | 4% |

Multi-response
SOURCE: HealthLeaders Media Intelligence Report, *Population Health: Investing in a Risk-Based Future,* October 2015; *hlm.tc/1OR3JWl.*

journey began, because that is where the opportunity to improve care and reduce cost is highest," Dahl says. "If you can reduce your length of stay and your complications in the ICU, then in a population health model, your ACO benefits financially."

Using APACHE (Acute Physiology and Chronic Health Evaluation) methodology, Banner Health's eICU was able to account for 1,890 people who lived who were predicted to die, and 45,000 fewer ICU days than predicted, with a cost avoidance to the system somewhere around $109 million, Dahl says. Those savings are then invested in other quality programs.

"You have to ask yourself what is the really big cost," she says. "And yeah, we do get distracted by squirrels and shiny objects and all those things, but you know, we try to keep coming back to where's the clinical quality opportunity and where's the cost. Start with that."

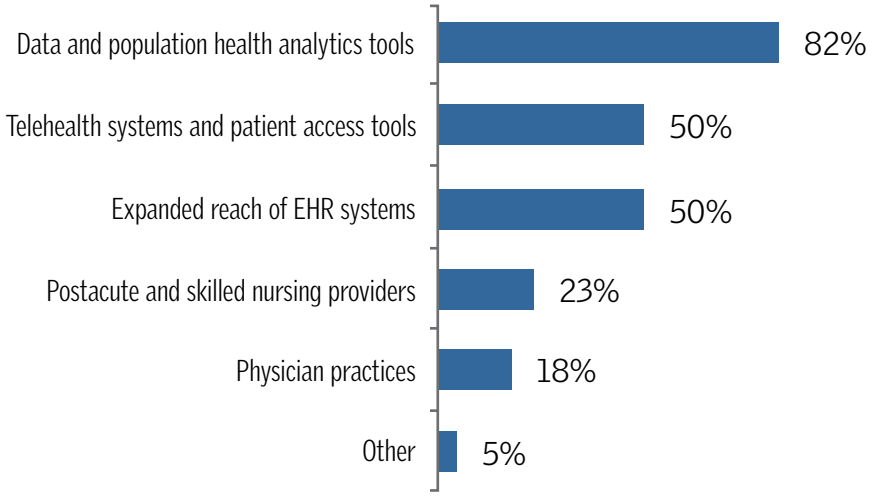
"I would echo that very much," says Christopher Stanley, MD, MBA, system vice president of population health for Englewood, Colorado–based Catholic Health Initiatives (CHI), with 103 hospitals in 19 states. "We have a couple of different answers. One is we do tend to focus on the high-risk individuals, not necessarily only on the inpatient side, but who are the high-risk individuals through stratification and where are we really going to be deploying our resources? When we're talking with employers, we also tend to see that they focus on shiny new objects, like wellness clinics, biometric screens, important things that are sort of around employee engagement—but where the real dollars are is really around the high-risk individuals."

Pamela Beckwith, FACHE, system vice president of quality at Charlotte-based Carolinas HealthCare System, with

40 hospitals and more than 7,500 licensed beds, says it's important to get the sequence right in driving toward population health.

"It has to start with good clinical performance," Beckwith says. "You can't sell bad performance. You can't give it away. You have to focus on the basics in getting that right. If you devote a specific process and strategy to what you have to be good at, and energy to improve the things that you're not good at, that's where it has to start. If you have great access, but not great care, it's impossible to put it all together. In sequence, these other things are not going to be as difficult."

To reach your goals in population health, which of the following does your health system plan to buy more of?




SOURCE: HealthLeaders Media Population Health Exchange Pre-Event Survey. Multi-response. Base = 22.

## Much data, little information

The headlong rush to gather healthcare data in recent years has led to a predictable point: too much data overall, and not enough correct data where it can do the most good. Tanya Arthur, vice president of information technology services business operations for CHI, sums up the distinction: "We have a lot of data, but we don't have a lot of information."

CHI has focused on harvesting data that drives meaningful outcomes, she says. To do this, leadership is making sure team members are concentrating on the proper investments of capital and team bandwidth, says Arthur. The framework for those goals is their "mission metrics," a set of nine metrics around patient experience, safety, quality, and employee engagement that operate across CHI's geographical markets.

"Now, how we get to them may be a bit different depending on the geography, depending on the competitive environment in which we all operate and some of those challenges, but we all are operating from that same framework," says Arthur.

Luis Saldana, MD, MBA, FACEP, chief medical informatics officer for Texas Health Resources, which has 24 hospitals in Dallas and Fort Worth, says IT has done a good job in scaling out the technology to this point.

"We've set expectations very high, that all the infrastructure is going to be there, but we tend to forget about the people and processes along with it," Saldana says. "Optimization is about the people and process side of it; we often tend to make it about the technology piece of it. "

He adds that there is a tendency to "chase shiny objects" that promise increased quality of effectiveness, but in doing so, "my concern is that we somehow dilute our effectiveness by doing that in a way that's not really targeted and focused."

Shafiq Rab, MD, vice president and chief information officer of Hackensack University Medical Center, a 900-bed, nonprofit research and teaching hospital in New Jersey, says, "What we are trying to understand from our institutional healthcare systems is that if we don't know the person, how are we going to understand what their healthcare needs are? So we are spending time in redefining our data strategy to understand that every individual is unique and unprecedented. Every human being is different. We cannot put everybody together in a group."

*Jim Molpus is leadership programs director for HealthLeaders Media. He may be contacted at* jmolpus@healthleadersmedia.com.

# Access. Insight. Analysis.

## Join the HealthLeaders Media Council to:

- Receive complimentary editions of our monthly Intelligence Reports as well as a complimentary Insider Report as a thank-you for your participation.
- Offer insights on the shifting healthcare climate to inform your peers and the industry-at-large of operative strategies and existing challenges

## Recently published Intelligence Reports include:

- *The Analytics Challenge: Gaining Critical Insight into Risk-Based Models*
- *The Outpatient Opportunity: Expanding Access, Relationships, and Revenue*
- *Patient Experience: Cultural Transformation to Move Beyond HCAHPS*

Join the nation's most exclusive executive healthcare intelligence community at *www.healthleadersmediacouncil.com.*

HEALTHLEADERS MEDIA Council

## About Us

**HealthLeaders Media** is a leading multi-platform media company dedicated to meeting the business information needs of healthcare executives and professionals. To keep up with the latest on trends in physician alignment and other critical issues facing healthcare senior leaders, go to *www.healthleadersmedia.com*.

Our Intelligence Unit is the industry's foremost source for executive healthcare business research. It provides proprietary analysis and forecasts through monthly Intelligence Reports on key issues impacting healthcare. Each month, HealthLeaders Media releases a new comprehensive report featuring cutting-edge strategies, benchmarks, and lessons learned from leaders at provider organizations across the country. Data is sourced from our 8,000-member executive Council—delivering the most unbiased industry intelligence available.

Access our full library of exclusive research online at
*http://www.healthleadersmedia.com/intelligence-reports*

HealthLeaders Media

Executive Vice President
**ELIZABETH PETERSEN**
*epetersen@blr.com*

Publisher
**CHRIS DRISCOLL**
*cdriscoll@healthleadersmedia.com*

Leadership Programs Director
**JIM MOLPUS**
*jmolpus@healthleadersmedia.com*

Editorial Director
**BOB WERTZ**
*bwertz@healthleadersmedia.com*

Managing Editor
**ERIKA BRYAN**
*ebryan@healthleadersmedia.com*

Leadership Programs Editor
**JULIE AUTON**
*jauton@healthleadersmedia.com*

Custom Media Sales Operations Manager
**CATHLEEN LAVELLE**
*clavelle@healthleadersmedia.com*




## Sponsorship

For information regarding underwriting opportunities for **HealthLeaders Media Exchange Insights Reports,** contact: **781-639-3390** | ***sales@healthleadersmedia.com***


**HEALTHLEADERSMEDIA.COM**

35 Village Road, Suite 200 > Middleton, MA 01949 > 858-900-2009
100 Winners Circle, Suite 300 > Brentwood, TN 37027 > 781-639-3390
For general inquiries, please email: *sales@healthleadersmedia.com*.