ROUNDTABLE

Bridging the Chasm Between Fee-for-Service and Population Health

Healthcare leaders agree on the logic behind population health: that the focus of a care delivery system should be on keeping patient populations healthy rather than waiting to treat illness. Yet transitioning away from single-patient, episodic care is a major economic and organizational challenge for hospitals and health systems. They must revamp the roles of physicians, midlevels, and care team providers; implement data analytics solutions and learn to incorporate the findings; negotiate risk-based payment agreements with payers and partners—all at the same time. The magnitude of change, and the risk of getting it wrong, is enormous. At this Roundtable, three top accountable care organization executives discussed the challenges of engineering changes in systems of care to enable the shift toward data-assisted evidence-based practice, a culture of wellness, and, for healthcare organizations, to ensure sustainable finances.

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Roundtable Highlights

HEALTHLEADERS: *When did your organizations realize the magnitude of the investment required to shift toward value-based care?*

DINGER: The mission of Ascension has always been population health-focused, with an emphasis on person-centered care, especially for those who are poor and vulnerable. Because of that, Ascension's leadership has had a deep interest in seeing how they could accelerate more of it in the communities we serve. The big question was how do we get all of us to work together more efficiently? Part of the answer was to make MissionPoint, which started at Saint Thomas Health in Nashville, part of a new Ascension subsidiary called Ascension Care Management, to help us focus our efforts as a system.

NEORR: Cone Health really started this from a position of how we could partner with physicians in a different way outside of employment. It was looking at clinical integration as a vehicle to work with physicians in a different way. A couple of the physicians came back from a symposium that Advocate put on in Chicago and approached the CEO and president at the time about trying this with key physicians. It's amazing how fast things have moved since three years ago.

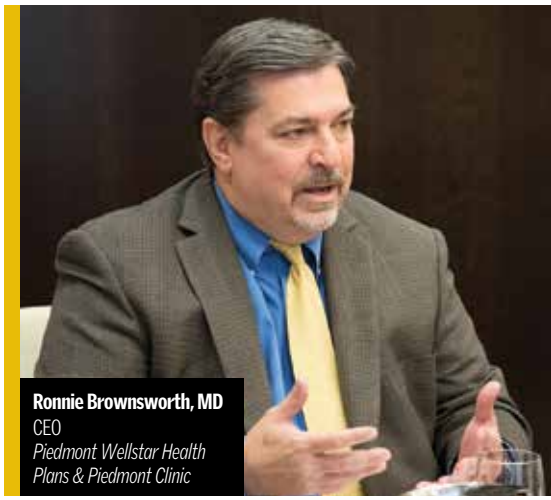
BROWNSWORTH: I came from a very integrated healthcare system that has been in population health for a decade or more. Atlanta was a town of no system dominance, no provider dominance. The physicians at that point were predominantly all in independent groups, though Piedmont did have a 500-physician PHO. We began around 2010 putting models and platforms together for them to begin to grow. Now, there's a real hunger among the physicians to continue to become more effective at this type of work. Beginning about three years ago, the hospitals began realizing that the world was changing and that the ability to just contract at higher rates was becoming more challenging.

SIMPSON: We partnered with Geisinger Health Plan, where for the last 30 years, they have been practicing some level of population health. We worked with them on how to attack the cost model, and how to focus in on what information you need to have an impact. Only about 15% to 20% of the data that you need for population health resides in the EMR, because the things that you really need to understand—a patient's motivation, what's going on with patients in the home—you need claims data. So we focused on how to collect and codify all that data. We focused on how we pull information from all those systems, codify it into the right terminologies, store it, and then build out a set of analytics to start to coordinate care across that continuum. It's about predicting so you can take proactive intervention.

HEALTHLEADERS: *This pace of change is unusual for healthcare. Is there a sense of urgency?*

NEORR: Once we made the decision to apply to the Medicare Shared Savings Program in 2012, we had to recruit many physicians and then we had to start looking at IT solutions, billing, care management, and scaling that up. In a period of about six to eight months, we did that. The downside of that, of course, is making mistakes. I was employee number one in September 2011. We're almost 70 now.

BROWNSWORTH: I was charged with moving 500 physicians in our five hospitals into a more clinical integrated care delivery process. It took us a year and a half to put together the platform to begin gathering the data and putting it in front of people. The Atlanta market previously went into this in the late '90s with an organization called Promina. Most of the physicians and hospitals remember it as a dramatic failure because they didn't have the systems and data to enable them to be successful. And two, they had not put the processes in place that enabled physicians



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or the hospitals to become engaged in work that's very different than an episode of care. Our moves have had to be much more deliberate. We can put in all the IT systems we want, but unless we have brought our physicians and our hospitals, critical staff, and care managers to a place where they know how to use those systems and the data, it won't work. Our system now has taken on full risk. So the pressure is coming.

DINGER: Ascension took a long view to this issue, which afforded us a good deal of freedom. We wanted to build a sustainable model that lowered costs, improved patient satisfaction, improved quality, and improved provider satisfaction. We conducted over 250 interviews with patients, providers, payers, and employers about what they needed from the healthcare system and used their feedback to build MissionPoint's model. Using their ongoing feedback, we have consequently added

a number of components that continue to improve the morale of physicians and, at the same time, be a clinical model that could be used across multiple populations. We started in Nashville and now we're in six other Ascension communities around the country. The challenge is going to be how we can get large enough to be able to modulate some of those risks and rewards and develop sustainability over time, even while we improve quality, lower cost, and improve satisfaction for patients and providers. The verdict's still out on that.

SIMPSON: The only way to address this spiraling cost problem is to take a longitudinal view. We're in the second inning of a nine-inning game. We're starting to make a few changes, but the reality is, when you think about big data and trying to stratify patients and understand the risks you have—knowing their social demographic and understanding who's at home—those are the keys that are going to drive more cost savings. We're going to learn over the next five to 10 years as this drives through that a lot of organizations will go down screaming. Fee-for-service is extremely profitable for many.

Jason Dinger
CEO
MissionPoint Health Partners

NEORR: Most people underestimate the speed in which this is happening. We are constantly talking to our physicians and letting them know about things like the value-based modifier. Even the government has moved quickly. And whether or not you like value-based care, it's already here.

SIMPSON: For instance, you might meet with a group of physicians and show them their quality measures, for example, from a smoking cessation program. They may say 100 percent of their patients are on a program. But where's it documented? It's not in the EMR. It's not on a piece of paper. You might have had the conversation but unfortunately, unless it's documented, you're not going to get credit for it.

BROWNSWORTH: I feel like healthcare is like the banking industry with its first ATM. Little did they realize where that first step would take it. Hardly anybody steps into a bank now. It's all done online. I don't think we're going to keep people out of the hospital fully. I don't think we're going to keep people out of the physician offices fully. But we're going to have a different future.

SIMPSON: Technology is an enabler to deal with productivity and some of the automation. But with true population health, there's people involved. And making sure you've got those training programs and really driving that is key. First, where's all your data? You probably have a 100–150 different silos of data. Our job is to enable the caregiver with more information so they can do more in that short period of time.

HEALTHLEADERS: *What is your most urgent priority right now?*

NEORR: It's how you make this big data actionable. How do you deliver it? It's a culture thing. Physicians like data. They may not like what the data says, but they like it. But how do you get them what they need to make a decision? And how do you have everyone operate at the top of their license? That's still difficult because it is changing the way they're practicing medicine. We've got about 60 organizations participating and 60% of our physicians are independent. We deal with 30 different EHR platforms. And trying to interface with each of those, aggregate and standardize or codify and then report—we're still working on that. But then, how do you deliver it? What are you delivering? And to whom?

BROWNSWORTH: How do we have the right technology tool with the information that individuals can accept and use? And if we do, it's not just about delivering the information. For instance, this information can come to the office manager. They can see five physicians' data. They can do their work list for them. They can look at their population of diabetics who haven't had their screenings done. And they can schedule those individuals to get them in and the doctor doesn't have to touch it. Secondly, how do you let every physician in your pool see every other physician at a certain level? That transparency is important, because within several years, the public's going to see exactly what we're sharing internally today.

SIMPSON: And if it's not in the workflow, forget it. They need one workflow and they need actionable big data to build it. This top-of-license issue is huge. We've got massive shortages from nursing to physicians and all specialties in between.

DINGER: One thing unique to healthcare that's fascinated me is how little acknowledgment there is of other members in our ecosystem. We need to inspire and incent all parts of the healthcare system to be a population health manager. When we talk with many providers, most are still looking for higher rates, but very few are saying, 'How can I care for more patients by being a low-cost provider, which would make me the most desirable partner for every narrow network in this region?' For example, CareMore, which was bought by WellPoint, developed their own extensivist clinics for their high-risk Medicare Advantage folks, which allowed them to develop unique expertise in caring for people who have a

complex set of issues. Simultaneously they reimburse primary care through a capitated model so they're not penalized when they refer those patients to more specialized care.

SIMPSON: In training, one of the great outcomes I'm aware of is with Geisinger, which deployed a true care coordination and care management system. There's one system, all of their tasks are right there in front of them, it's all automated on one desktop. Training has now gone from six months down to two or three weeks. When you can take variance of care out of the equation, it's huge. Now their diabetics are getting the same treatment whether they're a five-year care manager or a first-year care manager, the care plan is the same for all. And the systems drive adherence to those plans.

HEALTHLEADERS: *Is having your own health plan a necessity to really push these changes through, whether because of the completeness of the data or the shared financial goals?*

BROWNSWORTH: With our own health plan, systems embrace the need for looking into care delivery more extensively. And they feel more of an ownership to make it happen. Also, other insurance companies do not want to give full data. They want to give pieces of data. What providers and health systems want is to do what they went into healthcare to do, which is to care for people and to feel like they are a valuable part of the team. That doesn't mean holding back information that would allow them to understand what's going on around them more. The captive health plan has allowed systems to suddenly have a broader visibility into their care delivery process that they had not seen. They've suddenly got a full visibility into what all care had to happen for someone, and why people leave the system for some care.

DINGER: Ascension does have various health plans. But we really try to collaborate with the payers for a number of reasons. One is that it's actually its own unique science to draw up a claim correctly. We like to consider ourselves "payer agnostic" in the sense that, when possible, you're partnering with multiple payers across multiple populations. That gets to your ability to obtain scale.

NEORR: We don't have a plan yet, but we started taking global capitation in September. One of the reasons we did that is for the information. We partnered with North Texas Specialty Physicians to transplant their care model. What resonated with our physicians is the ability to look at all the data transparently and compare this physician to that one to allow the physicians to have much more of a say in setting the care standards for the community. That enabled us to move away from fee-for-service.

SIMPSON: Claims data is rich but not rich enough to impact what patients are doing. So providers are in a really unique position now if they've got clinical, financial, and claims data. They've got all the data. As you develop your clinically integrated network, you want to have payers at the table. You want to have everyone at the table but you own the data fountain, and now you've actually got the ability to manage risk and drive a change in the quality of care that your network delivers.

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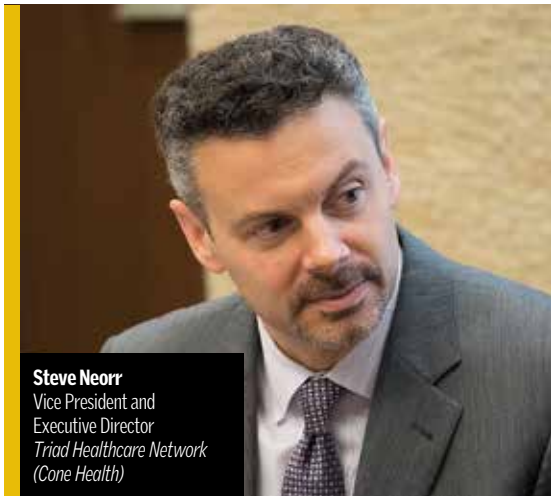
NEORR: We found PCPs to be open to getting feedback around their specialist referral patterns and inefficiencies. Assuming there's no quality difference,



Steve Neorr
Vice President and Executive Director
Triad Healthcare Network (Cone Health)

they're very willing to move those referrals. Once in a while you have the guy that they go on vacations with, which makes it a little more difficult conversation but they don't mind. Health plans have tried to do care management for 30 years and haven't had clinical information, but they also haven't had physician engagement. One of the advantages we all are working with is once you start developing your own care management, you have the opportunity to develop a patient relationship, and it's much different than someone who occasionally calls them from Aetna or United or Humana.

DINGER: The underlying issue is that in a lot of places there is a crisis of trust. Fundamentally, when we reach out to a member, the first question they are likely going ask is whether the conversation is determining the services they're asking for. Another reason why payers have struggled, not by intent but their very role of doing utilization review, is it's hard to build trust with somebody when you are the decider. So how we navigate building trust is going to be a big part of the population health manager's job.

BROWNSWORTH: Environment may help us a little because some of what's driven the problem is people were afraid of losing business. With shortages of beds coming because our population is growing, with shortages of specialists coming because we're not putting as

many specialists out, we have a perfect time to be able to continue to look at utilization and trim it back because demand is beginning to outstrip some of the people we have to be able to do that work. It could not have happened when there were such excesses. Our physicians have not previously been given the data to let them know that they are a higher cost than one of their peers. That causes physicians to talk to other physicians about how they practice.

Michael Simpson
CEO
Caradigm

SIMPSON: Another issue we're going to have to solve is consent and security. As you're formulating a clinically integrated network, who sees what? What is the patient granted access to? What are they not? The rules change from place to place. As an industry we're going to have to grapple with that and finally get to the bottom of it. It's sad that Visa knows more about you and what you do than any doctor does in the continuum of care simply because this doctor doesn't have a trust relationship to see that data. With the number of breakins that providers are facing right now, chief security officers are trying to go back to not sharing data. Because when they send their data out to the payer or to somebody to do advanced analytics on it, it's out of their control.

NEORR: There's already much more aggregation with clinical and claims, and you're seeing some employers struggle with how much they get to see. You have to navigate that carefully even with your own data. Just with Cone Health employees and dependents, we have a lot of the clinical information. We have all the blood pressure information. Assuming they've been to a doctor and the labs, we have that. But there's a lot of concerns about what we can have access to. Once you start opening the door to having access to clinical information especially when you get to behavioral health, people are very sensitive.

BROWNSWORTH: Georgia has a law that says we can't share mental health information. We can't share drug and alcohol abuse information. We can't share sexually transmitted disease information. So we have to have scrubbers in our system that ensure we do not have that information. So if you can keep it where you are only dealing with utilization and which drug they're using and it's a cost discussion, that's one thing. But to the view that you're trying to associate it with the disease management program around those three categories, you're in trouble. Physicians can know it as long as they are treating the patient. But when you're dealing with it from analytic standpoint it can't be used. As we start looking further into the future, we're going to have to understand how we can connect that clinical information. Today we're using the minimal use rule on mainly claims information. But when you start bringing in other information, we will have to give patients the option of whether more of their health data can be used at the physician level to improve outcomes.

HEALTHLEADERS: *Ultimately a lot of the change that we're talking about driving is physician implemented. How do you get physicians to lead the change?*

BROWNSWORTH: I believe most physicians are starving for a significant focus on improving the care around patients. They're so busy dealing with the day to day, all they hear are the financial aspects. When we get back to basic principles that drove most of them into medicine, suddenly they become energized. Our job is to find individuals who are open to change, who are open to challenging how we do things, and who are respected by their peers, and you help lead through that.

SIMPSON: When you talk about how to influence a physician's mind-set, it's actually the easiest group to convince—as long as you have the data. They need data and they need respect. With change management, it's a slow process. Trying to keep that physician engaged while you are trying to get a new supply chain working, or while you are trying to change out the way they are doing remuneration--that's the hardest part.

NEORR: One thing that helps when you are starting this process is to have expertise on how an ambulatory practice works. You really have to understand what they are currently facing and what you are asking them to do and be realistic about that. For Cone Health, we not only give them respect but we give them opportunities to lead.

DINGER: First, we just ask them to work with us, not to do anything differently, so take our call when we call. If we ask you to do something, really think about doing it. And there may be good reason not to, but we really want you to think about it. In an ideal world, that first year they get a shared savings check for hitting their quality metrics. Their response is, "This happened from just working with you?" Second, you celebrate the folks who are hitting it out of the park in terms of quality and value. And then when a practice is big enough we put resources in the practice. Last is communicate. We ran a report to determine the single biggest factor explaining improvements in quality scores among physicians. The biggest factor was how often they logged in to look at their data. It was amazing how much of an explainable event that was.

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