# Getting Pop Health Right

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# Executive Summary

Ten healthcare executives gathered in Chicago for the inaugural Scottsdale Institute Population Health Summit. These leaders from a variety of organizations came together to discuss the current state of the healthcare industry, including challenges, lessons learned and what's next. This whitepaper summarizes the challenges, insights and learnings discussed that organizations might consider as they transition from fee-for-service to value-based care.

## POPULATION HEALTH FALL SUMMIT PARTICIPANTS

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# Introduction

During the inaugural Scottsdale Institute Population Health Summit, executives from across a variety of organizations came together to discuss the current state of the healthcare industry, including challenges, lessons learned and what's next. For many years, experts have projected a complete shift to full capitation. However, today, it's clear that we will continue to live with at least a partial fee-for-service (FFS) world for a long time. As healthcare professionals straddle the chasm between traditional FFS models and value-based care, the key question becomes: how do you manage these various risk models at a given time? Disruption of payment and care models means organizations will be forced to live in two worlds—reactive and proactive— trying to adapt business operations without a standard, one-size-fits-all strategy. The variance between the percentage of patients tied to FFS, Medicare Advantage, shared savings, patient-centered medical homes, full-risk and others will continually ebb and flow, requiring adaptable people, processes and technologies.

The good news—organizations are up to the challenge. Healthcare professionals have always managed complex business models and operated on thin margins, but require management tools to do so. As the market evolves and organizations find the right mix for their local population, FFS, partial-and full-risk models will all be needed.

# Balancing FFS and population health management payment streams

## FEE-FOR-SERVICE VS. VALUE-BASED CARE

Transformation driven by increasing healthcare deductibles and government policy changes has resulted in varying degrees of risk, from FFS to fully capitated value-based care. The degree of risk and composition of payment programs is unique to each local market and will continue to shift over time. Although this disruption is relatively slow, it's important to adopt strategies to manage FFS and complex, varied levels of risk, while health systems continue to thrive with their existing revenue streams. "We speak of this as 'managing the flip.' It is difficult for clinicians to manage in both worlds. There is no incentive to rethink and re-engineer the way care is delivered until there is sufficient volume under value-based or at-risk models," said Rob Bates, EVP, Insurance Services & Population Health, Avera Health.

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**Advocate Health Care**

"Leaders in this market know how to manage healthcare operations. These are very skilled operators, managing a complex business, so we need to let them apply their management skills—they just need the right incentive and management tools to make it happen."

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The importance needs to be felt from the C-suite level down to the clinician level with aligned goals and incentives. "After all, 20 percent of a large number is still important —it's substantial," said Don Calcagno, President, Advocate Physician Partners. "Incentives are already in place to begin encouraging executives to better manage their risk; at the end of the day, leadership needs to be deeply engaged and knowledgeable about their risk populations to answer questions such as, 'What percentage of business is capitated and what conditions are driving inappropriate utilization?' Leaders in this market know how to manage healthcare operations. These are very skilled operators, managing a complex business, so we need to let them apply their management skills—they just need the right incentive and management tools to make it happen," said Calcagno.

Organizations need to more closely align with partners and use the variety of data sources and expertise they can provide to improve population- and person-level knowledge. "As risk increases, we're getting closer to the data, so we're learning, and in some cases, we're learning more of what not to do," stated Carrie Nelson, MD, Chief Clinical Officer, Advocate Physician Partners. Resources are another critical factor to consider when managing the broad scope of risk. Plans have different benefit packages and assigning care-management resources to every patient is not an option. "We're at

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approximately 20-25 percent risk, but when you look at the patients we're actually taking care of, we suspect that 40-60 percent are in somebody's risk arrangement," shared Lara Terry, MD, Medical Director, Population Health and Clinical Analytics, Partners HealthCare.
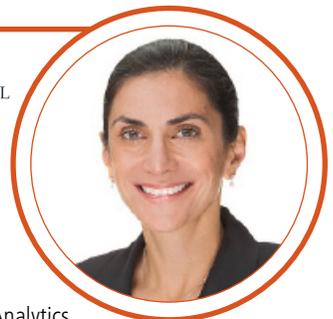
"There are incentive areas that align with the hospital goals, like readmissions. The oversized influence this has had on hospital operations relative to the absolute scale of the penalties is remarkable. You would think it was a lot of money, but it wasn't—especially initially when it was only three conditions. Readmission reduction has become its own service line. Another area is ED [emergency department] care. Especially for overcrowded emergency departments, it's important to make the case for SDOH [social determinants of health] and a more comprehensive view of wellness to decompress the ED and get people to use the right site of care. With that approach, patients still use your services; they just use the appropriate setting. It's a win, win for everyone," said Luke Hansen, MD, VP and CMO, Population Health, AMITA Health.

## MODELS FOR MANAGING CARE

Unfortunately, a perfect solution to solve healthcare challenges around the world is nonexistent. European models are starting to fail; the United States is encouraging innovation through alternative payment models as leaders continue to see the goal posts change. The only alternative to managing the various payment plans is dependent upon how fast your organization can become fully capitated. Is it best to begin managing your business like you're already capitated? The consensus from the attendees: not yet.

## MANAGED CARE ORGANIZATIONS

As of March 2017, there were 275 Medicaid managed care organizations (MCO)[1], supporting a little over 48 million[2] enrollments throughout the United States. Managed Medicaid requirements are subject to varying budget and administration conditions, making market entry difficult for some health systems. For example, low reimbursement levels pressure net contribution margins and challenge Illinois providers to manage and care (or pay) for Medicaid patients. In some cases, accounts receivables are more than a year old, placing more risk on providers.

## INNOVATION MODELS

Data is a concern for accountable care organizations (ACO), Medicaid Shared Savings Programs (MSSP) and patient-centered medical homes (PCMH), especially around value-based care. Timely, clinical and claims data is needed, although hospitals and payers lack coordination and collaboration to share information and work together to improve patient care. Claims data is comprehensive, but it's retrospective. "For patients attributed to you, you really want to know about all of those encounters that live outside your system. You're not going to know about it until the claim comes in, but you may have missed several opportunities to intervene. That's the cost bubble. So, I always ask, 'How much do you plan to spend on this person and how much do they cost?'" said Waldo Mikels-Carrasco, Sr. Director, Regional Population Health Research & Policy, Michiana Health Information Network. These questions are what health systems try to solve every day. Some, but not all Managed Medicaid programs have been able to move the needle for utilization, reduce bad debt while also improving quality of care.



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[1]  The Henry J. Kaiser Family Foundation. (2017, March). *Total Medicaid MCOs:* https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel= %7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2]  The Henry J. Kaiser Family Foundation. (2017, March). Total Medicaid MCO Enrollment: https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortM odel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

## FULL OR PARTIAL CAPITATION

Providers managing global capitation often have a very different perspective on business operations and how to manage them. "The benefit of managing clinical services under full capitation and



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payment based on a per-member-per-month rate is that the provider has a holistic message to deliver to patients. However, communicating a care plan that allows different patients to have different amounts of care management, for example, can be disconcerting," stated Hansen. "The varying care-plan options leave providers with the feeling of delivering different levels of care based on the benefits package the patient paid for, or not. It's tough to get the right language, and it doesn't feel good for the clinician, but we have to figure it out because the reality is providers will need to adapt to having these conversations as risk and payer models shift. It's about how you frame it—it's not about giving different clinical care to a patient, it's the benefits that plan offers that wraparound the clinical care," said Nelson. In lieu of these conversations, providers would need to treat every patient as if they're payer-agnostic. However, "if we're payer-agnostic, then we're not actually providing people with the



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services they bought," said Nelson. For example, if you send a patient to an out-of-network provider they will be forced to pay out-of-pocket rates or a delay in care will exist—so there are negative consequences to being payer-agnostic.

## HEALTH PLANS

Health systems that consider sponsoring their own health plan must balance opportunities to retain more dollars with the challenge of learning a new competency. Owning a health plan means owning 100 percent of spend that is going towards health plan expenses and not feeding the competition. "The future is not going to be survivable for health systems if they're giving up the health-plan dollar to the health plan," said David Classen, MD, CMIO, Pascal Metrics, Professor of Medicine, University of Utah and SI Board Member. The blurring of boundaries—payers going into the provider space and the providers going into the payer space—results in tension from contradictory initiatives.

The scope of the health plan comes down to a choice. "As a health insurer, we've found that we have to provide a variety of products and funding mechanisms. Narrow network or "channeled" health insurance products don't work for everyone. In South Dakota, where our unemployment rate is about 2%, some employers won't accept a narrower provider network if they believe it will make it harder for them to attract or retain employees," said Bates.

# Integrating population health management into clinical workflows

## PATIENT ACTIVATION VS. PATIENT ENGAGEMENT

"In the past, we had patients but never customers, which requires a different mindset," said John Glaser, Ph.D., Senior Vice President, Population Health, Cerner.

Engaging people in their own health and well-being is the foundation of value-based care strategies. The motivations of a value-based care strategy are very different from the conventional consumer approach, so the challenge for health systems is determining who owns the consumer strategy. Marketing has traditionally

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taken the lead communicating with consumers using their segmentation and behavioral experience, but the purpose of the relationship needs to shift to align with bidirectional, clinical goals. It's the difference between creating a patient portal as a channel to increase consumer loyalty versus to support a consumer's active participation in their healthcare. It's an important nuance that requires tighter collaboration between marketing and the clinical side of the health system. The shift in payment models is only a portion of the equation. Health systems need to become comfortable communicating with patients in a new, more open and collaborative way.

Meaningful Use 2 requirements drove the implementation of patient portals, yet the technology hasn't been used in its entirety to drive engagement, resulting in very low usage. The challenge is that the purpose of the portal doesn't encourage two-way interaction and every partner has a different portal with a variety of flavors (portal, gamification, wellness, weight loss, chronic conditions), which is cumbersome for the patient. That's not patient engagement; it is provider engagement. Without a two-way interaction, "the discussion [with the patient] goes from patient engagement to patient compliance. Patient compliance is telling the patient what to do which is very different from bi-lateral engagement. Some people still confuse the two," said Mikels-Carrasco.

The general idea is that "patient engagement" is not a one-size-fits-all approach.

In the short-term episode or "patient journey" of pregnancy, a patient often begins with a limited amount of knowledge about their condition, and often takes a very active and engaged role in learning from their provider what they need to do to have a successful outcome (this could also be true for episodes like joint-replacement or other procedure-based episodes). This relationship evolves as the patient learns and changes their short-term behavior and adjusts to the changes occurring and new information necessary for each stage (or trimester), on into and through the perinatal period. While the demands of the changes and challenges are stressful to the patient, the outcome is usually very specific, positive (a new baby, elimination of pain, greater mobility), and time-bound. The provider offers support and motivates the patient to "keep up the good work because *we're almost there*." However, once they have delivered and recovered, they return to or adapt to more self-directed behaviors, and are less reliant on the guidance and need of support of their providers, because they have gotten through the episode successfully, noted Mikels-Carrasco.

This is a different type of patient engagement, he said, than the long-term approach a provider would take with a chronic disease patient where there will again certainly be a good amount of patient education on their newly diagnosed condition at the outset. However, unlike the short-term episode, once the patient begins the ongoing maintenance of her condition, the demands on the patient and the provider are very different. In this scenario, there is no "*there*" that the patient and provider are going to work together to get to. Rather the goal is to develop a new *lifestyle* that will permanently replace the patient's previous behaviors. The provider role now becomes that of continual motivator to help the patient be as successful as possible at realizing and maintaining that lifestyle, said Mikels-Carrasco.

Strategies to communicate with the patient or consumer have typically included two flavors of interaction: patient activation and patient engagement. Although subtle, these two strategies result in very different outcomes.

### PATIENT ACTIVATION

*Patient knowledge, skills, ability and willingness to manage his or her own health and care.*[3]

"There is an emerging set of tools to help share knowledge and personal health information, such as electronic dashboards with patient safety information created," stated Classen. "The patient can see real-time safety concerns via their patient portal with key questions to ask the provider and actions the patient can take to improve the safety concern. Understanding consumer

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[3]  Health Policy Brief. (2013, February 14). Retrieved from Health Affairs: http://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/

behavior has improved participation by sharing the information in the form of short videos versus text," he added. Patient activation is needed to ensure behavioral modification is lifelong. The patient portal today is largely transactional and fails to support the personal journey based on an individual's purpose in life.

## PATIENT ENGAGEMENT

*A broader concept that combines patient activation with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly.*[4]

Patient engagement incorporates the shared clinical decision-making needed to implement interventions and improve health. Portals are expanded to manage care post-discharge or virtual care to interact with physicians, care managers, pharmacists or others to make a more informed decision.

## TELEHEALTH

Telehealth enables providers to access levels of care that are often in short supply in smaller facilities, rural locations or generally across the health system, such as behavioral health, care management or specialist services. Avera Health has created the nation's largest telehealth program that services over 300 Avera locations in South Dakota, North Dakota, Minnesota, Nebraska and Iowa. Avera Health's e-Care program connects medical professionals to other hospitals and health systems, long-term care facilities, schools and even correctional facilities. This capability enables smaller rural communities to improve quality and access to care. e-Care provides 24/7 telehealth options for pharmacy, intensive care units (ICU), behavioral health and emergency room care, enabling specialists and pharmacists to reach remote areas, especially when weather adds an extra layer of complexity. For example, many rural populations do not have 24/7 access to a pharmacist on duty or may receive a patient in the ED that requires the care of a specialist. Although the specialist cannot physically get to the location in a timely manner or a local pharmacist cannot be physically available, the telehealth program enables access to a pharmacist or specialist using a video monitor directly within the care suite to triage or treat the patient and fill this gap.

# Data analytics framework for population health management

Value-based care relies on quality data to understand attributed patients and the encounters inside and outside a health system. The acute space is such a small portion of health and care data. "It's not just what happens in your acute care; it's what happens after leaving your acute care. Coordination of post-acute is so critical," said Calcagno. "We need to spend more time outside the care facility where innovation happens. However, the data is fragmented

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4   Health Policy Brief. (2013, February 14). Retrieved from Health Affairs: http://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/

and coordination breaks down with limited accountability." The challenge is asking the right questions and capturing data closer to person. For example:

> What is the current state of your population?

> What is the quality of care provided?

> Are there payer variances?

> Are you asking the right questions?

> How do you ask the right questions?

> What can be done with the insights generated?

## DATA SOURCES

Data is only as good as its quality. The sheer volume of trusted data sources can be overwhelming without the right tools to aggregate, normalize and operationalize the output. Technology and skilled analysts/data scientists are needed to support the scale and reporting requirements. Alone, data can provide direction, but expertise is needed to make it valuable. "Ensuring data is meaningful and actionable throughout the organization is crucial. But data alone doesn't solve for the actions needed; it informs them," stated Terry. Consolidating clinical and financial data across an organization and all business models provides broader insights of usage, costs and quality versus siloed targets to better align initiatives with areas of improvement.

Data teams spend "a lot of time training the organization about how to get and use data to drive better care," said Cindy Kartman, Clinical Data Analyst, Population Health, AMITA Health. The key is to ensure the data is credible and easily digestible. Reporting can be at the patient, provider, practice, population, organization or system level, leaving self-service report meaning and necessary



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actions open to interpretation. If the report is complex or any piece of data is perceived as wrong, credibility is hindered. Data scientists are comfortable with unstructured data and can perform discovery incorporating third-party data with the clinical data, but the output must be actionable. The data and reports must be interactive using input from physicians, so users can interact with the reports to fit their individual needs, such as monitoring risk population trends as well as the current status. If the information is conveniently accessed and believable, the providers are more apt to use it.

Data sources discussed included:

> Centers for Medicare & Medicaid Services (CMS)

> Patient-provided information

> Behavioral health services

> Home health

> Health Information Exchange (HIE)

> Managed Care Organizations (MCO)

> Electronic health record (EHR) exchange data

> Census Bureau and American Community Survey data

> Claims data

> CMS certified nursing home assessments

## GOVERNANCE

Organizations have reached a tipping point. Formal governance plans are needed to create consistency across organizations and systems. As these programs become commonplace, the reporting structure is not consistent across the industry. Darby Dennis, RN, MS, VP, Clinical Systems and Informatics, Information Technology Division, Houston Methodist, shared that its governance team is led by the chief quality officer. "Although the Houston Methodist Hospital is more advanced



## HOUSTON Methodist

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on the finance side of the business, the governance team still struggles with field definitions," stated Dennis. Other organizations are undecided or have created new roles, such as the chief clinical officer, to manage governance responsibilities. "One significant challenge across the board, however, is data governance, the definition and use case for each captured term/data element with consensus across the organization," said David Mohr, MD, VP, Clinical Informatics, Sentara Healthcare.



## SENTARA

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## TECHNOLOGY

Technology is vital to facilitate access to information and scalable insights, however, when too many ideas are incorporated the technology can become bogged down. So, let's take a step back. First, let's define the questions we need to ask and then determine the tools needed to answer the questions.

> **Is the data actionable?** Clinicians should have a level of confidence that enables them to act and achieve results. The challenge is determining who should act on the data and when—care coordinators and case managers, and so on.

> **Are subject-matter experts helping to ensure the tools are meaningful and integrated into the clinician, care manager and provider workflows?** For Advocate Physician Partners, that means integrating tools across 3,500 independent physicians with a lot of disparate EHRs and 1,500 employed physicians with two EHRs.

> **How is patient-centric care measured?** Patient-centered care can be hard to measure without first identifying key objectives and where that information will be captured.

> **How will you shift manual processes to automated intelligent workflows?** Incorporate predictive analytics using vendor data and intelligence to improve care, customize plans and reach the patient using the individualized channels and methods most appropriate.

> **Are you aligned with your organization from leadership to individual contributor?** Implement unified information technology decision-making across the health system.

> **Is your technology prepared to incorporate third-party data?** Improve the technology architecture to handle unstructured and structured data with the appropriate storage capacity.

"Those who really adopt technology have started to see long-term benefits in closing gaps in care and utilization, although usability is more complicated than just the technology," stated Calcagno. However, providers are overwhelmed. No one is cutting back on the physician responsibility.

# Including the social/behavioral context

Per studies, half of all deaths[5] in the United States involve behavioral causes, highlighting the benefits of using SDOH to improve care and predict future risks. SDOH have been used, with manual processes, for a very long time in the public health space. Using this information to support value-based care is the next logical step for health systems; however, automated processes stand between successful, actionable programs and merely contributing information to a database without insight or action.

As part of value-based initiatives, health systems are driven to determine the highest-cost individuals, actions to reduce those costs and strategies needed to produce savings. SDOH data need to be captured quickly and consolidated with the clinical and claims information to develop a complete picture of the population, determine what has occurred and understand the purpose of behaviors.

At a high level, there are two primary questions SDOH can help to answer:

1. This part of the community has this issue, so how do we remediate the issue?

2. What's the care plan (clinical and social) for the individual? What are we doing about it?

Society, attitudes and behaviors change over time, sometimes decades. Today, there are key indeterminate problems, such as obesity, that remain challenging for providers. For many years, fear tactics and intervention programs have been created to solve issues, such as smoking or poor nutrition, without success. The missing element in all those tactics is understanding an

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5   Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Reports, 129(Suppl 2), 19–31:
    http://journals.sagepub.com/doi/pdf/10.1177/00333549141291S206

individual's purpose to impact long-term change. Smoking secession was only impacted when policy and environmental changes were effected. In other cases, nutrition and health were impacted by focusing on safety in the inhabited neighborhood, creating community bike trails and providing access to fresh foods.

*"There is value in bringing the community together to eliminate the social structural barriers, however, the health system doesn't need to fund or coordinate the programs."*

"There is value in bringing the community together to eliminate the social structural barriers," said Mikels-Carrasco. "However, the health system doesn't need to fund or coordinate the programs." Strategies to bridge SDOH and clinical health to improve outcomes have been developed in pockets across the United States.

Health systems should partner with existing community services to solve individual patient challenges. In nearly every community there are existing organizations that provide essential services to those in need. Identify those groups and collaborate when appropriate. MHIN is piloting a program to determine when risk factors are identified and how to address them through a local community program.

Regardless of wealth, aspects of SDOH impact every person and population. Being able to identify the issue and resolve it is vital to reducing healthcare expenses and unnecessary usage. However, the challenge remains—how does a health system add this level of complexity to an already multifaceted, complicated environment? The consensus among attendees: no one has the answer yet. Years of innovation and trial and error will occur before SDOH are used to their full capacity.

The perspective gathered from the Scottsdale Institute Population Health Summit attendees confirmed that population health management is not a one-size-fits-all strategy to achieve value-based care initiatives. The mix of payer risk, care models and operational structure is unique to each health system. However, the shared challenges, insights and lessons learned offered overarching knowledge about managing a massive amount of data and individual model programs as organizations continue to transition from FFS to value-based care.

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