H&HN

Executive Dialogue

Population Health

A look at strategy and the impact of consumerism

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POPULATION HEALTH AND THE RISE OF CONSUMERISM

As never before, hospitals and health systems are reinventing themselves, working with providers and their communities to position their organizations for success in an environment that demands high-value, lower-cost and efficient health care. But as hospitals and health systems transition to value-based care, they must do so with an eye on the consumer. Patients, and their families, will be more informed and savvy in making health care purchasing decisions. Health Forum convened a panel of health care executives and industry experts June 11 in New York City to discuss the intersection of population health and consumerism. Health Forum thanks all of the participants for their open and candid discussion, as well as Boston Consulting Group for sponsoring this event.

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MODERATOR (Matthew Weinstock, Health Forum): Population health and consumerism are two very broad terms, and they mean different things to different people. For the providers in the room, what does population health mean to your organization? What is your strategy to advance population health management? And, what is your organization pursuing to advance population health management?

NANCY AGEE, R.N. (Carilion Clinic): Five years ago, we restructured our primary care practices. We have about 62 primary care practices, all of which are now medical homes. We changed the way the practices are designed; we added resources, including case management and social work. We've since taken a step back and re-evaluated our clinics. Our initial effort was good, but we took a step back to evaluate and felt we were taking on too much. We were so enthusiastic at the beginning, trying to do all things for all people and we realized that didn't make sense. Now we are focused on patients with three or more chronic illnesses, patients at risk for the degradation of their disease or for readmissions. We're focusing on reducing their readmission rate and emergency department visits about one-third. That's one of the things we're doing in relation to population health management.

Like many other organizations, we are focused on our employees' wellness. We've added gyms to our hospitals and encourage employees to participate in things like Weight Watchers and smoking-cessation programs. And it's actually working. In one of our smaller hospitals, we've had amazing results in our weight loss program. People are excited and enthusiastic. Some of the things we do are quite simple. For example, we promote 'Stair Wellness,' which encourages employees to take the stairs instead of the elevator. The program

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Janice Nevin, M.D.

has been adopted by some of our downtown businesses, as well.

JANICE NEVIN, M.D. (Christiana Care Health System): As an organization, we've been talking about how we can create value in population health management. We've spent the last six months looking at what that means for us. We don't feel we need to redefine our mission; it's more about how we can advance and deliver our mission. We need to build awareness within our organization around population health management and the new level of responsibility and accountability that it brings. It's more than just what happens within our facilities. We aim to achieve optimal health for all we serve, with a special emphasis on populations for whom we assume risk. Our focus extends beyond our patients to all members of the community who look to us for information and the care they need.

The shift toward population health management has also shifted our focus financially. We are using a new phrase for our financial goals: 'organizational vitality.' We're being deliberate about changing our revenue model from fee-for-service to value-based services. We established Christiana Care Quality Partners, the clinically integrated network for our employees.

What will be the game changer for us is really getting into arrangements in which we're paid differently. We're partnering with an insurer developer at Medicaid and we're setting up a Medicare shared savings program that's aggressively looking at Medicare Advantage partnerships. Delaware is a state innovation model test site and that's driving the external environment to be much more participatory in the kinds of conversations we need to have.

AGEE: I really like your focus on organizational vitality. We've focused on sustainability, but I like organizational vitality better. It's not just about the money, but who we are and what's our mission. That phrase seems to encompass all of that.

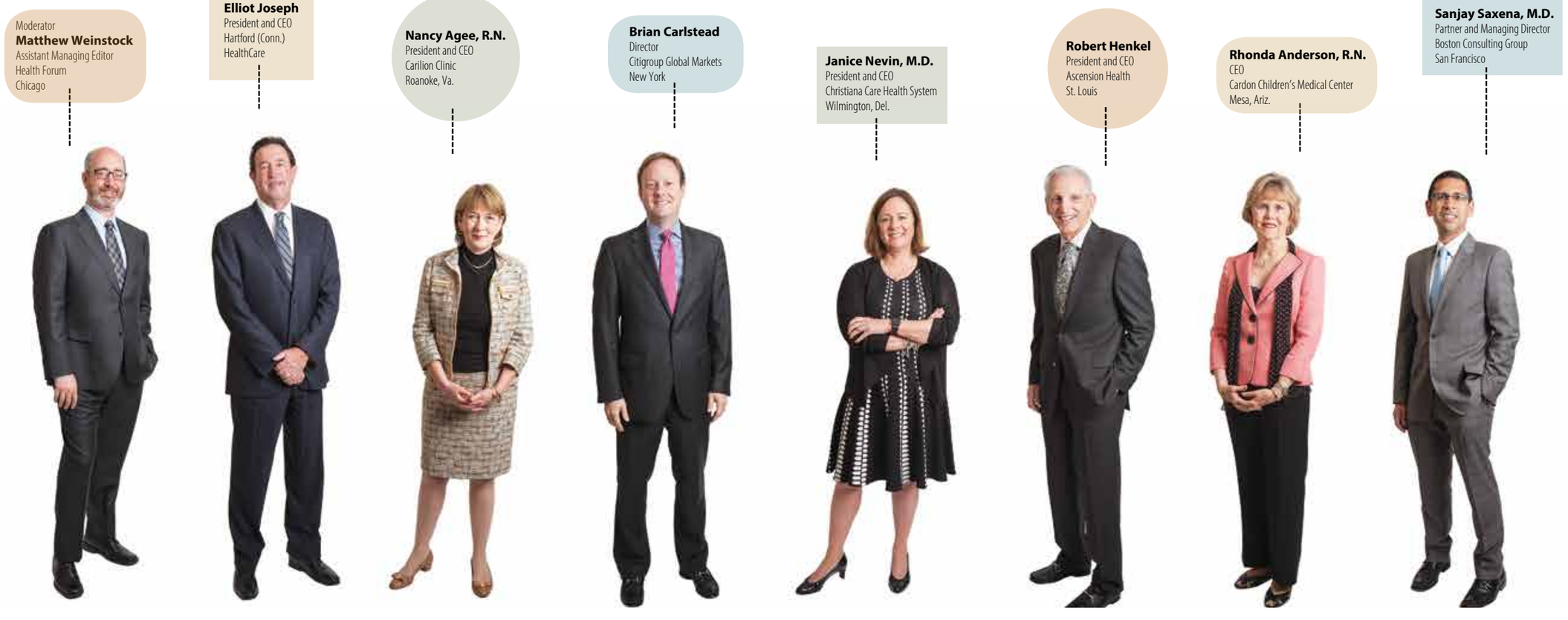
MODERATOR: Obviously, the shift from a volume-based environment to a value-based one that assumes greater risk can be painful if you're not prepared. So, what are those pain points, and how do you start to overcome them? What's been your experience so far?

ROBERT HENKEL (Ascension Health): We've gone through an extensive learning period during this transition. We've made investments in infrastructure to help us truly manage risk that will require new data analytics and actuarial capabilities that are necessary to really look at various populations. We've also made some acquisitions on the insurance side and we're buying insurance licenses in many of the states that we're in so we'll be prepared if we want to use them in the future. At the same time, we have 12 Medicare shared savings plans, several commercial accountable care organizations and we're on the exchanges in many of our states.

As Nancy mentioned, there are similarities in population health management and managing the health of our employees. We have about 300,000 associates and family members who are essentially all risks, and we've learned quite a bit in managing that population. And we've used that knowledge in developing our population health strategy.

When we think about how we serve our communities, we don't think in terms of networks. We talk about systems of care because we

PANELISTS



I've spent a concerted amount of time and energy telling people, 'We're not a hospital company anymore.'
Elliot Joseph

believe we're not going to be able to do everything for everyone, whether it's an employer population or a Medicaid or Medicare population. We're looking for community resources, including competitor organizations, to be part of these systems of care to effectively care for our communities, particularly the communities that are most at risk. So, that's where we are today. We currently have about 2.5 million lives under risk contracts as of June 2015. Just six months ago, we were at 1.9 million. We're seeing those numbers increase and actively making sure we understand the total financial risks that we have at any given point.

SANJAY SAXENA (Boston Consulting Group): Balancing between fee-for-service and value-based care is a nearly impossible situation. Investments in value-based care are unrewarded if you get paid the old way. But you have to make the investments to be ready in the value-based environment. Basically, the lines are blurred between financing and delivery, and the two have to come together. Organizations must ask, 'How do we begin to take on more risk?' Whether intended or unintended, population health management is inextricably linked to financing and delivery methods.

It's important for hospitals and health systems to think outside their walls. Dollars that aren't in the organization's control don't have an impact in the current fee-for-service environment. So naturally, for many systems, that's taking them into managing post-acute care. The final piece is the physician piece. When you start talking about managing a population outside the hospital, organizations will need a clinical engagement model that will allow them to do that. The only way to rationalize all of the necessary investments is to get more of the premium dollar, whether it's through an arrangement with an insurer or, ultimately, having the option of being the insurer.

HENKEL: We pulled all of our physician employment contracts out of the hospital and into new corporations that are being set up in each state. The intent is to show that the purpose of the physician groups is not to fill the hospital beds in the future.

ELLIOT JOSEPH (Hartford HealthCare): I'd like to build on that point. We've asked ourselves a fundamental question as this movement has begun to take shape, and that is: 'Who are we as an organization?' We have found that difficult to answer during this phase of the transformation. I've spent a concerted amount of time and energy telling people, 'We're not a hospital company anymore.' We're trying to get people to think differently because of where we're headed, and because of the objectives of this transformation, which we probably all agree are the right objectives and the right purpose. So, this is a pretty important question for us to ask. There are still many people across our organization holding on dearly to the 'we-are-a-hospital' mentality. I know it's confusing, and our behaviors and comments may come across as schizophrenic at times. We have monthly operating reviews and we demand performance at the hospital level. But all the while I'm saying, 'We're not a hospital company.' So it's a challenging, yet exciting moment for us in the industry.

In regard to physicians, we see three things: physician alignment, building capability, and access to information. Those three things are fundamental to this transformation and in answering the question, 'Who are we?'

We've looked closely at how we organize our physicians and, like others here, we've created a new company — Integrated Care Partners — to house our physicians. We've directed them to lead the way toward contracting for risk. We've invested significantly in this endeavor. There's an interesting tension inside our organization between the people who are responsible for our current operating margin performance and those building this chassis and installing it for the near-term transformation. I don't think of it as a long-term transformation at this point. It's a healthy tension. We started this company a couple of years ago and we now have seven value-based contracts with about 145,000 covered lives. We've also done a great deal of work on our employee network. We went from a 6.5 percent increase in year-over-year employee costs to a negative trend this past year. We're proud of that fact; we're energized by the early results.

RHONDA ANDERSON, R.N. (Cardon Children's Medical Center): I can speak from two different perspectives. Banner Health was part of the first group of Medicare ACOs, the Pioneer ACO program, and actually did quite well. One reason it did well is because we changed the infrastructure, as all of you have mentioned. We aligned our physicians, including those not employed by the organization and we supported their practices. We hired 40 case managers to help physicians and their office staff with the transition, assisting them with risk stratification and using the technology available to them.

The case managers helped to eliminate some misperceptions about our patients. For example, some people may perceive that high-risk cardiac patients — who are mostly elderly — don't use technology. But we've found otherwise. We give them iPads and they have e-visits, checking in daily with their nurse practitioners. It's made a huge difference in keeping them out of the hospital. And these patients love the fact that they don't have to get in their cars and drive to a doctor's office and sit for hours. They do visit with a physician once a year for a thorough assessment. I think this example illustrates the need for systemic change.

Working for a children's hospital provides another unique perspective. Patient and family engagement is more natural in that setting. Family engagement is central to what we do. We've taken our learnings on the children's side and are starting to apply those to the adult side in terms of shared decision-making, and shared plans of care. Those applications to the adult world are extremely important.

SAXENA: As hospitals and health systems determine their paths and question what they will be in the future, they should also ask whether 'patient' is the right word anymore. If we borrow from other industries, we see there's a difference between a customer and a consumer. Health care organizations tend to think about patients as the people within their walls, under their care. But that narrows the organization's opportunity to care for them because there will be instances in which organizations will want to engage with them when they are outside of their care. You want to have a long-term relationship.

Another piece of this is now the next generation of population health. Organizations need to start thinking about the consumer engage-

KEY FINDINGS

As hospitals and health systems strive to become more consumer-friendly, they may need to rethink some common terminology, such as "patient-centered medical home" and "discharge" to reflect consumer sentiment.

Population health management does not mean an organization needs to provide all things to all people. Instead, hospitals and health systems should focus their efforts on providing preventive care and wellness to certain populations, such as patients with comorbidities.

Price and brand are top of mind for consumers. However, consumers are willing to go out of network for services if they find poor ratings among in-network physicians. Other important considerations for consumers are convenience and wait time.

Organizations need to start thinking about the consumer engagement components, beyond patient engagement.
Sanjay Saxena, M.D.

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So what do investors want? They want to know the organization's goals and objectives.
Brian Carlstead

ment components, beyond patient engagement. If we look at financial services, we can see an example of how businesses are trying to build lifelong relationships with consumers. All of you should ask, 'How can we have a relationship with consumers over their life span?'

The health insurance industry provides another example. The insurance industry had its existential crisis when health reform passed. And the industry changed as a result. Every insurer is no longer a health insurance company; they're all health care companies. They've rebranded themselves as health and wellness organizations. As has been discussed, many delivery systems are in the process of repositioning themselves away from the hospital. Soon, everyone will be a health system. That's where the consumer part comes into play. Hospitals and health systems need to become consumer-friendly. Some of the terms used — accountable care organizations and patient-centered medical homes — are unappealing and confusing. There's definitely work to be done in this area.

ANDERSON: I agree. I refer to patient-centered medical homes as 'health homes.' That's a better characterization of what they are.

JOSEPH: The language aspect actually gets to the core of answering the question of who are we. We are so embedded in the old system of care. And we do need to focus on our terminology. One of the words we're trying to eliminate from our lexicon is 'discharge.' We're trying to find the right language to use. 'Discharge,' to me does not correlate with population health management. It goes against everything we're talking about and trying to do. But it's embedded in just about everything we do.

ANDERSON: One possibility would be 'transitions.' We are talking about transitions of care and that covers all of the places where the individual might go for support.

HENKEL: As we've moved toward value-based care, one of the things we focused on is our measurement. Under fee for service, we focused on market share, which is typically based on acute care. Share of voice is a measure of our dimensions of Ascension on social media. We started measuring this in July 2014. We look at our social media presence in all of our markets, compared with our traditional competitors in those markets. We're looking at Facebook and we're looking at Twitter — all of the social media components. Some of the things we look at are whether our organizations are mentioned positively, what do people "like," and what information is being shared? It's eye-opening. We have greater insight into what patients and families are thinking. And then we can focus on the problems or share what's working. It's completely different from how we've measured our business in the past.

MODERATOR: Brian, that's something I wanted to talk with you about. What new measures are investors looking at to determine organizational performance? It's got to be a challenge for the investment rating industries to get a handle on what should be measured now. What kinds of things are you starting to look at before you make a decision on whether or not to finance a bond?

BRIAN CARLSTEAD (Citi): That's a great question. There's been some notable investment changes in the nonprofit provider community that are worth mentioning first. For a long-time, we focused on tax-exempt bonds — it was bricks and mortar, tax-exempt bonds. It's an interesting market that got used to big issuers, who were given flexibility in paying back. The market is more restricted now. As priorities and investments have changed for the provider community, tax-exempt bonds have become just one piece of the financing puzzle. Taxable bonds have become another big piece. And equity partnerships, where for-profits and nonprofits are colliding to collaborate, are gaining ground.

From an investor perspective, tax-exempt and taxable bonds are more or less similar. The taxable bond folks were interested in large, proven systems at first. But we've seen that change over time. Large, high-performing systems have always been able to get a deal. Now investors are looking at strategy: How is the organization positioned to deal with the transition? We want a system that is positioning itself for value-based care. Of course, there's a risk. If they make a jump too soon, they may take a financial hit.

So what do investors want? They want to know the organization's goals and objectives. It's really something they are interested in. When you talk about population health, when you talk about consumerism, investors want to know about specific projects. They want to know why it's part of your strategy. They are listening. They do know that health care is local, and they want to understand the organization's rationale, because what's working in your market, might not work someplace else. Investors want to understand why providers are doing different things in different markets. And they want to understand the timeline for implementation.

Now, circling back to the question about metrics, investors are interested in what metrics the organization is following. Is it ROI? Quality? Is it patient experience? The number of attributed lives? It's all of these things. There's not one standard list of what investors take into consideration. That doesn't exist, and it will take some time to develop.

JOSEPH: One of the things we've been exploring is the total share of spend in the market. Is anybody else looking at that and making any progress?

AGEE: We have just starting to look at that and, no, we haven't made any progress yet.

SAXENA: Looking at total share of spend works great with attributed lives. It's easy to capture total spend. The challenge, however, lies among all other populations. Hospitals and health systems have a hard time understanding spend that's outside of their walls. That's where having a partnership with a health plan would be beneficial. And, even then, depending upon your market, it may be hard to truly understand. If you are in a market where you have a concentration with a single insurer, it might be easy to gain insight into total spend. But in fragmented markets, it will be more difficult.

JOSEPH: That's correct. So much of this seems to depend on the insurers in each market. Some insurers are willing to give you the data, or give it to you in a way that is useful. Lack of data adversely impacts our ability to make good decisions.

HENKEL: That's one reason why we started to look at share of voice. We think that this ultimately will be translated, or coordinated, in some way with our revenue streams. We're going to continue to look at whether there's a correlation between what we're seeing with share of voice and what we are seeing in terms of revenue stream. We don't have a full year of data at this point to make any conclusions. But there are interesting data on Internet usage for health care consumers. More than 70 percent of people who go online are looking for some kind of health information. And that's a growing number.

And, what I find most interesting, 44 percent of people online who are looking for physician information are willing to go out of network if they find poor ratings among in-network physicians. They are willing to pay more for higher quality. We'll see some big changes coming out of the consumer movement as more information on consumer behavior becomes available.

NEVIN: How do you explain all of this to your board, especially when we don't have the measures in place yet? How can we demonstrate that we are successful? We need new data, and they should come from the perspective of the person who's experiencing health and health care. It can't remain as it is now, which depends on where the patient received his or her care, or which site you happen to visit virtually. There's nothing that actually connects it together. I'm fortunate to have a board that is patient and understands our direction. I'm hopeful we can work together to really advance the science.

AGEE: It's a complicated discussion. We're a small system. We've managed to reduce readmissions and ED visits. We've added points of access to our system. And we've seen inpatient admissions going up. We are at a point, however, where we're considering whether to add inpatient space. We are turning patients away. So, on one hand, we are talking to the board about value-based care and shifting our focus while, on the other hand, we're talking about expanding inpatient care. It's an extremely confusing time.

JOSEPH: For me, the answer to how you deal with the board starts with a very pragmatic lifelong lesson, which is, as long as you make your numbers, you get more leeway. And I make sure we never forget that. People will listen to you as long as you meet or exceed expectations. And if not, your credibility will evaporate.

We'll see some big changes coming out of the consumer movement as more information on consumer behavior becomes available.
Robert Henkel

That's the whole idea of consumerism. It's about providing convenient access, a constellation of services, in some sort of systematic way that people can use.
Nancy Agee, R.N.

MODERATOR: Brian, is that the same case for you? You want to see organizations make their numbers, but you also want to see how they are transitioning to the new model of care.

CARLSTEAD: Exactly. Everything is relative; that's the problem of creating a data set. Ascension is big, but relative to whom? It is big relative to the rest of the sector. So, when we think about creating a metric, it needs to be a metric that's relative to the industry. Can the industry create metrics that make sense and aren't misleading and that can be used in each of your markets? Can we create metrics that are relevant for boards, consumers and investors? That's going to be tough.

AGEE: Walmart, presumably, only looks at whether they make a profit.

CARLSTEAD: Well, it might just come down to that. The financials will always be an important piece.

JOSEPH: What about retail medicine? Consumerism leads us to the idea of retail medicine. When you think about the retail industry, what are the measures of success?

MODERATOR: That's something I wanted to address. As Walgreens, Target, CVS and other retailers enter into your space, are you going to have to measure your organization against them? And, if so, how? Are you going to look at their outcome metrics?

ANDERSON: For a consumer, going to a retail market to see a provider isn't any different from coming to us to see a provider. It might be a little more convenient now. The game changer will be harnessing technology so the consumer never has to leave the house.

MODERATOR: That's interesting. Are you getting paid for the e-visits?

ANDERSON: Yes, our providers do get paid for e-visits. But, why not just partner with Walgreens, or with whomever is entering your space? If their locations are more convenient, partnering with them may not be a bad idea. I'm not sure that urgent cares centers are going to be that helpful to us. If we're really building health homes appropriately, then we need to expand our hours beyond what you would find in a typical physician's practice. I'm concerned that if we build urgent care centers, we would have created just another location and another expense, without adding value.

JOSEPH: Rhonda, I have a similar view on partnerships. I also believe that if we're not the one partnering with retail entities, someone else will. It's going to happen anyway, so why shouldn't it be us?

ANDERSON: That's exactly what I'm saying. If we partner with Walgreens, for example, maybe we won't need to build an urgent care center. We need to look at these retail providers and look at what they can bring to this system of care that we've been talking about. We also need to consider what the consumer wants. The conveniences that certain age groups want are different. An 80-year-old in Sun City, Ariz., does not want the same thing as a parent with young children. So, it's knowing your consumer market and then trying to devise the system of care that will work for that market.

AGEE: That's the whole idea of consumerism. It's about providing convenient access, a constellation of services, in some sort of systematic way that people can use.

JOSEPH: Our largest growth engine, right now, is a technology platform we put in that's akin to OpenTable. People can schedule appointments with our providers. But, for it to work effectively, we had to fix our operations so we could guarantee 24-hour access to a physician through that technology platform. And people respond to it. It's amazing. It's far and away driving more growth for us than any other thing we're doing.

HENKEL: We've done that as well. We feel we don't need to build more buildings and spend more money on bricks and mortar. Our physician groups have started to open their schedules, 24 hours a day, 365 days a year, both for in-person capabilities, but also virtual capabilities. I have a 25-year-old daughter who lives and works in the tech world of San Francisco. I learn more from her and her friends about what they think about health care than anything that I could ever read. If they can make an appointment with their smartphone, when and where they want it, they're there. And if they can't, they're going somewhere where they can. That's what we have to understand, and it's so foreign to many of us who have grown up in this industry.

SAXENA: We've now surveyed 25,000 consumers across industries, everything from airlines, retail, luxury goods and the like. For health care, we've found that the fastest-growing segment in the commercial market has been the high-deductible health care plan. If you look at the exchange market, most high-deductible plans are Bronze or Silver. So, consumers are shopping for price.

If you think about where the market is going over the next five years, you can make a strong argument that 40- to 50 percent of the market is going to be consumer-directed in how they select health insurance. Forget about where they go for care for a moment. Consumers are going to pick their insurance. That's fundamentally different. Patients were usually assigned a Medicare plan. Now Medicare Advantage is the fastest-growing segment. Medicaid is going to be consumer- directed, too. And there's a great deal of talk about private exchanges potentially taking over the employer market. With consumers selecting their insurance product, if you aren't in their network, you may never be considered as a choice.

Our research shows that there are two attributes that make up almost 50 percent of the purchase decision when consumers shop for any service through the plan, and that is price and brand. There are other pieces, including convenience and wait time. Most hospitals and health systems can't compete on price relative to CVS or Walmart. Traditional health care providers are never going to be cheaper than the retail providers, right? Large retailers can scale and subsidize. Hospitals and health systems can find ways to differentiate their services, including harnassing their ability to integrate with the entire continuum of care in a way that a Walmart or CVS cannot. That's a big differentiator.

It does make sense to collaborate with retail on some levels. They offer convenience. They have strong brands. But an important question that all health care organizations should ask is, "What's their endgame and what is ours?" If, at the end of the day, your organization's intent is to own the relationship with consumers, that may be the same intent of Walgreens or Target, whoever is in your space. You're never going to out-Walmart Walmart by playing the game that is Walmart. So, organizations need to find ways to differentiate, collaborate and compete with them. I worry a little bit about the mindset of, if we don't do it, someone else will. We've worked with several organizations that have actually undone their relationships with CVS, Target and other retailers because they have found that their interests are not as aligned as they thought.

ANDERSON: The other piece that we should talk about is direct contracting with businesses. Many of the larger employers, such as Intel, are looking to the major health systems to bypass the insurer. I think there will be more of that as we go forward. And there is a great deal of potential in these arrangements.

JOSEPH: I want to follow up on Sanjay's comment about brand. We're spending a great deal of time creating what I'm calling an "operating brand." How will the consumer experience us, whether they show up online or in person?

We're early in this journey, but we're getting very granular about what that experience should look and feel like. That's going to be a key element in how we're able to get that share of the market. And we're a relatively young organization, so people don't really know who we are. And, quite frankly, who we are is mostly that they relate to us as a hospital. We have to bring new talent into the organization to help us create and install our new brand from an operating perspective. That's an essential piece for us going forward.

Many of the larger employers are looking to the major health systems to bypass the insurer. I think there will be more of that as we go forward.
Rhonda Anderson, R.N.

THANKS

Health Forum would like to thank the panelists for taking part in "Population Health and the Rise of Consumerism," with special thanks to our sponsor: The Boston Consulting Group.