The Population Health Secret

BY BRIAN J. SILVERSTEIN, M.D., AND RICK WEIL, PH.D., HC WISDOM

Population health is alive and well and working in small scale all around the country. You can experience the difference in these models where there is benefit to both patient and provider. However, most acute care health systems are having the opposite experience with population health: significant investments followed by limited results. The current wave of support towards population health creates a crushing pressure. Why is it so challenging to get results from something that we have proof of concept for? What is the secret that makes population health work?

The secret is in understanding the operational details of population health. Most organizations are framing the issue as a system strategy and applying traditional operational expertise and best practices to implement the strategy into daily operations. However, this deployment strategy does not work with population health for several reasons including:

- Acute care needs for any given patient are largely unrelated to payment status or any other external factor.
- Population health is largely a clinic strategy.
- Payment for population health is dramatically different than payment for other healthcare services.
- Population health requires operational tools that are not contained in traditional healthcare delivery.
- The present day financial opportunity with population health may be limited and using existing deployment models have negative ROI.

In addition to exploring why traditional deployment strategies are not producing the expected results, this special section will highlight models that do work and explore some of the operational details that result in success including:

- Clinics designed to manage proactive care
- Smart patient segmentation
- Staffing strategies for results
- Systems and processes that support the care model
- Little to no change to acute care services

After there is a clear understanding of the smart strategies and operational keys to success for population health there is a local market factor to calibrate rate and depth of adoptions. It is well known that healthcare is local and part of the secret related to population health is doing the things that are smart based upon your market. There are a number of local market factors to consider including:

- Total cost of care
- Price of services
- Insurance status
- Employer interest
- Market maturity

This special section aims to uncover the secret to population health success. Your understanding of the secret is what will lead to your market success.

Why Population Health Does Not Work

At The Governance Institute's January and February 2017 Leadership Conferences, we surveyed a large group of healthcare executives and board members about their readiness and proficiency for emerging population health models. They told us that while they are pretty certain that population health will work in their market, presently it is not working all that well. Further, they do not believe they are well prepared for it; 57 percent said they are somewhat prepared while 23 percent said they are not prepared at all (see **Exhibit 1**). Most interesting is that they do not believe they have a thorough understanding of just what population health is (see **Exhibit 2**).

Many health systems today are "all in" when it comes to population health.

Key Board Takeaways

Many healthcare organizations are finding population health management to be a challenging endeavor, but one worth pursuing since there can be significant benefits to both the patient and provider. Some proven secrets to success include considerations around the following ideas:

- Population health is largely a clinic strategy; this is the epicenter of population health and where the real opportunities to deliver care differently exist.
- Payment for population health is dramatically different than payment for other healthcare services.
- Operating a value-based clinic includes smart patient segmentation, adjusting the staffing model, setting different success metrics, and new workflow tools.
- Little to no change needs to occur to acute care services.
- It is very important to have a clear picture of your market and identify the right strategies for your organization.

Exhibit 1: How Prepared Is Your Organization to Operate a Population Health Model?

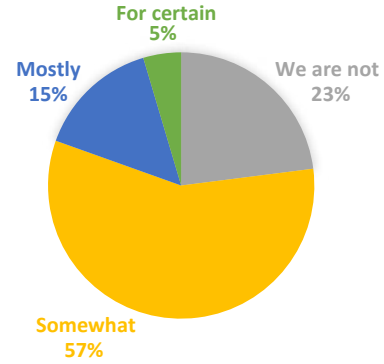
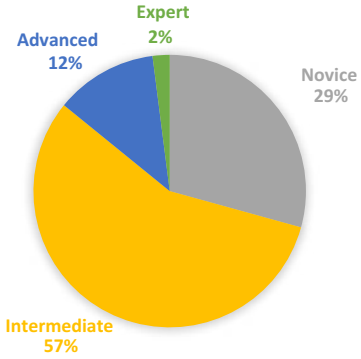


Exhibit 2: How Well Do You Understand Population Health Management?



However, we are commonly not seeing results from their strategies. This introduces the question of whether they are bad strategies or they are poorly executed. Or perhaps both? We would suggest that the secret to understanding the results is to review the expected goals of a population health strategy and how it is being framed.

Population health is largely a clinic strategy. While we would like to change a whole system to be focused on the needs of a group of patients and create strategies to optimize care delivery for the group, the epicenter of this interface is where the patient interacts with the system, outside of the hospital.

Acute care needs for any given patient are largely unrelated to payment status or any other external factor. Health systems grew out of an acute care mindset even as the majority of their revenue and an even larger portion of their profit come from services other than inpatient care. In the acute care setting, when a patient presents with a heart attack, or a congestive heart failure patient presents with shortness of breath, the stabilization and management of the acute issues are of paramount importance to get the patient out of the hospital. These goals are largely the same irrespective of insurance status.

However, if we are managing the same patient in the clinic setting, except that they do not have any acute symptoms, the management of the patient could be dramatically different based upon their insurance. For example, the key interventions for this patient type are behavior modification to impact diet and medication compliance. In a fee-for-service model, the incentive is for delivering more acute care and there are not systems and processes in place to prevent the breakdowns that result in admissions. The range of interventions in the clinic setting is larger and more expansive. This is the epicenter of population health and where the real opportunities to deliver care differently exist. To make the shift from just treating the acute problem to identification of risk and implementing strategies to improve outcomes requires a different staffing and operating model.

In a capitated environment, the clinic focus shifts from managing the problems to identifying potential problems and implementing interventions to avoid the breakdowns. This requires a completely different operational setup than the fee-for-service environment.

Population health requires operational tools that are not contained in traditional healthcare delivery. The core of population health is mass customization of segmentation and interventions to help better manage outcomes for patients with disease and, to a lesser extent, reduce risk from future diseases. To bring this strategy to life requires data and analytical capabilities that are typically not a core competent of most health systems. As health systems have recognized this need, there has been increased attention to this area. However, most of the source data comes from historical claims, which is not a good predictor for the future on an individual basis. In addition to more sophisticated segmentation and interventions, workflow tools are necessary to implement new processes, along with dashboards to monitor progress.

Payment for population health is dramatically different than payment for other healthcare services. We live in a world where payment is on a per unit of delivery basis. The core revenue cycle function is smartly designed around what we are doing for patients and the resultant documentation that is required to receive payment. Population health changes this foundational model to payment based upon how many people are under care management. The revenue model completely changes and, along with it, the systems required to be successful have a different focus and orientation.

When you examine the present day financial opportunity with population health and then look at the investment required, the opportunity may be limited using existing deployment models. It is going to require a more nuanced approach to find the path forward.

What It Takes to Get Population Health to Work

While it is interesting to understand why many of the current strategies for population health don't work, it can be more relevant to look at organizations that have had success with population management and understand key strategies and operations that have resulted in improved clinical and financial outcomes. As we explore these models it has become clear that deploying population health across an entire system without the contracts and financial models is a challenging situation.

It is very challenging to deliver different types of care to patients in a clinic setting. The most notable difference is going to be the processes to manage patients before they have an acute crisis. Many physician offices today don't have capacity even to see patients on the same day when they have an issue. In a capitated environment, the clinic focus shifts from managing the problems to identifying potential problems and implementing interventions to avoid the breakdowns. This requires a completely different operational setup than the fee-for-service environment. If in the clinic, a segment of the patients is fee-for-service and another segment is value-based, it is operationally difficult, if not impossible, to deliver both models of care.

The beginning point for a clinic to operate in a value-based environment is smart patient segmentation. Segmentation is a process for dividing all people into sub-groups based on some type of shared

characteristics. In healthcare most segmentation is done based upon historical healthcare utilization. (See **Exhibit 3** for an example of healthcare consumer segments.) A key competency in population health is identification of segments where you can deploy interventions to improve health and reduce costs. It is interesting to note that when these concepts are applied to the whole U.S. population over 50 percent of the people are healthy and account for less than 7 percent of the total spend. There are other groups where spending is highly concentrated. In some cases, it is easier to identify which people need what services. However, in many cases, changes in health are more challenging to predict and past healthcare utilization is not always a marker for future needs.

Staffing a value-based clinic can be done in several ways. One option is to use a traditional staffing model and reduce the panel size to allow increased access and time to focus on proactive outreach. An alternative approach is to enhance the care team with other professionals including care coordinators, care navigators, a nutritionist, a pharmacist, and community health workers, and then expand the panel size. In this alternative model the role of the physician migrates from primarily focused on direct patient care to overseeing and managing a team that is taking care of patients.

Current operations are typically focused on volume of patient visits, relative value units, and the resultant revenue from these activities. Value-based clinics require a completely different set of success metrics as well as tools to achieve these goals. For example, a value-based clinic is by far more concerned with the total cost of care of the patients that are either enrolled or attributed to the clinic rather than the revenue from the visits due to those patients.

Since the fundamental care model is different, the staff will need tools to operationalize the segmentation and reach out to the right patients with the right proactive care options. This requires workflow tools to support outreach to the right patients at the right time. These tools need to feed into dashboards to monitor the right metrics.

It is worth noting that all of these changes occur in the clinic setting while at the same time there needs to be little to no change to acute care services.

What You Should Do in Your Market

We all know healthcare is local and as such is it very important to have a clear picture of your current market and identify the right strategies for your organization. This requires a calibration exercise to compare and contrast how your market is similar or different than other markets.

There is no one single secret to identifying the right strategy for your marketplace. Even if you do have the optimal strategy your results are by far more likely going to be dependent upon operations rather than the strategy in and of itself. That being said there are several metrics that you can look at to help understand where your market is and what population health opportunities exist.

The first metric we would recommend looking at is total cost of care by population. This number should be an all-in number that accurately represents the total financial cost of a given patient for their healthcare in any given time period. This analysis should be performed for each payer type individually and compared to a national, regional, and local normative value. For example, you will want to look at the total cost of care for Medicare, Medicaid, and various commercial insurance products. It is possible and even likely that in some payer categories your total cost of care will be higher than normal values and in others it will be lower. This will be informative and help identify opportunities for population health.

Exhibit 3: Healthcare Consumer Segments Example

Effective patient segmentation and interventions

Segment	Population	Cost/Person/Year	Total Cost/Year
Healthy	160 million	$800	$130 billion
Maternal and infant health	10 million (4 million mothers and babies, 2 million fertility)	$12,000 per delivery, $2,000 per infant, $1,000 per fertility problem	$60 billion
Acutely ill but mostly curable	12 million	$25,000	$300 billion
Chronic with adequate function	110 million	$7,000	$800 billion
Stable with significant disability (often not elderly)	7 million	$40,000	$290 billion
Short period of decline near death (mostly cancer)	1 million	$45,000	$50 billion
Intermittent exacerbations and sudden death (mostly heart and lung failure)	2 million	$45,000	$100 billion
Long dwindling course (mostly frailty and Dementia)	6 million	$45,000	$270 billion
Totals	300 million	$6,600	$2.0 trillion

Source: J. Lynn et al., "Using Population Segmentation to Provide Better Healthcare for All: The 'Bridges to Health' Model," *The Milbank Quarterly,* June 2007.

In addition to the total cost of care, it is going to be relevant to look at your pricing compared to competitors. This analysis has traditionally been done by looking at a charge master. The charge master rarely reflects the actual payments received for services. We recommend looking at an average collection for each service by payer category. That collection number should include any patient co-pay or deductible. This can then be compared to normative values to determine whether you have a pricing advantage or disadvantage.

It is worth noting that the actual cost of the service is not as important as the total cost in treating the problem. There is a more sophisticated analysis called episode analysis that looks at the cost to treat a given complaint. With episode analysis there are standards that define the beginning of the episode, what is included and excluded from the episode, and the end of the episode. This can help truly reflect when a provider is more efficient in delivering care. For example, if your provider orders a relatively expensive test more frequently, this may be viewed negatively on a pure utilization report. However, an episode analysis may demonstrate the provider is more efficient overall when the other services required to treat a given problem are considered.

Another marker of market readiness is employer interest. In most marketplaces there is an employer coalition on health. These groups will meet on a regular basis and review what benefit changes they're making and how they expect that's going to impact your healthcare costs. Some employers are very aggressive and willing to take chances on benefits in order to save money. However, other employers are more conservative and more likely to not want to make a change until the results are known or proven. Based upon your local employers that will be a key indicator for market readiness.

As healthcare costs have increased, many employers have shifted some of the burden of that cost to employees. As employees are exposed to more of the initial cost of healthcare it will have an impact on their utilization and choices. Thus, as your market moves into products that expose the patient to the true cost of healthcare, patients will make different choices and your health system should be prepared to anticipate and assist patients in this new paradigm.

While there is no one metric that identifies market maturity, we have articulated a number of factors to consider to present a clear picture of where your market is today as well as where it is likely to move to in the future.

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Conclusions

Population health presents a difficult conundrum for provider organizations in determining short- and long-term strategy, as there will be a period of time in which providers will be dealing with both fee-for-service contracts and value-based payment models. It is yet to be determined how long this transition will take, but providers can consider proactive options now to interact with payers and create payment strategies that will succeed.

Healthcare is still very much a local business and it will be critical to understand local market dynamics in order to select strategies that will bring success. Different strategies will be relevant depending upon the provider organization's aspirations and roadmap.

A key factor that most organizations will need to consider is the depth in which the organization can operationalize population health. It is increasingly clear that a broad-based approach is not viable for most organizations and has resulted in some believing that population health is a failed strategy.

Yet when you understand how population health really only applies in the clinic setting and the acute care operations are unchanged it unlocks a new perspective. So it seems there is indeed a bridge from volume to value that likely requires two different organizations to implement both models successfully. Companies that are successful at population health management don't look like the traditional hospital system. Hospital systems can certainly take advantage of this trend by creating a separate organization that manages the value-based population contracts, while simultaneously preparing for the cost and volume changes to the current business. Population health management has the potential to drive traditional volumes down; however, the opportunity to operate at a lower cost structure can convert the value delivery to incremental volume. Healthcare boards and senior leaders have a long list of questions to ask themselves to help determine viable strategies. Below is a list to begin the discussion.

Key Questions for Board Members

1. What are our current financial and clinical results for our inpatient business, outpatient business, and physician enterprise?
   - » How do these results compare to local and national benchmarks?
   - » What is our competition in each area and how are we differentiated?
2. What is the current supply and demand for essential healthcare services in our market and how is this going to change over time?
   - » In a market where there is a shortage of hospital beds, it will be difficult for any outside organization to play a significant population health management role.
   - » Primary care physicians are the foundation to a program.
   - » Select specialists based on effectiveness.
3. What current competencies do we have for population health management?
   - » Data infrastructure
   - » Management talent with experience in population health management
   - » Patient-centric care management systems
   - » Business processes that have proven results of increased quality and reduced costs
4. What percent of our revenue comes from performance-based contracts?
   - » How are we doing this calculation? Is it based upon the amount at risk vs. the total contract?
   - » What are we doing to manage this business?
   - » What about the impact of MACRA?
5. Who in our market is best positioned to be the population health manager?

The Governance Institute thanks Brian J. Silverstein, M.D., Managing Partner, HC Wisdom, and Governance Institute Advisor, and Rick Weil, Ph.D., Partner, HC Wisdom, for contributing this article. *They can be reached at briansilverstein@hcwisdom.com.*