Population Health NEWS

Catching Up With ….

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- **Elected member, National Academy of Medicine**
- **American Hospital Association/HRET TRUST Visionary Leadership Award, 2015**
- **Past Editor, *Health Services Research***
- **Past President, Association for Health Services Research (Academy Health)**
- **Dean Emeritus, School of Public Health, UC Berkeley (Dean, 2002-2013)**
- **Fellow, Center for Advanced Studies in the Behavioral Sciences, Stanford University, 2006-2007**
- **Author, books and papers**

***Population Health News**: The industry touts integrated delivery systems, such as accountable care organizations, patient-centered medical homes, Kaiser and like organizations, but what will it take to move the entire healthcare system forward in their direction?*

Stephen Shortell: One way of thinking about this question is in terms of incentives on one hand and capabilities on the other hand. Both are needed to move the system toward more integrated care. Incentives that move away from fee-for-service payment toward value-based payment based on outcomes of care create the motivation for changing how care is delivered.

CMS is moving strongly in this direction with such payment innovations as shared savings arrangements with accountable care organizations (ACOs), bundled payments and the recently announced MACRA payment reform legislation that will reward doctors with a 5% bonus if they choose to practice in an ACO-like entity. They also could choose to be paid under an incentive program that depending on their ability to meet cost and quality metrics will reward them with additional income; however, If they fail to meet the metrics, they will be subject to loss of income.

But incentives alone are insufficient. One also needs to take into account the capabilities of providers to respond to the incentives, and this varies widely across the United States. Hence comes the need to calibrate the pace of change in rolling out new payment models with the ability of providers to respond to risk-based payments. It is encouraging that a number of technical assistance programs are being made available to small physician practices to acquire some of the skills that will be needed to succeed under the new value/risk-based payment models. These include support of electronic health record implementation, formation of healthcare teams, training in patient engagement methods, the use of health coaches and related approaches.

Among those providers that are currently ACOs or ACO-like entities, our research and that of others suggest six keys to success. These include:

1. Having a sufficient number of enrolled lives to spread costs and create economies of scale and scope. The more successful ACOs appear to be to those that have at least 35,000 and more patients under an at-risk contract.
2. Implementing innovative care management programs particularly for patients with high-cost/high-complex medical needs.
3. Having a high degree of electronic health record (EHR) functionality that facilitates real-time communication among all members of a healthcare team including patients.

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4. Developing effective partnerships with behavioral health providers and post-acute care facilities in order to manage a full continuum of patient care.
5. Effectively activating and engaging patients as full participants in their care.
6. Being able to use a core set of actionable quality and cost measures for purposes of improving performance and external accountability.

Overall, I believe the movement toward more integrated delivery systems over the next five to 10 years will be gradual and unevenly distributed across the country. The extent to which incentives and capabilities can be calibrated will determine how rapidly integrated delivery systems will grow and spread.

***Population Health News**: What are the components of total quality management, and how well is the healthcare industry doing in achieving it?*

Stephen Shortell: The Institute for Health Improvement (IHI) and the National Academy of Medicine (formerly the Institute of Medicine) have played key leadership roles in improving the quality of healthcare in the United States over the past 25 years or so. I think most observers would agree that the quality of care (in most areas but not all) has steadily improved using generally accepted measures. But the progress has been slow and uneven, and there is much work still to do.

Some of the key components of total quality management include:

- Setting priories consistent with an organization's strategic priorities.
- Training staff in quality improvement techniques and tools, such as those involved in planning, doing, studying and acting cycles, or the Plan-Do-Study-Act (PDSA).
- Developing the data infrastructure to support the effort.
- Learning to sustain and spread resulting improvement gains.

These are particularly challenging in healthcare because of the multi-level interdependencies involved in providing patient care. Thus, there is need for an overall systems approach to improvement. For example, a recent study of quality improvement in the Veterans Administration (VA) found that focusing on systems, structures and underlying processes was associated with greater improvements in quality than focusing on individual projects or staff training in isolation.

These and related findings are calling increased attention to a new way of managing and leading our nation's healthcare organizations. One approach to this is the LEAN operating and management system most commonly associated with the Toyota production system. The major focus is on increasing value by eliminating waste, inefficiencies and redundancies that do not add value for patients using a variety of tools such as value process mapping. But the key to success appears to lie in developing a new model of leadership based on the leader as a student and learner of what frontline caregivers are doing and removing the barrier to their success. For those interested I strongly recommend reading *Management on the Mend* by John Toussaint, M.D.

***Population Health News**: How can the healthcare industry repair the payment system to enable population health management?*

Stephen Shortell: Moving away from the fee-for service payment of physicians and paying hospitals for each admission towards value-based payments that reward outcomes achieved is central to beginning to change behaviors that emphasize keeping people well and healthy. CMS is currently experimenting with a variety of these approaches, as is the private commercial insurance sector. There is much to be learned from these efforts. One key will be determining a core set of cost, quality and patient experience metrics that do not overburden providers in a measurement morass that benefits no one.

There also needs to be recognition that the measures provider organizations may use to improve care internally may not be the same measures desired for external reporting accountability purposes. But to the extent possible, they should overlap.

The current payment focus is largely on providing bonuses for hitting quality targets, some shared savings for providing care less than expenditure targets and bundled payments for selected conditions.

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But ultimately, the most traction will likely be gained by upfront capitation payments (per member per month fee) or setting a global budget/payment. This creates the greatest incentive for innovations in care delivery to keep patients out of the hospital and emergency department and, indeed, to reduce the number of office visits as patients become increasingly capable of managing their own care and maintaining their health.

So far the term "population health" has been used primarily to refer to a given delivery system's or medical group's own population of patients. But more recently, there is growing recognition of the importance of the underlying social determinants of health in the community and the need to address true community/population-wide health. One approach has been the development of accountable communities for health (ACHs) or accountable care communities (ACCs) In which a cross-sector, community-wide coalition leadership group or "integrator" body accepts responsibility for payments (from multiple sources including wellness funds) for an entire community population to achieve predetermined community health goals. In addition to healthcare, typical sectors include public health, social services, education, housing and transportation. Initiatives are currently underway in a number of states including California, Minnesota and Washington and will be important to evaluate and summarize the lessons that will be learned.

***Population Health News**: What are the best ways to engage and empower patients?*

Stephen Shortell: The best way to engage patients is to meet them where they are. Instead of asking, "What is the matter with you?" ask, "What really matters to you?" Our Center at Berkeley, the Center for Healthcare Organizational and Innovation Research (CHOIR) is currently involved in several patient engagement research projects. These include examining the relationship between patient activation and engagement and patient reported outcomes of care. One of the things we have learned is the importance of considering the entire ecosystem of the provider/healthcare team and patient and family relationship. The way in which you use healthcare teams, health coaches, EHRs, patient portals and digital tools all come into play.

It is often helpful to stratify patients by their level of activation and knowledge of their condition and then jointly develop with them and their families their goals and treatment preferences. The ability of providers to effectively engage patients and their families will be increasingly important under the new payment models, particularly given the growing number of Americans with multiple chronic illnesses in the years ahead.

***Population Health News**: What are the best ways for physicians to partner with other healthcare entities, and what are the benefits of these alliances?*

Stephen Shortell: As physicians and the organizations with which they are affiliated become increasingly accountable for the entire continuum of care, they will need to form partnerships not only with each other (merger of medical groups, joining an independent practice association) but also with hospitals, integrated delivery systems, post-acute care facilities, health plans and related entities. They will be best prepared to do so by examining their own Strengths, Weaknesses, Opportunities and Threats or what is commonly called a SWOT analysis. They then should do the same in assessing potential alliance partners.

The key is to partnering with another organization that will bring strengths and capabilities to the table that you do not have and yet, their culture is compatible with yours. It is important that there be mutual goals and mutual respect. Ongoing communication is key—timely and accurate. Never surprise your partner. Keep each other informed about new developments. Look for opportunities to deepen the relationship. Celebrate successes. Share the credit.

In the coming years, we will see more vertical integration partnerships (between physician groups and hospitals and between hospitals and insurance plans), as well as horizontal (between physician groups, between hospitals and between insurance plans). By 2025, I predict that nearly all of the nation's hospitals will belong to a system or network, and there will continue to be consolidation of physician practices and more physicians practicing in groups of varying sizes. The major question, of course, is whether a more integrated, consolidated health system in the United States will produce any marked progress towards achieving the Triple Aim of better heath, better quality and a lower rate of growth in cost.