Table of Experts:
Value-based care trends among Nashville's healthcare leaders

A SUPPLEMENT TO

NASHVILLE BUSINESS JOURNAL

PRESENTED BY

Lumeris

Meet the Experts

Carol Murdock
Lumeris, Senior Vice President and Head of Market

Carol Murdock joined Lumeris with more than 25 years of experience in strategic marketing, management and business development in health care. She most recently worked at HealthTech Holdings, where she served as Chief Marketing Officer for its three companies, Healthcare Management Systems, Sentry Healthcare and MEDHOST. Earlier in her career, Ms. Murdock founded, ran and later sold Coactive Systems Corporation, a health care technology and services company focused on nurse triage and disease management for payers and hospital systems. She has also held executive positions at Healthways, a population health and wellbeing company, and at three large hospital systems: OrNda Healthcorp, Summit Health and National Medical Enterprises. In her current role, Ms. Murdock is responsible for sales, client management and operations, including driving business development, key customer partnerships and revenue growth.

Jason Dinger, PhD
MissionPoint Health Partners, Chief Executive Officer

Jason Dinger is the Chief Executive Officer of MissionPoint Health Partners – one of the first dedicated accountable care organizations created in response to the overwhelming need to improve quality outcomes and lower health care costs. MissionPoint currently supports tens of thousands of people throughout the country by developing custom population health strategies for small and large companies, health systems, and payors. Jason is responsible for the strategic, operational and cultural stewardship of the organization.

Prior to his work with MissionPoint, Jason directed Saint Thomas Health Ventures – a social venture arm of Saint Thomas Health focused on developing non-acute services such as rehabilitation clinics, sleep centers, clinical research organizations, pharmacies, and other health care services.

Prior to joining Saint Thomas Health, Jason was CEO of a consulting firm whose clients included FedEx, Caterpillar Financial, and the World Bank.

Victor Giovanetti
LifePoint, Western Group President

Victor Giovanetti is President of LifePoint's Western Group, which includes 19 hospitals in 10 states. Prior to assuming his current position, he served as Chief Operating Officer (COO) of the company's Eastern Group of hospitals since July 2013.

Among his accomplishments as Eastern Group COO, Giovanetti guided several new hospitals during their transition to LifePoint and led multiple initiatives to build regional health networks in strategic markets across the company's footprint. He also has been deeply involved with Duke LifePoint Healthcare, ensuring the innovative joint venture's vision successfully advances within its hospitals and communities.

Giovanetti has more than 25 years of management experience in operations, legal, financial, clinical, and strategic aspects of healthcare administration. He joined LifePoint in 2013 from HCA Lewis-Gale Regional Health System in Roanoke, Va., where he was president.

Jeffrey Guy, MD
TriStar Health, Chief Medical Officer

Dr. Jeffrey Guy received his medical degree from Northeastern Ohio Universities College of Medicine and completed his residency in general surgery at Northeastern Ohio University College of Medicine, Akron General Medical Center in Akron, Ohio. He completed fellowships in trauma surgery research at Case Western Reserve University School of Medicine in Cleveland, surgical critical care and trauma surgery at University of North Carolina at Chapel Hill in Chapel Hill, N.C., and burn surgery at North Carolina Jaycee Burn Center at University of North Carolina at Chapel Hill. He also completed the Charles Fox Traveling Burn Fellowship with the American Burn Association. In 2009, Guy received a Masters of Management in Health Care from Vanderbilt's Owen Graduate School of Management.

As the Chief Medical Officer for TriStar Health, Dr. Guy supervises the implementation of initiatives and best practices that improve clinical outcomes and ensure patient safety.

Lynn T. Simon, MD, MBA
Community Health Systems, President, Clinical Services & Chief Quality Officer

Lynn Simon, MD serves as President of Clinical Services and Chief Quality Officer for Community Health Systems where she has leadership responsibility for all aspects of clinical services, quality and safety, physician engagement and physician practice management. Dr. Simon joined Community Health Systems in November 2010 to oversee the Department of Quality & Clinical Transformation. She was promoted to President, Clinical Services in January 2014.

Prior to joining CHS, Dr. Simon was a full-time practicing neurologist in Louisville, KY for over 10 years before becoming Vice President of Medical Affairs at Jewish Hospital, and in 2005, the Senior Vice President & Chief Medical Officer of Jewish Hospital & St. Mary's HealthCare after those organizations merged.

Simon received her medical degree from the University of Louisville, completed a medical internship at Rush-Presbyterian-St. Luke's Hospital in Chicago, IL and a neurology residency at Stanford University.

What Nashville's healthcare leaders have to say. . .Hear from the experts

Carol Murdock, SVP and Head of Market for Lumeris, led the discussion. Those taking part in the discussion were Dr. Lynn Simon, President and Chief Quality Officer of CHS; Victor Giovanetti, Western Group President of LifePoint; Jason Dinger, CEO of MissonPoint and Dr. Jeffrey Guy, CMO of TriStar.

Carol: *Let me provide a little context about Lumeris. We are a population health solutions company with a proven management model that helps payers and providers transition from volume-to value-based care. We act as an operating partner that helps customers align their business models with the right technology-enabled services to deliver improved outcomes, lower costs and improved patient plus physician satisfaction.*

Lumeris operates its own value-based Medicare Advantage Plan in St. Louis. Essence Healthcare, Inc. (EHI) has been in operation for nearly 10 years. Medicare Advantage plans are rated based on stars by the Centers for Medicare and Medicaid (CMS), with five stars being the highest rating achievable.. EHI has been a 4.5- star-plan for the last four years. We have been successful achieving cost and quality goals in our own health plan and decided to take this model to market. For the past five years, we have been working with Medicare and commercial patient population plans to help them reach similar efficiencies.

I'm excited about this panel because I want to hear your assessment, as healthcare leaders, of the Affordable Care Act and its impact on value-based care. I travel across the United States and talk to many healthcare executives, but I've always felt that Nashville's healthcare leaders are at the epicenter of the healthcare industry.

Carol: What is your position on value-based care and how are you trying to make that transition? I know MissionPoint is an Accountable Care Organization (ACO) and you're already engaged in value-based contracts, but I don't know if you're taking capitation. Organizationally, are each of you actively pursuing a value-based model, or are you in a wait and see mode?

Jeff: At TriStar, we've had some performance-based contracts for some time, but as you've alluded to, each market is different. The markets are evolving at different rates based on the degree of fragmentation, degree of employment, magnitude of integration and employer mix. We've always been on a performance-based model and each market will migrate to more value-based purchasing, based on the market. We're in a 'prepare and wait-and-see' mode. The preparation part of that is really defined by how the individual markets are evolving. What is that tipping point in which that conversion makes sense in that particular market? A global answer is hard to define because of the reasons you've already mentioned.

Jason: MissionPoint — we're a subsidiary of Ascension Health — and our local partner here is Saint Thomas Health. We're in seven different markets around the country. I think we're obviously bullish on population health. That's what we do every day. One of the things that's been

fascinating is to watch how different geographies behave in different ways, based on the dynamics that Jeff acutely named.

I will say we are excited by the reception that we're getting. We believe that the providers at large, both facilities and physicians, are anxious to really be rewarded for the quality and value of care they've been delivering. I think they're anxious for that. I think they've seen that fee-for-service is probably not a long-term solution for our country. It's not sustainable and it's not really delivering on some of the consumer promises that people want. That being said, we are aggressively changing a number of reimbursement strategies. We're in capitated models from a first dollar perspective and also have capitated agreements with our physicians. We're talking about capitation with facilities. We're doing some non-traditional things like paying extra dollars for staying open later during the week and

emailing with your patients. These are a number of things the health care system has traditionally not been reimbursed for, but consumers at large have been asking for, for a long time. We're excited about the future. We think there's a lot of work to do. We think it's very, very early in this process. We learn more every day.

Victor: Population health means so much to so many different people. We're fortunate enough to not only be in the provider space but the payer space as well, across the country. We have a unique perspective from both sides. We are in the 'prepare' stage, but also the 'wait-and-see.' We're in the infancy stages of what population health means to most folks across the country. I think what we are seeing as we look at things the government has deployed is that it's not always successful. The majority of ACOs in the country have been unsuccessful. We're going to be anxious to see how this evolves over time. One of the things I believe in, even as a clinician, is 'pay for performance' and 'pay for good quality care.' For those providers, whether they're hospitals or physicians, if they're not driving high quality patient care, then they shouldn't get paid for it. The question is how do we get there consistently? The third part of this is what role do the health care consumers have related to the success of our endeavor to improve the quality of care in our country and reduce the cost, as it relates to compliance with physician expectations around taking medications and treatment of their disease process, quality of life and lifestyle choices. All of those are important parts of the discussion we have not had yet and are part of the population health discussion. It's going to be interesting to see how that evolves from a health care consumer perspective. Because I am not only a health care provider, but a health care consumer as well. It's interesting when I'm thinking about my role as an executive and health care provider, but when I need health care I am not willing to wait for it as a health care consumer. It's an interesting dichotomy. It will be interesting to see how this evolves over time. We are absolutely prepared both on the payer and provider side, and are waiting to see how this evolves.

Lynn: We're also in the 'prepare' mode, so the interesting thing looking at our company from Alaska to Florida is the markets are different, the payers are at different stages, the doctors are at different stages, and so in those markets there is readiness for these things such as contracts with incentives and those types of things. We're participating in those. We're not anxious to take on risk at this point but we are preparing. We're developing clinically integrated networks with our physicians who are employed and our independent physicians. We're participating in the Bundled Payments for Care Improvement (BPCI) Initiative and the Comprehensive Care for Joint Replacement Model (CCJR). Those are mandatory, but are learning opportunities. We're trying to figure out what works best for us and how to participate the best. Is it a people, process, or technology issue? The answer is yes, it's all of those. We're trying to figure out how to get our physicians to participate with us. Clinically integrated networks are one of those ways that we're looking at. That can evolve to an ACO stage and then developing the process of care and care redesign. Then we look at technology and what the analytics show us. We're not anxious to jump into risk until we know what the data shows us.

Carol: The American Academy of Family Physicians has just released research about physician incentives. It indicates in the absence of incentives, physicians are not going to change their behavior. Are any of your organizations employing physicians, and if so, are you incentivizing them in any way. Can you share any insights from your experience?

Jeff: Yes, we employ physicians but the degree of employment varies from market to market. When you look at models that have been very successful in this kind of strategy, they've had a high degree of physician alignment. It would be my opinion that physician employment and physician alignment are not synonymous. There are a variety of ways you can have independent physicians be aligned with a plan, but it's also possible to have physicians with a high degree of employment and not have them aligned. Employment doesn't necessarily equate a positive incentive for an alignment to make these strategies successful.

A lot of it is change management in addition to incentives. Getting people past the barrier that this isn't important to them. Leading what's right for the patient incentivizes physicians greatly. Now we're talking about what's right for the patient. We're taking the patient through the continuum of care, rather than episodes of care, and how does that translate to better patient care? When you look at the payers, they're becoming a partner with the patient from the pre-hospital space and the post-hospital space. Capitated contracts are market-based and payer-driven. There really isn't an overall 'this is the equation' solution. An advantage of larger systems is that we can do

"We're trying to figure out what works best for us and how to participate the best. Is it a people, process, or technology issue? The answer is yes, it's all of those."

LYNN SIMON, MD, MBA
Community Health Systems

experiments or test pilots in different markets of a particular strategy and create variations of those strategies, run them in parallel, and then adopt the best practice in order to affect change quickly and adapt to the market dynamics. Small independent hospitals have a large investment of capital or time into testing a model, and it might take them a year to discover they need to change course. At HCA, we're running different models in similar markets.

Jason: There's inherently a sort of a chicken and egg issue. Our fundamental approach has been that value-based care has been the right thing for the community, and is inevitably going to create sustainability around health care at large. We're committed to being a leader in this movement. Consequently, we believe the first step is creating incentives for providers to help in this transition. We are creating partnerships among payers, employers and others. We pay the practice and let the practice decide how they're going to transition around that incentive. I think the change-management piece is absolutely crucial. They have to want to participate in this process. This is an opt-in process. Providers need to believe that this will be good for their patients and be good for them. I think incentives are a first step.

I think the second step is support. How are you delivering people and processes to that practice in a way that they feel supported in that transition? We recently completed a satisfaction

survey of our providers, and support turned out to be a higher satisfier than incentive. We talk a lot about incentives. Having a health partner in your practice who's doing home visits and following up with people in the hospital turns out to be really critical in that transition.

Third, is data. It's very hard to transition to a new process if you have no idea how you're doing in that process. Do you have the right data and the right information to know how you're improving, to what degree you're improving, and that this change is a good thing for you? I think those three components are absolutely critical to the transition to value-based care at large.

Carol: The Lumeris model is very similar to that. Our Medicare Advantage plan was started by physicians, and there are still several physicians who serve on our board of directors. Our network physicians do patient rounds in the hospital, as well as home visits because of the alignment Jeff talked about. It took a long time to get to an outcomes-based approach. What are your thoughts about the model Jason described? When you talk about trying different care models, are you experimenting with this kind of an approach?

Victor: Informatics needs to drive the decisions that we make going through the transition we're going through with health care. The idea that hospital providers only take care of those that are sick or injured is a fallacy. We have a responsibility to create a healthy environment in the community we serve. Most providers are actively engaged in not only taking care of the patients that are sick or injured, but in doing the things that help create environments where patients can stay healthy. I think that's probably one of the best parts of the evolution we've seen over the past 25 years.

Related to physician employment, as a company we're approximately 16 years old and we employ roughly 1,500 physicians. Eighty percent of those or more have been employed over the past five years. That gives you a sense of how the physician space is evolving in terms of health care reform, and how they think they need to be partnered with someone appropriately to make that transition successful.

You talked a little about physician employment versus independent physicians and I think when you create integrated delivery systems and the opportunity to improve quality of care at the bedside, it's not just through employed physicians. It's through clinically integrated networks that involve sometimes the preponderance of those providers being independent. It's really a focus on a quality agenda and a patient safety agenda that's driven at the patient's bedside, not whether or not you're employed or not employed. The majority of the ACOs that have not been successful are in larger teaching institutions where the physicians are employed. That's one of the challenges we've found with the driver of evidence based medicine and the way that ACOs and some of the other population health structures have been propagated. They have not been able to drive consistency or savings. Not to say they haven't driven quality, because in many cases they have, but what we haven't been able to sustain is the ability to reduce the cost associated with that increase in quality.

If you remember in the 1970's when the Health Maintenance Organization legislation was propagated, that was almost the beginning of the end of the HMO structure. The main reason for that is that the health care consumers in the 1980's and the 1990's said 'this is unacceptable to us as health care consumers.' We're not talking about the role patients play in being successful in evolving our health care system into a true 'pay for performance' structure. There has to be some accountability on the part of the patient or consumer.

Lynn: I agree employment does not equal alignment and it's different from market to market. We have about 3,200 employed physicians and about 22,000 physicians on our medical staff. That's not the predominant relationship model we have, but in some of our markets, the vast majority of physicians are employed. In some markets none of them are employed. It may be a financial relationship, but it's not an alignment relationship. I do think there are things that engage the physicians, such as taking care of the patients, providing the data to show whether they're doing a good job or not, or what the evidence shows is the best way to produce the best outcomes, and then the incentives. You have to put all of those together and come up with what works. Whether it's an engagement through an ACO or a clinically integrated network, I think you have to have those components and the financial model is less important than some of those things we've talked about.

The things we're doing with either our employed group or otherwise is how to close those gaps in medical care. There are certainly technologies to help close those gaps in care, or take care of those folks across the continuum. We're looking at access points that are not necessarily the physician's office but urgent care and telemedicine as well. So, how do we engage folks and consumers in the system and keep them within the system by providing them the access they want, when they want it, the way they need it? There are a lot of different things we're expanding and doing differently with different care models.

Carol: What is your position on the transparency of cost? The Lumeris model provides full cost transparency. Ten years ago, we published a paper titled "The Collaborative Payer." As a collaborative payer, we built our model around sharing all costs with physicians so they can better manage care. We have a lot of payer partners that are uncomfortable with the level of transparency we provide. To your point, it is very hard to control costs, and we are not seeing costs reduced in a lot of ACO models. My hypothesis is that providers are not seeing true cost transparency. With the infrastructure that each of you have put into place, what level of transparency do you provide physicians so they can make decisions about sites of service or generic versus brand name drugs?

Lynn: There are certain programs like BPCI that is an easier dynamic to see different levels of cost when you discharge someone to rehab versus a skilled nursing facility or home. Some drug cost information is very hard to get to. I'd like to have some more transparency and evidence, but I think there's data lacking around that.

Victor: I agree. I think this gets into even a deeper discussion about the different forms of competition that exist within health care. Out West there are no Certificate of Public Need requirements so on almost every corner, there is an urgent care center, or surgery center or a diagnostic center owned by different providers. The inherent true cost of operating those facilities is different than what it means to operate a hospital that's available to the community 24 hours a day, seven days a week that takes all patients and all payers. I think this goes back to a larger discussion that needs to be had among health care consumers. I would argue that it's not

"The idea that hospital providers only take care of those that are sick or injured is a fallacy. We have a responsibility to create a healthy environment in the community we serve."

VICTOR GIOVANETTI
LifePoint

just employers. Our largest population base in many of our hospitals is Medicare or Medicaid, and they are not employers.

Jason: I think transparency is inherently a good thing. It's good for markets, for consumers, for most participants. I echo that good cost data is really hard to come by. Our general approach to this has been to build the networks that we participate in. We are selecting quality providers and contracting for that work. We think about threshold issues on the front end, so our providers don't need to worry as much about what the cost is because that's been managed from the design perspective. They're just asked to refer to other high-quality people within the network. I think cost at large is a function of price, of utilization and of quality. Part of our challenge as an industry is teasing out what we're really trying to manage from a cost perspective.

The point was well made asking is it appropriate for that patient to go to a skilled nursing facility or to home health? There's no bigger cost decision in post-acute care than that; and, that is separate from a function of price. As we mature as an industry in this arena, we are

"Another dimension of cost that warrants examination from an individual patient perspective is that improved access to patient health care is good in the prevention of future disease."

JEFFREY GUY, MD
TriStar Health

going to be better able to know what the true cost is, the factors of that true cost, and the most appropriate way to manage that.

Lynn: We even take into consideration that the cost of one drug might be less than another, but the later could produce a better outcome. It gets really complicated. It's not just about selecting the lowest cost and driving that utilization. It might be that there's something that's more effective and costs a little more, but has a better outcome. Then 'cost' is very hard to get to.

Jason: We pay for palliative care before you qualify for palliative care. So in that regard we're adding to the cost. We're paying for something that traditionally has not been paid for, but the outcomes from a patient perspective and a family perspective are so overwhelming that we think the value of that it is extremely high, so we do it.

Jeff: Cost is difficult based on how we define the cost. What are the variable costs with a hip replacement - implanted versus the post-acute. Looking at cost from that perspective is looking at consumption for a single individual. In moving forward, we think about where the health care economy is going to reap benefits. Is it going to population health, which is avoidable cost? That goes to Jason's point of whether you're going to spend money today, that you didn't spend 10 years ago, to basically avoid a large future cost. Reconciling that gets very difficult. Another dimension of cost that warrants examination from an individual patient perspective is that improved access to patient health care is good in the prevention of future disease. But what is the impact of high deductible plans and the increase in co-pays? Does that create a barrier to entry that prevents people from getting access to health care, regardless of what the facility costs may be?

Carol: Let's talk about consumer engagement. Medicare Advantage has tried some models that provide incentives to consumers for being more engaged in their own care. They appear to work in instances where patients have a good relationship with their physicians. What are the paths for consumer engagement from your perspective?

Victor: I'll use myself as an example, not as a health care provider but as a health care consumer. It's interesting because personally I don't want a payer, nor do I want the federal government, to tell me when it's time for my mom to come off the ventilator. I had the opportunity to make that decision for my mom, and I was able to sit down and have an objective discussion with my mom's physician. If you remember, 8 or 10 years ago, there was a big discussion about at what point, when you were having health care provided to you by the state or the federal government, do we talk about end-of-life discussions. I think this is very difficult. I don't want someone else making that decision; I need to make that decision. The question as a health care consumer is, who's responsible for paying for it? This is why people have struggled with managed care or HMO structures as consumers. The number one reason why the HMOs have failed is because consumers have walked away from it because decisions were being made on their behalf. This is why ACOs and the way they're structured can indeed be challenging.

Carol: We are facing this risk again. Even in fully capitated instances, often times the health care plan still controls utilization management without delegating these important decisions to physicians. In the Lumeris model, we train the physician to manage appropriate utilization, perform

end-of-life counseling and how to have conversations about difficult health care decisions. Jason, I suspect you are nodding because you agree that at the end of the day, success rests on patient and physician relationship.

Victor: Managed care products, independent of traditional Medicare, have been fairly successful, but they, just like ACOs, have not traditionally been successful in reducing costs. There are many reasons for that. The consumer's expectations around not only quality of care but also access to care is part of the reason that they have not been as successful.

Lynn: In Atul Gawande's book, "Being Mortal," he addresses that and it's about how people define the goals of their care. That is what the health care system hasn't engaged consumers on – asking them what their goals of care are. Things become a little clearer if you can understand that. Then you don't get into a lot of those difficult conversations because you understand upfront what the decisions are and how best to deal with those situations.

Carol: You're right. A financial planner won't touch your portfolio without you stating what the goals of your portfolio are.

Lynn: But it's a different conversation when I'm healthy versus when I'm facing a health care challenge. Until we engage people in those conversations, we're never going to get hold of that.

Jeff: I have a different perspective. I'm a critical care surgeon by training and I've had two mentors of mine die in the last month. They were luminaries in the field of health care. They both died at home in their own beds with their families around them. Large members of the medical community at the wakes said, 'This was a good death. The family made the right decisions here. This is the way I want my death to be.' When you survey physicians, the data shows, among medical providers, we don't want to live our last days in a hospital. We want to live it in our homes with our families. So Lynn's point and part of the barrier to climb over is that the medical community is uncomfortable with that. Our mission is to eliminate suffering and preserve dignity. It's not preserve life at all costs. Whether the conversation happens in medical

school or residency training, physicians have to be comfortable with recognizing that giving a dignified and compassionate death is a good end and not a failure.

Victor: I agree that episodically, it is a clinical discussion to be had with a physician. When we do talk about the cost of health care, we're separating the clinical practice of medicine with the macroeconomics of health care. When you talk about the macroeconomics of health care there is an impact when we as consumers choose to prolong life when it's very clinically clear that that's probably not the right choice. There's a

"Our fundamental approach has been that value-based care has been the right thing for the community, and is inevitably going to create sustainability around health care at large."

JASON DINGER, PHD
MissionPoint Health Partners

financial impact to the health care system to do that and we don't talk about that. When my mom was dying, I didn't want to talk to anyone about her Medicare or her co-insurance. That was not on top of my list. And, I certainly didn't want to see anybody from accounts payable come in to talk to me. So having said that, there is an impact to the decisions we make as consumers. Whether it's an end-of-life decision or my decision not to take my Lipitor or take care of my diabetes, it's not only a clinical impact on me, but there is also a financial impact to the payers, to society, to Medicare and Medicaid. Those are the difficult conversations we struggle with. And, when we get to your point about cost of health care, we need to have those discussions as clinicians, as businessmen and women, and as politicians as well.

Carol: Our Chief Medical Officer has three children, two of whom are in medical school. She believes that medical schools are not preparing students such as her children to function in the new reality of modern value-based healthcare. Jason, you just mentioned that conversations about end-of-life care between patients and physicians need to happen when the patient is healthy. When someone is sick, the family might have very different priorities than the patient. Can you share how your organizations are tackling this issue?

Jason: We believe that delivering different models of care is complicated, but is best done in partnership. In our world, we create cross-disciplinary committees to handle cross-disciplinary issues. I think bringing that diversity of perspective to a conversation is really important. What we found is that people bring different perspectives to a situation, depending on how you're participating in that care. Some feel they are called to be more stewards of the process and some feel they are called to prevent more bad things from happening. So whether or not we're talking about genetic testing or a NICU event or an end-of-life event, it's our job to empower people with processes and support that will discern care in a quality and supported way, instead of a protocol way. We teach more about process than protocol.

Lynn: Your organization had people join because they had some enlightenment or vision about what they want to do. For the most part, academic and medical schools are not the first place to innovate and challenge, notwithstanding some of our local ones that are more entrepreneurial and progressive. I think you're right, people are being trained the way we were trained. I think that is a challenge to be in a large organization where you can have pockets of experiments and innovation, and can take people that want to move to a different model and want to innovate and experiment and you have to translate that to others. Physicians aren't trained to work in teams, yet. I think there are people doing that locally in certain organizations around town. I think Nashville, with all the different health care organizations and companies and academic centers, there are labs to do those sorts of experiments and learn, but that's not widespread and it will be a challenge for an organization to say 'I've got to flip that switch from fee-for-service to value'. There's not a good road map or play book for them to do it. There's no training and education for the providers to get it done.

Jeff: Data is very powerful. Jason made this point earlier. As we prepare, wait and see, the infrastructure to collect the medical informatics material of what are risk factors that identify the high-risk patients for a poor outcome or even a futile outcome have been helpful. Physicians are scientists that are wrapped in compassion for their patients. If you present them with the attributes of a futile outcome in a patient and know they want to do what's right for the patient, then we need to focus on the patient's comfort and dignity rather than on a heroic effort. Once you have the environment of care in which to provide that, you can be impactful. We're dealing with 50 years of tradition. That change management will occur slowly.

Lynn: It is important for physicians to see data on their own performance. There's been a huge void in that type of feedback. As a practicing physician, my feedback was pretty anecdotal, whether the patient was doing well or not. No one was accumulating the data to tell if I was doing the right things upfront and what really were the outcomes; and, more importantly, how they compared to someone else's outcomes. Physicians don't get that data, maybe in the hospital or maybe feedback from a payer but it's a very limited slice of what we're doing. I think that's going to be one of the drivers, if we can get the data and show the physicians their performance as compared externally, then people's behaviors will start to change.

Victor: I do think evidence based medicine is a great example of the challenge we have in health care in the United States. Nobody's teaching better physicians than we are in this country. Nobody's getting better health care than we are in the United States. We've all read the articles. We're very fortunate in this country to have access to this type of health care by multiple providers. Evidence-based medicine is

a challenge, and will continue to be a challenge until the health care system evolves.

Edwards Deming was the master of eliminating inconsistency in manufacturing, and he tried to turn that ideology toward health care in the 80's and we didn't accept it. Part of the reason why is because we as physicians believe we take better care of patients than other physicians do. When you look at MS-DRG (Medicare Severity Diagnosis Related Groups) data you will find patients with the same diagnosis who will have had 10 different physicians who treated that patient 10 different ways. And, that's part of the driver of cost. That's why you have to have the complicated conversations with physicians and try to get them to understand that there generally are not 10 ways to treat that patient. It's a very difficult conversation to have. And, were doing a better job now of taking care of patients than we ever have, and I think it's getting better every day because at the end of the day we're all focused on doing the right thing at the bedside. Are we perfect? No. Are we human? Absolutely. But, no one comes into work each day and says 'let's see how we can not improve quality of care today.'

Again, I still believe that what we're doing around 'pay for quality care' makes a lot of sense.

I think we will continue to evolve as a health care delivery system in this country and be second to none, which I believe we are now.

Carol: How are you using technology and infrastructure to move in the direction of value-based care? At Lumeris, we believe in full transparency and our customers do too; our technology analyzes all lab, pharmaceutical and medical content and then presents the physician's performance against his or her peers. How do you incorporate the concept of evaluating physician performance against best practices in their market? How do you overcome the fact that many systems in effect today are internally focused within the four walls of the hospital, plus maybe an associated ambulatory setting?

Jeff: We've invested a significant amount in the technology and infrastructure to measure that. Who is the audience or consumer of the technology? Is it the employer, the patient or the physician? If you look at the physician level, you can look at overall physician performance, across service lines, across hospitals, across markets. How is that benchmarked? Is that benchmarked to reflect that we don't want any program that's less than top 10 percent? Benchmarking in a particular market and everybody's a laggard but I'm beating my three competitors, but the outcomes are in the bottom quartile, that's not to the advantage of the patient. You have to take each of those technologies and look at the provider, look at the hospital, look at the market and look at the service lines and then provide appropriate benchmarks. It's clear that the employers and payers are looking at claims data and making decisions about that. The claims data is high level. You can't get under the hood and see how to improve the outcome. I always say this is like walking up an escalator. If all of us around this table are doing our jobs well, we're all looking forward. What's good today will not be good enough five years from now. Physicians should expect that, hospital providers should expect that and consumers should expect that. The data that's available to the public, though, I love that. The consumerism is a good thing. But, some of the publicly available data is dated and doesn't tell the whole story. What consumers will have available to them over the next decade will get better and better.

Lynn: The data we have may be by doctor, by service line, or national registry. We participate in a lot of those, and setting goals compared to national benchmarks is a good thing. But, for the consumer to internalize and make a decision on the data is difficult. There's a whole lot of information out there, but is it information that is actionable for decisions? That's where it becomes challenging.

Carol: Does that come back to the physician-patient one-on-one relationship, since they are not going to digest that data?

Lynn: Yes, but then I go back to my previous thought that, as a physician, I may refer to people I thought did a really good job. But, I didn't have data to prove it unless I have a patient who comes back and says they had a bad experience or complication. For the most part, I didn't know if I sent someone to a surgeon and what his complication rates or mortality rates were. That's where the networks become more powerful, and the data becomes more powerful. If you're within a network and you knew where you could send patients to a facility or clinician that had data to suggest they had better outcomes at a better cost, then you could get some synergy and people would start changing their behavior. If the data is transparent and I am not the best provider, I'm going to look to change what I'm doing because I've got stay in business. So, I'm more likely to change if I'm understanding people are making decisions based on some objective data.

Jason: We found this area fascinating. Most of the data we're interested in, other people aren't interested in. What we are hearing are requests for technology and information around, 'I just got diagnosed with cancer and I hear this juicing program is really effective; or Do you have a stress reduction program that I can virtually get on and participate with in the afternoon?' We're looking at the whole Internet of Things arena. We know that if you don't open your refrigerator by 10 a.m. that's a problem; if you don't go out during the day that's a problem. Most people are asking how do I stay at home longer? I don't want to go to a facility for my end of days. I don't have a caregiver, is there a partnership with Uber so I can get to my doctor's office? I think we are getting more and more consumer-driven. People are more engaged with their health, but they're solving their problems without us. I think we as facilities and providers need to increasingly build an eco-system that includes many non-traditional players that continually deliver what patients want.

Carol: Jason, you already have a high-performing network that includes effective patient engagement elements, but this might be harder to accomplish for larger systems that haven't narrowed their network. Once they find themselves in capitated contracts, they will have more impact.

Jason: I think we have a high-performing health system, and I think we find very few bad providers. And so I think what we've got to do is transition from thinking about people as patients to people as people. They want to think about themselves as patients as little as possible. So, I think that's one of the big transitions for us as an industry. I think consumers are going to drive that change for us. We work with over 250,000 people all over the country, and that is true wherever we go.

Victor: I would submit to you that more than patients or people providing that change, employers will provide that change. They're ahead of us. We're nibbling around the edges of the whole issue of technology and data, and we have a lot of work to do. We're all searching for the right way to effectively and consistently manage the data around the quality of care and share it with providers. That will evolve too. Employers are ahead of us. There are employers that won't employee you if you smoke, or if you're chronically obese. Many think that's horrendous that employers can discriminate against you. People are being tested for tobacco each year. If you use tobacco, you will find your premiums go up. They're looking at providers and saying you have to meet a minimum expectation around quality of care, especially if they're self-insured employers, or we're not going to send our patients to your hospitals or affiliated physicians. They're saying to the integrated delivery systems that if you can't prove that you're providing good quality of care in a consistent, pragmatic way and show us data that we can understand, we're going to turn our business somewhere else. We're going to take the best care of our employees. And, we're also going to hold our employees accountable for their role as health care consumers in their health.

Jeff: How do you define the quality? Because if I'm an employer or a plan, I might define quality based on consumption metrics or utilization metrics. If I'm a physician or a provider, I might look at outcomes such as the five-year disease free survival rate for breast cancer. That might look to an employer as an unfavorable metric because a particular physician has a higher cost per utilization member even though their outcomes are different. To a patient, how they define quality may be defined around experience. That care is that you take the time and listen and hear what's important to me. A physician may say 'I did a great job of curing them of cancer.' So how we define quality has to fulfill all of those dimensions in order for us to really fix the system.

Victor: If we're talking about data, I don't need Jeff or Lynn to sit down with me and tell me if I continue to use tobacco, I'm going to increase my risk for cancer. We don't need a whole lot of data for that. We know if you smoke, you have a higher incidence for cancer, lung disease, Chronic Obstructive Pulmonary Disease (COPD). We know if you chew tobacco, you're going to increase your chance of some form of cancer. Employers recognize that. We don't need any more data to recognize that. That's an easier discussion to have than what Jeff's talking about in terms of 'how do you measure quality of care?'

We don't need a whole lot of data to discover that. We need to know how to measure quality of care. This is a very difficult discussion for us to have and get our heads around, let alone the health care consumer who just wants good quality care and someone to treat them with respect and kindness; which by the way, they should get everywhere they go. The reality is there is more to it than that. And, to say I want higher quality care as a health care consumer and I want it at a lower cost, isn't getting to the issues that are driving the success and lack of success in our health care system.

Carol: In conclusion, we all agree that more utilization is not better utilization. How do we get to the right care at the right cost? It will take time to get to the right answers, but it is encouraging to see so much innovation happening in support of value-based care.