Talking Pop Health
Transcript: Eric Tower's interview with Dr. Lee Sacks
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Eric Tower: Welcome to the first episode of Talking Pop Health. As we begin our exploration of all things podcast-related, I can think of no better way to kick things off than by having a conversation with Dr. Lee Sacks, who's widely known as one of the creator of clinical integration and who's been a pioneer in population health since, well, since before it was called Population Health. This is a rare opportunity to hear why population healthcare is important, understand what challenges we face and get a sense of where health care delivery in America is headed. Welcome, Lee. Can you tell us a little about your career and what you've done?

Lee Sacks: Well, by training, I'm a family physician. I've practiced in the northwest suburbs of Chicago for 13 years learning what the front line is about. I progressively got involved in management. I was the leader what became Advocate Physician Partners from 1995 until I retired in the summer of 1998. At the same time, I served as the EVP Chief Medical Officer at Advocate Healthcare and ultimately became Advocate Aurora Health with that. I was involved in everything related to clinical care in that organization as well as managed care, clinical integration, population health.

Eric Tower: What are you proudest of in your career?

Lee Sacks: As I look back I think the work we did at Advocate Physician Partners and the team that really paved the way for clinical integration both in the organization but really set a precedent and a role model for other organizations across the country. We did a lot of sharing. We put on seminars. We had a small consulting division. As I look across the country at the different ACOs there are, many of the successful ones have roads coming back to Advocate.

Eric Tower: I guess the question comes to mind, why? What were you trying to do to fix things [in health care]?

Lee Sacks: I think you'd say it was all about achieving what today we call "the triple aim" which is improving the quality of care, creating efficiency and reduce the cost and improving the satisfaction of the patients with the population that we serve. I think almost everybody that goes into health care, whether it's physicians going into medicine or

nurses, other professionals, really want to do that and we've all been frustrated by the current U.S. healthcare system. But I'd like to think that Advocate Physician Partners and the work on clinical integration started a pivot in that right direction.

Eric Tower: What's wrong with the U.S. healthcare system?

Lee Sacks: Well, it comes down to the financing mechanisms and all of the misaligned incentives and disparate interests. Historically, U.S. healthc are has been financed under a fee-for-service basis and basically that leads you to say more is better. Needlessly to say there's a tremendous amount of waste in the system and it's just fueled by that fee-for-service mentality.

Eric Tower: Sure, but there have been other attempts to address this. You've got cost containment commissions. You've got certificate-of-need programs. High deductible health plans, how do these fit in or how do they not address the issues?

Lee Sacks: Well, I think the things that you just rattled off all were trying to put guard rails or bumpers around something and at minimal success. You really need to change the foundation and it comes back to how delivery systems and individuals get paid. I think we are starting to see a shift that really goes back to the ACA [Affordable Care Act] in 2010 and change is coming out of Medicare and the Center for Medicare and Medicaid innovation, all the experiments**,** they've thrown so many different models out there, I liken it to throwing spaghetti up on the wall. But some of them are showing promise but it's also leading commercial payers and employers to do the same type of experimentation and recognize that we need a fundamental change to create aligned incentives and to get away from rewarding people for doing more. We want to do the right thing and get rewarded for doing only the right thing and generating high-quality outcomes.

Eric Tower: You've been doing this for a long time. Where did you start on this journey towards population healthcare?

Lee Sacks: You know, Eric, way back in medical school I was intrigued with prepaid healthcare HMOs [health maintenance organizations]. I actually interviewed for residencies in a couple of organizations that were closely tied to health maintenance organizations and for whatever reason that wasn't where I matched. Early in my practice career, like the second year, in the early 80's, we were in the midst of a bad recession. Not quite as bad as what we saw a decade ago but at the time it was the worst recession following the great depression. The myth that all you had to do was put a shingle out and you could build a practice was getting destroyed. We saw that

patients were migrating to local HMOs and there were more coming into the Chicago market. So a group of physicians got together and said how can we participate in a product like this. It led to the formation of a hospital physician organization up at what's now Advocate Lutheran General Hospital.

Eric Tower: You mentioned clinical integration. You also mentioned population health. Can you tell us what the difference is between them?

Lee Sacks: Let's start with clinical integration. I use a very specific definition, a legal definition. It's a structured collaboration between and among physicians and hospitals to improve the quality and efficiency of healthcare. I liken it to the foundation that you have to have. What we saw over time was following the ACA and the move to "value-based care" the term "population health" got thrown across virtually every organization and every product. Everybody said they were doing population health. The way I look at population health is that you identify a specific population, whether it's a population that you have a value-based contract for, whether it's your employees, whether it's a specific geography, and you attempt to achieve the triple aim of improving quality, reducing cost and enhancing the satisfaction of that population. That's how I look at population health, but in most cases unless you have a completely employed delivery system you need to be clinically integrated if you're serious about achieving population health.

Eric Tower: How did you get started in clinical integration?

Lee Sacks: As Advocate Physician Partners came together and grew from 1995 to roughly 1999, we were taking care of 400,000 professional service capitated lives. We did a strategic planning exercise and brought in probably 100 to 150 physicians, mostly from practicing physicians on the frontline and then in the iterative process. I remember hearing that there are three things that this organization needs to do to be successful. One was that we know that we're creating a lot of value for the HMO patients, we think we're creating the same value for all our other patients, in particular the commercial PPO which still dominated the market. So help us demonstrate that value. Number two, was help us with PPO contracts. Number three, help us with information technology. Number three probably was the hardest thing to do and it took probably until there were federal incentives to help physicians invest in information technology. But one and two came together really quickly led to what became known as clinical integration. We sat down with the major payors and we said this has to be a fair partnership that we can create values for the patients that you're insuring but we need to get something back and we started to create some value-based contracts with incentives tied to quality.

Ultimately, through a prolonged process with the Federal Trade Commission, we reached an understanding that what we were doing to fit under their definition of clinical integration but by that time we had contracts with every player in the marketplace and we had lots of data to demonstrate how valuable it was.

Eric Tower: What population are we talking about here now?

Lee Sacks: It depends. And you can define it in lots of different ways. It could be the population in a specific manage care contract. It could be your employees. It could be a specific group that have a disease that you take a value-based contract to improve their status witht. Theoretically, it could be the population of the metro area that you serve but the reality is even in a place where a delivery system has an excess market share, they're not going to be responsible for more than 50% of that population so it's not realistic to think that they could totally invest in improving the population of a specific urban or suburban area.

Eric Tower: Let's assume I want to start into population health care. Where do I begin?

Lee Sacks: I would say you need to start with structure – and that takes us back to clinical integration. Whether you need to technically be clinical integrated across disparate entities or you are all under the same tax ID in an organization, such as Kaiser, you need to have that same infrastructure. You need a governance structure. You need infrastructure in terms of information technology, electronic medical records and databases. You need a compensation system that supports the goals. You need transparency. We found that if you can share outcomes with providers, they tend to want to improve. Everybody thinks they're an A-student and wants to demonstrate that. You need constant feedback. If you have those things in place you're going to move in the right direction to improve the health of the population and at the same time create efficiencies that reduce the total cost of the care.

Eric Tower: Do you need patients to cooperate with you in this process?

Lee Sacks: It's helpful to have benefit plans that align patients with a delivery system. The reality is that not all patients are going to cooperate but I think that if you're doing this well, you're going to have a delivery system that's attractive to patients most of them are going to be happy to cooperate. I think all of us who've had an experience as a patient understands how frustrating the health care delivery system can be. How hard it can be to navigate it. How you can get caught between providers or lost in the shuffle and if those things

start to go away, patients are going to be much more cooperative and amenable to what their providers want to do.

Eric Tower: How would you characterize the payor attitude towards population health?

Lee Sacks: There's a lot of lip service and good press coverage about what they're doing but the reality is that I've never found payors who've been able to really improve the health of a population other than partnering with a delivery system and creating the right incentive. The reality, in my experience, is that most of the time the incentive has still been stilted towards the payer. Whether it's some of the Medicare shared savings or commercial payors. When you factor in the cost of additional infrastructure, additional administrative expenses to meet their needs, the savings that come back to the delivery system frequently aren't even enough to offset the additional cost and yet the payer reaps some of that benefit with that. It's only when a payor is willing to globally capitate and create a beneficial design that supports that a delivery system that can reap the real benefits of being successful in population health.

Eric Tower: So another way of saying it might be: payers can't medically manage patients so they should just get out of the way?

Lee Sacks: I would say it exactly that. I distinctly remember a meeting in 2010 with the senior leadership of one of the large payors in our market with senior members of the Advocate team and we looked at each other and they said, "we can't manage care." We said, "we're not prepared to sell insurance, but together we can do the right thing and be more successful."

Eric Tower: Let's talk about this a little bit because as we ramp up our new system, we'll call it St. Elsewhere. In pop health we start emptying out all these hospital beds, how do we transition because we've got a lot of fix costs. Where do we begin there?

Lee Sacks: Well, the reality is that it's probably going to be a gradual improvement, so you're not going to empty 20% of the beds on day one. I've already advocated that the first place for a hospital system to start is with their own employees to create a benefit design that supports the population health and use that group who tend to be high utilizers to start with. Demonstrate that you can improve their outcome and start to reduce costs and then you can use that – move into commercial or Medicare contracts to do that. I honestly think that some of the hospital-based systems are going to find that they have way too much capacity and that they can't support the capital investments that they have and they're going to need downsize significantly; and some may close with that. Between

reducing unnecessary care and the advances in technology in medicine that's leading to so many more things being done as an outpatient as opposed to requiring a hospital bed, in most parts of the country, we're going to be way overcapacity.

Eric Tower: Let's assume I dive in on this and I go get my employees in, maybe even go Medicare Advantage, Medicaid Managed Care, I've got protocols and ways of treating patients that are saving people enormous money. Don't the payors just get a free ride there?

Lee Sacks: That's good insight because the reality is most clinicians will treat all their patients in the same manner. They may not have all the same tools and data. They may not have Care Managers assigned to patients who aren't in a value-based contract, but there will be some free riding. I think if a significant part of your population is in a value-based contract and you're successful in Medicare and Medicaid, there is going to be spill-over to the commercial side. That's where, you know, having the data and understanding the impact that you're having hopefully will either allow you to restructure some of the contracts or possibly go directly to employers and say, "let's eliminate the middle man. If you're willing to commit to our delivery system, we can be 10, 15, 20% better on costs with higher satisfaction and proven top-notch outcome."

Eric Tower: So as we transition and we begin this, we've got our employees in a couple other programs like Medicare Advantage and Medicaid, how would you recommend transition in as far as private payers?

Lee Sacks: First of all, the products that you just mentioned are probably more than half of the business between Medicare and Medicaid and Medicare Advantage is going to grow probably double-digit amount year over year just because of the cost advantage with that. You know right now we're in a very record of low unemployment rate and employers are very skittish about changing benefit design or healthcare contributions. At some point in the future, there's going to be a recession and that will change. I think we all say it's a certainty, except nobody knows if it's going to be in a year, in five or ten years, but when that happens and when the labor market loosens up, there will be a lot of pressure on costs and employers will be much more open to either putting pressure on the commercial payors to make changes that will align to reduce costs and improve quality or they'll start to seek out direct delivery system contracts with that. So I think you need to be ready. You need to have data that supports that you can do it and be successful in Medicare and Medicaid in particular because in every market I know of neither one of those cover all of the costs of care right now. Taking unnecessary costs out and starting to create a margin will

help sustain a delivery system in the near term and better position you for when the commercial market is ready.

Eric Tower: I can't plunge right in and take full-cap, right? I mean there has to be a lot of data and a lot of analysis done before I can contemplate doing that, right?

Lee Sacks: Yeah, I think you need to be realistic and have a glide path, whether it's partial capitation for professional services. Whether it's some of those Medicare shared savings, some of the bundled payment programs, over a couple of years you can collect a lot of data and insight and understand who the poor performers are and where the waste is and at the same time start to create that culture. I keep going back to when I was in class probably 25 years ago and we all laughed when they put on the board "culture eats strategy for lunch every day." If you create the culture, you'll be successful. It has to be a culture of a delivery system that wants to be successful in population health.

Eric Tower: Where does the physician fit in this culture?

Lee Sacks: Physicians are key. I think they need to play a significant role in leadership because they have insight. I'm talking about physicians who truly have taken care of patients and have been in a delivery system that's focused on value with that. On-the-job learning is really important with that but it takes physicians to gain the trust and respect of the physicians in the delivery system to help them make the changes, to help them understand the data. Every physician thinks they're doing the right thing and a great job; the initial reaction to any piece of data is: it must be wrong. So you have to be able to sit down and gain their trust and confidence and help them understand what the challenges are and the opportunity to make changes to better align with population health.

Eric Tower: Sure, but every health care system has a Chief Medical Officer. Is there physician leadership or are you talking about something more?

Lee Sacks: When I talk to you about infrastructure one of the things that come to mind is that you need local physician leadership. Depending on the size of the organization, but certainly, in my experience as a Chief Medical Officer in an organization that had 5,000 aligned physicians and a couple thousand more just on the medical staff, there was no way I could interact with even a fraction of them, let alone know them and know their nuances. We had local Chief Medical Officers and local Medical Directors. One of the things I always insisted on was that the local manage care Medical Director

had to be a practicing physician who had the respect of the colleagues in that service area.

Eric Tower: So you're really talking about giving the physicians a voice up and down the organization. Not just a top-down driven voice?

Lee Sacks: Top-down is not going to work. I came to use the term that I took from my nursing colleagues: shared governance**.** Shared governance really reflected the fact that the frontline practitioners had input into the strategy and the governance and without that, you're not going to be successful.

Eric Tower: As I transition toward pop health at St. Elsewhere, is there any low hanging fruit? Where could I start with actual programs?

Lee Sacks: Most of the low hanging fruit, related to generic prescribing, has been squeezed out through benefit design but that was an area that we put a big focus on and saved multi-millions of dollars in the first few years. The next level of low hanging fruit are the very frequent chronic conditions. Things like diabetes, congestive heart failure, COPD. The issue with those conditions is that much of the savings come over a number of years. If you can demonstrate improved quality and get rid of some small amounts of waste initially, you will be in good shape. But, getting big savings in diabetes means taking care of a population for many years and avoiding serious end-stage complications. It's just an opportunity to start to impact an important segment of the population and collect data to demonstrate the improved quality of the short term.

Eric Tower: Would some other conditions be? Say, asthma, cardiac patients, that kind of thing?

Lee Sacks: Some other conditions that probably lead themselves to short term savings are the ones that bundle payment initiatives have focused on. I look at that for like discreet surgical procedures like joint replacements, cardiac surgery, spine surgery. You can even expand that a bit to back care. It's pretty well known that there's a lot of unnecessary services related to back pain and avoiding unnecessary surgery, avoiding unnecessary or prolonged physical therapy. Things like that can generate savings. Another area for commercial populations will be obstetrics. It's a 9-10 month cycle, making sure that patients get all the appropriate prenatal care and everything that you can do to avoid complications and premature birth can have a big impact both on outcomes but every day you save in a neonatal intensive care unit you start to multiply thousands and thousands of dollars with that. So those are areas that I would certainly focus on and try to create physician-driven protocols to standardized care.

Eric Tower: Let's look at the other side of the coin. What mistakes have you observed? Other entities? Or even experienced yourself in the info of population health?

Lee Sacks: Mistakes would include things like overconfidence. Not having an integrated electronic health record. Not having access to all the data. I can't quite recall the title but there is an article about five or six years ago, it was only two pages in the Journal of American Medical Association by Steve Shortell, an associate, and it was the 10 mistakes that ACOs [Accountable Care Organizations] make. It really resonates with me. It's something that I frequently share in talks. I'll say, keep this in front of you and make sure that you're not going down one of this road because they all too common. A lot of it's tied to overconfidence and as you suggested earlier, you don't want to jump in and take a global capitation or full risk contract on day one without any experience because you'll have probably a bad result financially and that will undermine the culture and the confidence that you need to go forward.

Eric Tower: Lee, what have you experienced around behavioral health and population healthcare?

Lee Sacks: As we started to look at our data, it was a real eyeopener about how behavioral health issues drive expenses. What we found was that about a third of our medical-surgical inpatients had a behavioral health comorbidity. If we could address that, we could shorten their inpatient stays and lower the total cost of care and behavioral health was clogging up the emergency department because of lack of access. So by creating a way to provide those services, and that's where technology came in, we deployed tele-medicine so that we could connect all of the emergency departments with a central hub that could be staffed with a psychiatrist and other ancillary providers who could help evaluate patients in the emergency department instead of having them sitting in the ED for 3, 4 or 5 days waiting for an inpatient bed, the prescribed medications took affect and they could be discharged home the next day and followed up as an outpatient. We also created multi-discipline inpatient rounds so that every one of these medical-surgical patients was looked on for behavioral health conditions and they could be addressed in real-time. It showed that it started to have a significant impact in reducing length of stay and reducing overall costs of care.

Eric Tower: We talked a lot about the information systems. There are a lot of different data sources out there. How hard was it to get them all to talk to each other and link them together and find actionable data and drill down on particular locations?

Lee Sacks: I'm not the tech geek, but I think my former team would kick me if I didn't say it was very hard. We had multiple electronic health records but you're also talking about claims data, pharmacy data, lab data and social-economic data about your population. We partnered with Cerner Corporation because we had a common vision and helped them create what they called the HealthIntent cloud database. Over a couple of years, we're able to put all of those disparate data feeds, I think at one point we were getting data from 50 or 60 different sources and then the challenge is to create a unique patient identifier so that Lee Sacks' lab results is for the same Lee Sacks from the physician's electronic record and the hospital electronic record. It sounds easy but it isn't because sometimes I register with my middle name and sometimes I don't and I've got a cousin with the same name – just think if it was John Smith how easy it would be to mix up records. But ultimately over the course of a couple of years we felt that we were 99.5% accurate with an identifier and with that database we could start to produce reports in real-time that showed clinicians all of the things that they need to know in terms of managing their patients as well as how they were doing with their population.

Eric Tower: So say I've got this massive data warehouse with every fact imaginable, how do I then determine an actionable intervention? How do I change care?

Lee Sacks: We used our clinicians to sit down and identify the disease conditions that were amenable to changes. Every year we would set goals for managing conditions, like diabetes, asthma or coronary artery disease, and we would set the targets for physicians to show what their baseline performance was. It used to be that they could get quarterly reports but ultimately online it became real-time so that they could see how they were performing and even with the patients that were coming in today, who were the outliers who needed special attention. Earlier I eluded to that when you give clinicians credible data, they do it right. It moves the entire population in the direction of improvement. Some will move faster than others.

The other key is transparency. We migrated to total transparency over a number of years. I think today organizations will move much quicker, but once physicians know that the results on all of the agreed-upon metrics are available to everybody else in the network and even to their patients, they get very serious about making sure that they're not an outlier in the wrong direction. With that, I can share a quick antidote, one year, one of our local physician leaders decided to put names in the doctors' lounge of those who scored 100% on our metrics. As soon as he did that, people came in and said, "well, I had a 98 or a 99 shouldn't my name be up there?" And it just told you the power of that transparency.

Eric Tower: So you've got a lot of data in your network. What happens when a patient goes out-of-network?

Lee Sacks: Out-of-network was always a frustration. The claims data lagged for a long time. We were under the delusion that electronic records would become interoperable and that we would be able to both share information when our patients went out-of-network as well as keep what was done. And that became very frustrating. It was an issue. I think that if you're serious about managing a population, you need a benefit design that really incents patients to stay in-network for everything except true emergencies or travel. Our experience was that with that type of benefit design over 90% of the care was in our network but with a loose design like regular Medicare or commercial PPO, 40 to 50% of the care was out of network. We're talking about an urban area like Chicago where there's lots of credible competition, academic medical centers and geography can be an issue. The difference between half the care out-of-network versus under 10%.

Eric Tower: So as you get all these data systems, what do you think the future holds as far as artificial intelligence and the population healthcare? Do you think that's a credible solution to a lot of issues or do you think it's sort of a little out there right now?

Lee Sacks: There's a lot of great people trying to figure out how to use artificial intelligence to help improve healthcare. I'm serving on an advisory board of a company that has a large claims database of upwards of 20 million claims. It is able to predict which patients are going to be expensive for the next 12 months. It's pretty impressive with its high level of accuracy. The next iteration is, of those patients, that it can determine which ones can benefit from an intervention to alter their course which will lower the cost and improve their care. I think we're going to see a lot of opportunity with large data and artificial intelligence.

Eric Tower: Can data do it alone?

Lee Sacks: No. One of the reasons I was asked to join their advisory board, alongside a few other clinicians, was with the reality that you have to be able to interpret the data and you have to understand what's actionable and what isn't with that and obviously that's going to change over time as there are newer medications, there are newer interventional procedures with that. But you have to leverage the science and the softer side of medicine and clinical care with the objectivity of the hard data and what the artificial intelligence engine is telling us.

Eric Tower: With data being so important in the process of clinical integration and population health, are there any lessons that you've learned around how to scale inoperability, how to get all that data together in one place where it becomes usable?

Lee Sacks: Eric, I think in hindsight that's probably one of the most important lessons or bitter lessons that I've learned. My former organization grew up with multiple vendor partners and merged in different medical groups, the ambulatory record, the non-employed clinical integrated physicians and another product in the hospitals. In spite of that, we did a really good job of achieving our goals and ultimately created one cloud database that had all the information. From a patient perspective and from a frontline clinician perspective, having access to all the relevant clinical information in real-time really differentiates you in terms of avoiding duplication. For a long time we honestly felt that there would be true inoperability much like all the banks. ATMs will work regardless of what bank you're with. It isn't close to happening and I'm not sure it's going to happen in the rest of my lifetime. In hindsight, the benefit of having one vendor partners that can provide in and outpatients and home health services all under a single platform really differentiates you. You look around the country at the organizations that are really can become premier and successful in population health and that's the key ingredient. It's not an absolute but it certainly makes it a lot easier and if you're somebody or an organization that's just getting started now, I would think really hard about getting alignment with an electronic health record that's across the entire continuum.

Eric Tower: How would your answer differ if it was the same EHR [electronic health record] providers, epic or what have you, but different builds? So we've got St. Elsewhere and St. Nowhere and they combine and they both use one or the other of those and you've got to adjust it. I mean they do have different builds, they scrape different data. Just what do you think about that?

Lee Sacks: Having different builds or different instances of the same vendor, we see that even in modest-sized systems that have had acquisitions that one part of the system is on one instance and another is on a different one. That's probably second best to have one instance across the whole organization.

Eric Tower: Let's look to the future here. Shifting gears, slightly. What do you think is going to happen if the Affordable Care Act is repealed or invalidated? How is that going to affect pop health?

Lee Sacks: It's a frightening and fascinating conversation to have. I mean, there are about 20 million people who will lose coverage mostly through the expansion of Medicaid and that would be very

unfortunate. It would create a lack of access for a lot of people and probably would undermine a lot of plans that are focusing on early Medicaid managed care. With that, needless to say, from the delivery system perspective, it creates a lot of bad debt and probably will greatly increase emergency department inappropriate utilization because that will be the only place they can get access. The commercial marketplace probably won't have as a dramatic effect. One of the key things that we sometimes lose track of is getting rid of the restrictions on preexisting conditions from the Affordable Care Act. That would be a shame because what I used to see was that people would postpone retirement or stayed in a marriage where a spouse had access to employer-based insurance because they knew they couldn't buy a policy in the individual marketplace because of their preexisting conditions and it would be exorbitantly expensive. The irony is that - I've been on a soapbox about this in other places – this is in spite of the Affordable Care Act. They never dealt with preexisting conditions for Medicare. In that, if you sign up for a Medicare supplement or Medicare managed care plan and you decide to change or you move to a different geography and you need a new plan, you suddenly get rated with preexisting conditions. Your base Medicare would stay the same but the attractive plans, like Medicare Advantage, are affordable but if you would switch while having an existing condition it would become much more expensive. That's kind of below the of the radar screen for most people until it happens and then you go, oh my gosh I can't afford healthcare anymore.

Eric Tower: I've got to admit that's a new one to me. Interesting. Regardless of what happens with ACA, you know, what do you think is going to happen in population health care, let's say over the next five years? Where do you see things going?

Lee Sacks: I think it's going to get more sophisticated and more successful in terms of achieving the goals of higher quality, lower cost and a better patient/ consumer experience. I see that it's ultimately driven by the marketplace, that there's going to be incredible pressure by the purchasers of health care at a lower cost. There are all these disruptive innovations and companies that are looking to take a piece of the health care dollar. The reality is that health care is consuming over 18% of the GDP. I can't count that high, but it's a huge number so if you can disrupt it and make a profit on a half of percent of that, that still is a huge number. You'd probably be in the Fortune 500. So, there's all kinds of investor money and private equity venture capital looking to do those things and ultimately many of them will fail, but some of them will be successful and help advance the ball forward on population health.

Eric Tower: Sure, but if you were to do population health, you know, a lot of times don't you have to cover a significant geography? And, there's more and more feedback, like almost background noise. When providers do get that geographic coverage, will rates go up? How would you respond to that?

Lee Sacks: You know, there certainly have been publications about how provider consolidation leads to higher costs. I think that most of those studies predate serious efforts in population health and value-based purchasing, but as long as there's some competition in the marketplace and the pressures of the payors, whether it's an insurer representing self-insured employers or employers going direct to the marketplace. If there's a credible organization that can take on the risk for both the clinical risk and the financial risk for managing a population and do that better than others in the marketplace, they're going to grow their market share and the competition will help keep the pricing reasonable. Just in the last couple of weeks there's another big paper that reaffirmed the data that says there's a big 25% waste for the U.S. healthcare system. But, just think if you could take 10% of that out over the next 5 years and keep costs flat, you would be incredibly attractive because today everybody is seeing that healthcare costs go up more than inflation and it's to the point where it's really crippling economic growth and the ability to compete globally.

Eric Tower: Well, do health care costs rise faster than inflation? Because I know a lot of providers who say, you know, they're bleeding money. They would tell you they're not making much money at all and they're not increasing rates. They make less every year.

Lee Sacks: Well, when I say health care costs are going up more than inflation, it's what we're spending overall in health care. And it gets parsed in different places. Whether it's the profits of the insurance companies with the profits of the pharma and device manufacturers, it's not spread equitably with that…the other thing I think there have been repeated studies that show based on Medicare when congress would freeze physician reimbursement, the volume would go up. So, if payors are signing contracts with hospitals that are freezing rates or having rate decreases, I suspect you'll see unbundling of services and a push to do more discretionary services to make up in volume what you lost on unit pricing. That's the unfortunate downside of the fee for services, that it creates the wrong incentive.

Eric Tower: Let's assume I get my St. Elsewhere health system up and running and I'm doing population health in a geography where things are going well, but the other providers in that market are a traditional fee for service. How do you think that those other systems would

respond to that? I mean, they still get paid on their unit volume. I can't see that that would necessitate a change in behavior by them.

Lee Sacks: I think you'll see a change in behavior is when St. Elsewhere starts to grow significant market share because they're creating more value for that marketplace. If their volume of the population served starts to go up and the other competitors start to see that they have fewer appointments, fewer surgeries and some more empty beds they'll wake up. Now, I think you may start to see that in some markets. Unfortunately, there's many organizations that are going to bleed fee-for-service until there's nothing left and they run the risk that they won't be able to turn on a dime. I liken it to musical chairs, when the music stops not everybody has a seat and if you're a physician group or you're a hospital, you want to make sure that you're looking far enough forward that there's a seat for you.

Eric Tower: So, where do you see the tipping point being?

Lee Sacks: I think Medicare Advantage is going to become the lever that creates the tipping point in the next few years. The reason I say that is that there's a decided cost advantage for individuals that sign up for Medicare Advantage versus regular Medicare with a supplement. These days most retirees don't have insurance from their employer anymore. That's a benefit that's gone by the wayside in the last generation. So, they're going to be dependent on Medicare and it's an individual choice and you get to make it every year. Just judging by the amount of marketing that's going on today because we're in the middle of the open enrollment period, it's becoming very consumer-driven. I think 10,000 seniors are aging into Medicare every day in the U.S. and that's probably going to go on through the next decade until we get to the end of the baby boomers. In many markets that's the only growth opportunity where populations have been fairly flat and stagnant, so it may start to differentiate and I think that employers will take notice and want to have the same type of options with more restrictive networks that create value as they feel more cost pressure. They'll offer a broad network that they've traditionally done, but the cost differential for their employees is going to be so great that short of the, you know, highly compensated senior executive, nobody's going to, you know, rationally think that they would want to spend their money that way.

Eric Tower: You seem to be hinting that consumers will give up choice in return for reduced costs. Is that what you're saying?

Lee Sacks: I think we're going to see that. Obviously, there has to be a significant cost difference and giving up the choice means possibly leaving somebody or some organization that you're familiar with and instead going to one that you know is very credible and will be able

to meet your needs with that. I think we've seen that in the airline industry, which is very price sensitive and clearly nobody wants to get on a plane that they're not comfortable on. The health care market will continue to evolve over the next 5 to 10 years and move more towards the real market place.

Eric Tower: So how do you see that affecting hospitals, such as Children's hospitals or maybe even broader, the academic hospitals?

Lee Sacks: I think transparency and data is going to take the halo off of some of those places. They tend to be very expensive. Some of them offer very unique services, but there's also a lot of waste and unnecessary care and no focus on efficiency in many of them. The ones that are strategic will figure out that they can partner and be in a network where they can add value and get quite an area types of referrals, but there'll be a shakeout there as well.

Eric Tower: Do you think that one strategy for St. Elsewhere as it grows, maybe it doesn't have to push into that high-end care. It doesn't even have to provide it. It can just acquire that on a unit-of-care basis itself, through its own plan?

Lee Sacks: It's very possible. It depends on the market, but if you're in a market like Chicago where there's seven academic medical centers, there's probably a lot of competition for high-end quaternary care and you could probably buy it on the market place or negotiate a favorable, financial arrangement knowing that your partner knows that there's all kinds of alternatives if they can't meet your needs. If you're in a more rural geography where there isn't a lot of access to quaternary care you probably want it to be part of your system because otherwise you may become a price taker and it could become exorbitantly expensive. I mean there's reality in terms of how far it's realistic to transfer patients and to have them to move, especially for things that aren't elective.

Eric Tower: If you look at ordinary care, the simple stuff, will people move for that? You know what I'm getting at here?

Lee Sacks: Yeah.

Eric Tower: How far will patients travel for care?

Lee Sacks: I think we're starting to see some real experiments. There's certainly a number of national employers that were trying to send elective cases like joint replacements or spine surgery to Centers of Excellence and it started off with one center: Cleveland Clinic, who has a lot of notoriety with contracts. Now, it seems to be more regional. You might not have to go two-thirds of the way across the

country from the west coast, but they're looking for five or six regional centers that will adhere to similar protocols with that. There's only a handful of conditions that lend themselves to that, but within a geography I think you're going to see hospitals evolve to specialize in different areas. It's part of St. Elsewhere. There may be a Center of Excellence for obstetrics that could, depending on your population, could do ten or fifteen thousand deliveries and be really focused on, you know, everything related to obstetrics and another center that focused on minimally invasive surgery or orthopedics. With that, it's the old adage about the focus factory. As a physician, it just hurts me to think that a lot of the work I or my colleagues do could be likened to a production line, but it really is if you want to get variation out with that and having the same team doing the same thing over and over again is the quickest way to produce your unnecessary costs and to drive high quality outcome.

Eric Tower: Another way to frame this might be to say, are you telling me that population health is functionally commoditizing medicine?

Lee Sacks: I'm going to disagree a little bit with that because when I think about commoditizing I think about picking and choosing and buying individual items like on Amazon or walking into Wal-Mart and there's five different shampoos with their prices on the shelf and you decide what you want to do. At the end of the day, a lot of those choices have to be made by the delivery system and the providers and they have to be made in advance, because things evolve in real time. If you're having a heart attack that's not the time to be shopping. In looking at data you need to have trusted that the organization that you've trusted your care to has done that and has outstanding care to deal with the heart attack whether it's the emergency department, the cath lab, if you need to have a stent or if you need to have surgery. It could be likened to a commodity, but it's on a much larger scale.

Eric Tower: Let's be clear here, in the case of a heart attack, you're going to the closest available ED and that's a function of plan design. You can't possibly imagine that under population health people would say, oh you can only go to St. Elsewhere's ED because there would be times when you just have to go to the closest place and that's priced in.

Lee Sacks: No. That's true and there's a handful of conditions that are time sensitive, like heart attacks, strokes, and other major trauma. Everybody will agree that you need to go to the closest place to have the best outcome, but there's a next level of condition that still evolves pretty quickly. Again, you want to pick the system that's designed to provide the best outcome that and efficient price as opposed to saying that you want to have surgery at St. Elsewhere,

but will do follow up at St. Peters with a different group of therapists. Most patients won't have the sophistication to be able to manage that in the interaction between the various caregivers. That's where you want to rely on a truly integrated organization.

Eric Tower: That makes sense. How do you think improved technology is going to affect healthcare in the coming 5 to 10 years?

Lee Sacks: I think we're only limited by our imagination. As I think back over my career in medicine there have been so many advances related to technology and pharmaceuticals that have eliminated, you know, diseases or allows you to manage them and has eliminated expenses and dangerous procedures. And that's going to continue. So what does that mean? It probably means fewer inpatient days. With that, much more care at home, many more procedures done in ambulatory settings whether it's a surgery center, a cath lab or an outpatient GI lab and the level of sophistication of those procedures is just going to continue to grow as the devices become more sophisticated, as clinicians become more comfortable using them and having fewer complications all determine that it's safe to do things on an outpatient basis that we didn't dream about 5 years ago.

Eric Tower: How much of a hurdle are insurance requirements or employer preferences for geographic coverage and network design?

Lee Sacks: It's been a challenge. I think some of this is because of the lack of data and listening to loud voices saying that I need St. this and St. that in the network, certainly especially when its senior executive, with that and certain market places, you know, there's neighborhoods where the senior executives live and the expensive organization tends to be put in network because historically they have a reputation. I think that's going to change with more data and transparency on cost and quality and break through some of the myth. Everybody wants to have the best outcome and I'm generalizing, but in most cases it's not the places with the fancy reputations that drive the best outcome. When you factor in the difference in price people and employers and the benefits team at the employers will make more rational decisions, but we need transparency.

Eric Tower: Under the current system, do you think competition is working and healthy? A traditional economist would say, the more healthcare providers we have in a given market the cost will be lower and everything will be better, and people will be able to choose. How do you view that?

Lee Sacks: I mean the reality is that for most people the price is irrelevant because of their insurance, even if with a high deductible plan, there's certain elective items that are price sensitive, like outpatient imaging and lab testing and there are entities that have come into market that have dramatically lowered the price there. But, the real costs are the patients who exceed that deductible with the chronic conditions or the catastrophic conditions and once you exceed your out-of-pocket, your immune to the price even if you could know what hospital or system was charging. It's all the same, you've paid your premium. With that, so it's more discreet networks evolve and with insurance products that have pricing that you need to that network. That's where the decisions will be made and that's where competition will help lower the cost. I think you start to see that in Medicare Advantage many of the plans have very discreet networks and the different benefits and different pricing and if they continue to add benefits as part of the competition there it will become more attractive to more and more people, and the fact that every year there's open enrollment so if you're not meeting the needs of your population they can leave you the following year and move somewhere else.

Eric Tower: So, how does network size correlate with the ability to take risk and total cost of care? You know, again a lot of economists would argue that as health systems get bigger they just impose more costs.

Lee Sacks: I think what it's important if you're going to take risk for a population is that you never have to be right sized to be able to provide access to all the necessary services. In other words, you have enough primary care physicians so that with a reasonable workload they can meet the needs of the population that you're at risk for and then have access to the appropriate specialty services. In the case where there's something that's fairly uncommon it might not make sense to have that in your organization to be able to contract for it So, I think it's less about skill and geographic coverage than it is about matching the population. Obviously you want to have geo access as well. It doesn't make sense to take risk for patients who are 50 miles away from the closest site of care. That's not going to work well or meet your needs. Your out-of-network costs are going to zoom up and the patients and the providers will be very frustrated.

Eric Tower: What role does individual responsibility play here?

Lee Sacks: My physician colleagues will always talk about the patients who don't follow directions or who are not in compliance. There's always anecdotes and you can tie that into individual responsibility. I always try to turn it around instead of saying the glass is half empty and half full, but it's incumbent on the physician or the delivery

system to figure out how to engage that patient or the patient's family or if they can to guide them to a different provider who may be more capable and sometimes that means, you know, finding a good match for ethnicity or race because they'll be more attuned to some of the unique characteristics. There definitely were patients when I was practicing that were a handful who really need to see a different doctor. With that and probably having a direct conversation sooner rather than later would do everybody a service. At the same time, I had patients who came to see me instead of their same doctors who I thought were very good. I realized that they came to the conclusion that it wasn't working for them and that they were going to try our practice and figure out if we could better meet their needs.

Eric Tower: How do demographics and social economic status factor in the population health?

Lee Sacks: Well, we're certainly realizing more and more that social economic status and things like food deserts play a significant role in the health of a population and drive healthcare costs. Organizations that are doing population health and taking financial risks are going to more and more invest in some nontraditional things outside of actual medical care whether it's air conditioners for asthmatic patients or making sure that there are three square meals a day as patients are rehabbing from surgery. These are trivial expenses compared to the costs of some of the complications that happen now with patients that are disadvantaged.

Eric Tower: I guess if you take that to its logical extension, where does population health stop?

Lee Sacks: That's a good comment. It's the continuum. There's lots of factors that impact health. One of the things that I've felt, become more and more aware of is I've watched family members age, is dentition. Many, many seniors have lost most or all of their teeth and have a hard time eating solid foods and proteins and it just leads to a spiral downward. So investing in preventative dental care and possibly providing dental benefits under Medicare which, up to now, other than in Medicare Advantage Plan, there's no dental benefits, might be a really good investment that could avoid other issues. But you have to think about this really holistically in terms of everything that impacts a patient.

Eric Tower: At this point we're going to wrap up. I want to say thank you to Lee. If anyone has any questions please feel free to send me an email to etower@thompsoncoburn.com I'll do my best to reach out to Lee and get you answers since he's sort of the main event here. You are the event. And thanks everyone for listening.