Talking Pop Health
Transcript: Eric Tower's interview with Amit Vaishampayan of BKD
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Eric Tower: Welcome to the Thompson Coburn Podcast Series Talking Pop Health. I'm Eric Tower, a transactional health care attorney at Thompson Coburn. Our last speaker was Debra Geihsler, Founder and Principal at Activate Healthcare. We dissected the ins and outs of employer-based health plans that provide a high quality of care at a lower cost with greater patient satisfaction. In this episode, I'm delighted to welcome Amit Vaishampayan from BKD. Amit will be discussing compensation and culture in population health. Amit, welcome to Taking Pop Health. Can you tell us a little bit about yourself?

Amit Vaishampayan: I'd be happy to. First of all, it's great to be here. Let me start back in the beginnings, so to speak, I started my career in accounting and quickly realized that that wasn't my calling and so I fell into health care consulting. I spent several years learning the foundations of health care and health care consulting really in the perspective of a business valuation analyst. So looking at all kinds of deals in the health care space and there were plenty of deals to work on at the time. From there, and I was with Huron Consulting Group as I engaged in that kind of work and really, started to build the foundation for what would be a great launching point. After Huron, I was presented with an opportunity at ECG Management Consultants which is a boutique health care management consulting firm. And at ECG my specialty areas were really both the business valuation but then looking at the relationship between providers and health care organizations in the health care space. And so, what I was able to gather and what I was exposed to was really the relationship or sometimes lack of relationship between the providers of health care and the organizations that engaged those providers. The problems with alignment and the problems can be financial in nature, or strategic in nature, operational in nature, etc. But it's really understanding those relationships, aligning its incentives which many times comes in the form of compensation and other incentives and then to look at it from a regulatory angle or regulatory perspective. So just recently I joined BKD as a director in their physician enterprise consulting practice to help and build and grow their robust health care performance advisory practice.

Eric Tower: Through your career, you've got a lot of insights into the health care system here. Are there any particular areas that you feel present an opportunity for improvement?

Amit Vaishampayan: Certainly. There's a lot of low hanging fruit. There's also some pie in the sky stuff. Financially speaking I think it's not a great secret that the state of health care is in disarray and that a lot of organizations around the country are really dealing with and having to overcome some significant financial challenges. So that's where my specific world starts. But there are certainly other areas as well

Eric Tower: So your real focus is on transforming enterprises towards population health with a focus on sort of the financial? It sounds like you're helping them get there without going bankrupt, right?

Amit Vaishampayan: That's exactly right. If we think about the financial piece. So, compensation, aligning incentives, making sure that you understand the disincentives that are created by a system. There are certainly operational, strategic, and even IT-related elements to those but I think that a fundamental starting point is really the financial aspect and when you're looking at a hospital, their biggest expense line item is really what they're paying their providers. So that relationship is extremely important to analyze and assess on an ongoing basis.

Eric Tower: So how do you go about that? How do you transform an organization's culture which is probably unit-based, to embrace population health?

Amit Vaishampayan: It's a great, great question. I think it's really important first of all to have the conversation. A lot of organizations talk about the transition to pop health and there's a lot of talk and there's a lot of pointing fingers at systems and organizations that are taking the leap. But a lot is just talk and so not actually having population health as a priority in the culture, like integrated in the culture, is a real problem. It's difficult for an organization to get started when it's not ingrained in the culture. For example, you could have a lot of money, rather you can pay a lot of money to go and have a compensation plan developed but the culture matters more. If you believe in pop health it should be part of the compensation plan and part of the greater culture. All the stakeholders in that organization need to agree that population health is a critical and important part of not only what we're trying to do but what we're doing today.

Eric Tower: So how do you go about that? I mean, anyone can say "hey we do pop health" and they might think they're waving a magic wand and all of a sudden they're doing pop health. But it's a lot more than that, isn't it?

Amit Vaishampayan: It is a lot more than that. I would say a great starting point is, and this is obviously after getting the buy-in from the key stakeholders,

the board members, the key members of governance, but I think a lot of folks just forget that really physicians are a large driver of the actual change at these health care organizations. And so really it's getting the right buy-in from the physicians. So once you've got it ingrained in the culture, part of that isn't just lip service, it's also sitting down with the physicians and understanding how we can prioritize population health initiatives in their day-to-day. A key example of why it's failed for many is because hospitals and health systems are unfortunately tied to an old world style of compensating their physicians. As you know, a lot of the vast majority of compensation plans across the United States are based on a pay-for-unit system. And what that does is – rather what it's done is, it's created incentives and disincentives. So in a population health world when you're trying to care for a population and really the focus is on triple aim and it's on the wellbeing of the patient, etc., what's difficult is if the physicians are compensated and incentivized in a system doesn't reflect the goals and objectives of triple aim, it makes it really difficult to get their buy-in and change behavior in an impactful way. Part of that is realigning the incentives. Part of that is really for all of the stakeholders in the organizations to come together and say these are the goals and objectives under population health and how do we translate these kind of things so that we can get behaviors out of our physicians. And we can incentivize those behaviors with a real financial opportunity and make it so that the physicians are more and better engaged.

Eric Tower: Let's just make sure that we have a common understanding. Can you explain triple aim really quickly?

Amit Vaishampayan: Happy to do so. Triple aim encompasses patient satisfaction. It covers the cost of care as well as the quality of the care provided.

Eric Tower: Excellent. Let's talk about the transformation process here. I'm a highly compensated doctor who's rewarded for a lot of procedures. As I transform my system, or as my system transforms and they add care coordinators, care management and additional team members who can take care of my less intensive needed patients and they can also hopeful redirect them from immunizations, prevent any sickness. Doesn't that take away from my compensation? And why should I support that process?

Amit Vaishampayan: What you're saying right now, Eric, is a fundamental fallacy. When you've got a system that compensating doctors for producing units, any activities that are outside of activities that are geared toward producing units take away from the compensation that the doctor is able to generate for themselves. And that's a problem because a lot of these activities that are non-unit generating, a lot of the activities that you just mentioned for example supervision of APPs [Advanced Practice Provider], helping other providers manage their patient panels, helping care for a total episode of care rather than just looking at it on a widget-by-widget basis. These are all things that

basically get in the way of successful achievement of this population health rollout. So in your example I think it's really important to basically structure the plan or the compensation in a way where it doesn't necessarily -- a doctor engaging in those activities isn't necessarily penalized for things that are actually going to eventually impact the triple aim.

Eric Tower: So how do we get around this? We're on an RVU [relative value unit] system now. A lot of HMOs [health maintenance organization] back in the day paid just a flat annual salary and that kind of thing and that was viewed as unsuccessful because the doctors didn't perform. I could pay a flat annual salary today and how do I make sure the doctors are actually doing some of the things you expect them to do?

Amit Vaishampayan: Yeah, that's a really good question. I think the starting point here is really data measurement. I think it's very difficult to redesign a comp plan that aligns with the triple aim and the population health initiatives if you don't actually know what the outcomes are going to be. So you almost have to start with the outcomes and then think about the data that feeds into those outcomes. A, you need enough data. You need quality data to do those kind of things. The way that it works right now, for example, is docs are paid let's say a set salary, $500,000 for the year. And perhaps some of that is a quality piece but you don't really know, there's really no rigor behind the measurement of a quality piece and so this is "easy money" for the doctors and the health systems and the organizations have a hard time thinking through that as well. Really what needs to happen is the physician's compensation plan needs to evolve in a way that also reflects the initiatives and priorities of the organization. If the organization needs to do a lot of upfront work to get the physician to interact with the care teams, etc. than a transitional comp plan should be enacted, it rather should be taken a look at to incentivize the physician to do those activities not necessarily into perpetuity, but it needs to reflect the evolving needs of the organization.

Eric Tower: So when you're looking at this, where does everyone get their data? Is it -- you know if a patient leaves my system, St. Elsewhere, and they go to St. Nowhere and get a whole bunch of procedures done, how can I measure my doctor when that patient – I don't have access to that patient's records typically, information, how do you go about structuring these plans under those circumstances?

Amit Vaishampayan: It's a good question; it's a difficult question because there isn't really an easy answer that's feasible as it currently stands right now. What we need to get is greater participation from all the stakeholders. And I'm talking not necessarily the stakeholders within one organization but there's got to be an understanding between the payers. There's got to be transparency and understanding between the payers, between the health system, between the providers to share this data to achieve the greater good

which is making sure that A, you have access to the data and B, you have access to quality data. The way that the system works right now when the patient leaves a certain hospital system and goes to another, that's the end of it. And so you don't really have a continuity of care. If a patient goes to see a primary care physician -- I have worked with a whole bunch of organizations where that data, rather than fact pattern is not communicated in the right way from when that patient gets referred to a specialist in the same hospital system. There's low hanging fruit here and I think that a lot of it is coordination and communication within these hospital teams to make sure that the triple aim can be achieved. That patient outcomes is front of mind.

Eric Tower: Where do you think we start at this point?

Amit Vaishampayan: Where do I think we start? Let's see, I would say the first step is getting buy-in from the stakeholders and that the board, that's hospital leadership, that the physician leaders. I think it starts with culture and putting your money where your mouth is. Where it's not necessarily just lip service but rather it's let's set up committees, administrative and similar to essentially take a look at how do we actually start to incentivize physicians. You can't go and redesign a comp plan if the physicians don't understand what the objectives are in the first place. So there's a lot of parallel tracks that are happening at the same time. One of them at the leadership level, it's understanding what's going to be required to basically got out and get these initiatives in play. The second initiative is getting the physician bought into this both from an incentivizing them perspective but then how are their care patterns going to change. How are they operationally going to either suffer or win from these proposed plans? And then it's also engaging in conversations with stakeholders that are also the organization but still play a big part in this and so we've seen this happen as folks are setting up ACOs [Accountable Care Organizations], to your point, HMOs.

Eric Tower: How do physicians respond to being told that their care patterns need to change?

Amit Vaishampayan: I can speak from personal experience that a consultant behind a computer that's typing away and analyzing vast amounts of data, if I'm going to go back to a physician and tell them that their care patterns need to change, that's probably not going to go over so well. But physicians are actually are data-driven individuals. The only way that you're going to get physician buy-in, that you're going to change behavior patterns, is to really have an intelligent conversation with the physicians and show them that the impact of a change would be on the care outcomes. I think, most physicians out there are wanting to do the right thing. They're wanting to improve their patient's care. The way to get buy-in, the way for them to change their care patterns is through a data-driven approach where you're really getting them involved early on. You're

really getting their buy-in, not only incentives but to get them involved and to tie real financial incentives to changing those data patterns.

Eric Tower: Who ultimately has this conversation? You can generate a lot of data. Do you stand up and tell the doctors "hey, time to change." Is it the hospital administration? Is it another physician? Is it the chief medical officer of the system? Who does this? Because I just want to make sure, we want to learn how you get the best buy-in.

Amit Vaishampayan: I think it can start at the physician level but really there's parallel tracks where you've got to get hospital leadership involved and you got to get the board involved because those are the ultimate yes/no decision-makers. But regardless of whether the decision is yes or no. Let's say the decision is yes, we're going to move forward on this. You've got to be able to get the physician to mobilize and buy-in and believe in this thing.

Eric Tower: You raise a great point with the management incentives. How do you transform those? Because a lot of management teams are paid just based on straight profitability, sometimes census. There are a number of incentives in many popular management programs that I would view as being detrimental to the transformation to population health.

Amit Vaishampayan: The way that management in hospitals is incentivized right now is they actually are incentivized to push away from any major changes. A lot of these folks are really, you know, going to be retiring soon or they came into the system 10 – 15 years ago and are very use to and comfortable with the way that things work in a fee-for-service world. And so that's all they really know, but there are a lot of barriers to getting them to actually change as well. So they may be compensated in some way, shape or form on some…somehow if something…somehow tied to the census or to activity at the hospital and when they see those numbers, because of a lot of these population health initiatives, when they see those numbers dwindle and there are more empty beds what ends up happening is they start to question, hey is this a good idea. What they don't realize is that the savings, the benefits of that are, there's a timing mismatch between perhaps some of the "costs" of transitioning to population health and some of the benefits realized. You've got a lot of folks who are incentivized for short term gains and not necessarily look at the long term. So a lot of it is actually bringing awareness to why it's not working and why it's failed time and time again up-to-date.

Eric Tower: So, would you advocate flipping the switch immediately going to more of a long term approach? Or is there a transition that we need to do?

Amit Vaishampayan: There's certainly going to be a transition and the only reason is because it's very difficult for a lot of these organizations who are

really built, all the incentives not just monetary but nonmonetary incentives the way that, the way that people judge a hospital, the wait times, the number of beds, etc. I think that changing all of those things overnight is going to be very difficult and it's going to create more burdens and more barriers to the population health transition.

The majority of the goals and objectives that are incentivized right now on any given leadership's dashboard are short term in nature. Right now a minority are really long term and this is just a management problem. However, to your point, what we need to do is really think about readjusting the split between short term and long term to make it so that your incentivizing behaviors that move away from the pitfalls of fee-for-service and start to embrace the low hanging fruit that's available to pave the path forward on population health.

Eric Tower: So…I've got a bunch of salary surveys sitting here. I would argue, and correct me if I'm wrong, those are directed at more of a fee-for-service world. How do you tell people how to approach this? I mean, what compass do you use if I can't use a salary survey published by ABC, do that have to go to Amit and get a customized one or…you know, where do we even get the data to do this kind of thing?

Amit Vaishampayan: It's really, really difficult to get that data. But it certainly, there are certainly some avenues to approach. So a lot of organizations, as you know, Eric, basically live and die by these surveys. And a lot of consulting firms out there live and die by these surveys. And I think it's no secret that the surveys in and of their selves are inherently flawed for several reasons. I mean it's the best thing that people had for a long time, which is to take a sampling of what's out there and then to extrapolate that to the entire population. But, the majority of the work effort that's captured by those surveys is in a fee-for-service world. So they reflect the behaviors of somebody who wants to succeed in a fee-for-service model.

When your transitioning to population health some of those things are not going to be applicable and others are going to be applicable. So compensation in totality might be applicable because you want to make sure that physicians don't feel like they're going to be losing out on real dollars as they move toward population health versus fee-for-service. I mean they're still caring for the patient. In fact, they're achieving Triple Aim in the population health model versus the fee-for-service, but if they're going to lose any of that compensation they're going to be left wondering why are we even doing this. But, at the same time you want to make sure that whatever data that you do have available, and I think that one of the ways I've seen this is for a lot of these programs to pilot programs.

So, for example, a client that I worked in the southern United States was basically trying to make it so that team-based care would be compensated as part of their population health initiative. And what I mean by that is, okay at a physician-level how do we incentivize physicians to basically provide holistic care through their APPs, through managing patient panels, through managing a comprehensive set of episodes or series of episodes rather than looking at it on an episode-by-episode basis. And, one of those ways is through PMPM. But up until now there really hasn't been a great way to compensate for team-based care except for the different avenues that I just mentioned. But one thing that's really interesting is that. There's just been a proposed Stark waiver for a whole bunch of different services where all of a sudden those population health services where the organizations are taking on a big portion of the risk… are going to be proposed, you know, there are going to be proposed waiver to the Stark law, which has historically been a regulatory obstacle as many people see it.

Eric Tower: Sure. Let's assume St. Elsewhere, my system, is transforming to population health. You know where I would want to start at St. Elsewhere at least is I want to systematize the practices. I really want to incentivize not just the physicians, but I want to make sure that everyone's rolling in the same direction.

So I go to my doctors and I say we're going to create some centers of excellence. We're going to do neurosurgery, cardiology, maybe orthopedics, oncology – we're going to start there. But hey doctors there's going to be a significant amount of work here. How do I even begin to figure out their pay because the RVU model there is broken? The doctors in theory here have a lot more responsibility than they ever did. And frankly the viability of my entire enterprise is going to depend on successfully making this transformation and transforming our entire care process. So, you know, it really seems to me that if some photocopied salary survey is…I don't know, I just don't see how that works.

Amit Vaishampayan: You're absolutely right. Being married to the surveys is going to be a big hindrance for organizations that are looking to make leaps and be innovative and truly be impactful in the population health space. One of the ways that I have observed a client be very…one of the ways that I've observed a client be very successful at this, the situation that you described at St. Elsewhere is rethinking the incentive structure. So to your point, if a physician is purely on an RVU model or has a base salary plus RVU model, any activities outside of our view generating activities are going to take away from that physician's ability to generate income. So what my client did is really start to think about what are the activities that we want to be attended by the physicians and how do we incentivize them in ways to actually go and achieve the given objectives. So, there were two parts to this. One part was, there's some payment for the time that physicians are spending in your center of excellence model to get

the medical director of primary care and the medical director of surgery and the medical director of quality to all come sit in a room, spend two hours together – five hours together in a room and think about how they can be better coordinated. So that…there's a time element to it and that's basically paying those folks for the time and that's a carve-out in addition to whatever they're doing on the clinical side. The other aspect of it is really incentivizing them to create meaningful objectives and incentives and then achieve those objectives and incentives. And so here is where you can basically tie a lot of the incentives to achieve of those outcomes. So, for example, you can have a way to fund the pool dollars and a different to distribute that pool of dollars. If you've got 30 physicians and you've got a pool of dollars for let's say patient satisfaction you keep those physicians that are paid a certain salary and if part of that salary is at risk, but it's at risk because the way that it's going to be distributed to its physicians is physicians who are able to generate a higher patient satisfaction score or who are able to control costs while still providing very quality care, they're going to get a larger piece of the at-risk compensation. So the two components that I've went over are, there's a set time-based component which is we know that these activities are extremely important and we're going to make sure that you're made whole because we're not going to dock you for not generating RVU use during that time, but also when you generating RVU use, let's think about the quality of those RVU used.

Eric Tower: So let's go back to the – we'll call it a physician culture issue. Are you noticing a difference in the outlook towards pop health between the primary care doctors and some of the specialists or even maybe a generational outlook as between different specialists and different generations? What are you seeing and how are you helping address this?

Amit Vaishampayan: Definitely. I think that at least, and this is based on anecdotal conversations that I've had with many of my physician friends as well as my colleagues on the hospital side. But, a lot of the education and a lot of the residency training in this day and age are really getting physicians to start to familiarize themselves with the population health initiatives. So, that's not to say that a doctor in their 50's or 60's is not bought into those ideas, it's just that when they were in their 30's, 40's and 50's and developing their careers the only way that they were incentivized was really through an RVU based model. It was the more widgets you produced – the more units you produced, the more money you're going to make. So there's a fundamental learning/unlearning and then relearning that's happening in one…in a couple of generations. And in other generations it's okay. We all understand that population health is really an important thing, but the way that we're compensated is still on a fee-for-service basis. And so for those people it's helping them tie together the initiatives and making sure that they're incentivized for the right behaviors. If you don't put money where your mouth is

– if the hospital health system doesn't actually incentivize those behaviors for these young physicians, we're going to have yet another generation that needs to…that has learned something, that needs to unlearn it and then relearn it.

Eric Tower: So Amit, let's revisit the cultural issue. In many organizations we have a situation where it's compliance versus finance. How does population health care change that dynamic within an organization?

Amit Vaishampayan: Yeah, that's a good question, Eric. The way that things have historically run, there's always been a conflict between compliance risk and business risks. So, the business risk folks would say we really need to enter into this contract with these physicians because if we don't we're going to lose our trauma status, we're going to lose this program, we're going to…our patients are going to suffer. And on the flipside of the table, you're going to have the compliance people saying, well is it worth entering into this contract if, for example, we don't necessarily have the right documentation, the story, the numbers don't quite add up and we're subjecting ourselves to a level of regulatory and compliance risks that could bring meaningful harm to the organization. With population health, what the population health mindset has really done is it's no longer compliance risk versus business risk. Rather it's compliance risk and business risk and let me explain that really quickly. So, everything both compliance risk is dealing with the regulations, Stark anti-kickback and the other applicable regulations when it comes to incentivizing physicians for certain behaviors and on the flip side you've got business risk, which is just the ability of your business or in this case your health care organization to provide the care that the patients need. So, when a hospital or a health system is provided with the opportunity to get into a contract, specifically in the population health realm of the triple aims is making sure that the cost of care is, well one of the focuses is the cost of care. It's not necessarily that a hospital is going out there and trying to pay above market. We know that a lot of hospitals are already financially squeezed and pretty much all of them are having to incur huge losses and big subsidies and having to subsidize some of their service lines. And so, it's less about okay can we pay – how much can we pay, it's what's the right amount to pay given the financial impact elsewhere. So, I think in a population health setting to have the right regulatory and governance framework and controls the place is of critical importance because those things aren't just cost centers anymore.

Eric Tower: Well Amit, you've given us a lot to think about. Thanks for your time.

Amit Vaishampayan: It's been a pleasure, Eric. Thank you.