Talking Pop Health
Episode 4: Mike Englehart on the health system perspective
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Eric Tower: Welcome to the Thompson Coburn Podcast Series, Talking Pop Health. I'm Eric Tower, a health care transactional attorney at Thompson Coburn. Our last speaker was Deb Geissler, founder and principal at Activate Health care, a dynamic company aimed at transforming health care delivery through OnSite and NearSite primary care clinics. In this episode, I'm delighted to welcome Mike Englehart, Senior Vice President of Medical Groups & Ambulatory Strategy at Trinity Healthcare. Mike has built his career around leading acute care and medical group transformational strategies and establishing clinical alliances and strategic partnerships by fostering collaboration to create highly integrated models of care. The road to integrated care and population health care has a lot of bumps and I'm excited to hear what Mike can tell us about that journey. Mike, welcome to Talking Pop Health. Why don't we start off with you telling us a little bit about your career?

Mike Englehart: Well, first of all, it's good to be back with you, Eric, and I'm happy to be here to have a conversation on your podcast. Here's a little bit about myself: I've been in health care for 25 years. Actually came into health care through the revenue cycle side of the business. I worked for a subsidiary of Rush, a company called Art Venture, so I really learned health care from the business office forward; how you bill, how you charge.

From there, I was recruited to work at PriceWaterhouseCoopers. That was a wonderful experience. I was with them for just shy of five years. I did a lot of turnarounds, strategic planning, both on the hospital and the medical group side. I learned a lot. I worked for some really good partners at PriceWaterhouseCoopers.

I got a phone call to join Advocate Health care and at Advocate Health Care they were at a point where they were looking to spend less on consulting and bring in some people with revenue cycle background and operational experience. That brought me to Advocate and I worked for Advocate for almost 12 years.

I had a stint away where I worked for the Sisters of St. Francis, now called Franciscan Alliance.

My last tour of duty with Advocate came when I got into population health, which I mentioned. That's where I imagine we'll spend a fair amount of our time. I worked for Dr. Sacks and Advocate Physician Partners. After serving in that capacity for just shy of three years, I was recruited to be the CEO of

Presence health and that was a financial turnaround and we were able to successfully merge Presence into Ameda Health in the Chicago market.

And then from there I took a little bit of time off and was recruited to work for Trinity Health, focused on medical group practice, total cost of care and ambulatory strategy, so I've been Trinity for just over a year.

Eric Tower: Before we go too deep, why should anyone be concerned about population health care?

Mike Englehart: It's interesting, this conversation continues every single year about why we need to make a change and I think it really just comes down to common sense. The amount of money that we're spending as a society, the United States, as a percentage of our gross domestic product, I think it's north of 18 or 19 percent and if nothing changes in a meaningful way, it will eclipse 23 or 24 over the next ten years. It's just on a shot that's going to take off and so I just think as a society, we have to come to some type of understanding as to what does good care look like and how do we have to change the model in order to make it sustainable and actually more impactful. We need to try to address things earlier on when it's less costly and actually affords an individual to have a better quality of life. I think it's one of the big threats against the United States if we don't come to some understanding of how we change the model. I think it's – the current model is not really meeting the needs of society and I think it's just a matter of time before we really meaningfully move to the next level of population health.

Eric Tower: So, we had Lee Sacks on as a guest, who obviously you're well-acquainted with. He was with a system that had a significant presence in a particular metropolitan area. We also had Deb Geihsler, who is doing some pretty fun stuff through Activate Health care in the workplace. To me, Trinity seems distinct insofar as it has a much broader presence in a number of geographies but not the same market position or the same interrelationship with particular employers. Can you, do you want to just address that a little bit?

Mike Englehart: Sure. Just a little bit of a thumbprint for Trinity. Trinity is in 22 states. We have 95 hospitals and north of 7,000 employed. Physicians, clinicians are part of our portfolio. And so there are a couple of markets where we have critical mass. I think of Michigan. We've got some sizable footprints in Columbus and New England. But you're right, unlike Advocate, who is based in Chicago where we had a real market presence when I was working – when we were working for Advocate and working with Dr. Sacks, it – we're a disrupter but not able to tip a market. And so what Trinity's philosophy has been, and it started under Dr. Rick Gilfillan who had time at Geisinger and worked for the government.

We were early adopters at Trinity, of all of the different CMS [Centers for Medicare an Medicaid Services] programs. And so, we felt that it was really aligned with our mission to really treat the wholeness of an individual and as a result, Trinity has been heavily involved in every single marketplace, taking on risks, total cost of care contracts, and all the CMS programs. We also

have a very successful Medicare Advantage plan that's based out of Columbus that's also something that we see as an asset and we're bringing it into other states because we believe Medicare Advantage is the right model and it's something that we think we can excel at.

Eric Tower: So have you managed to leverage MA [Medicare Advantage] to get insights that allow you to take – are you taking full capitation? Are we talking capitation on Part B?

Mike Englehart: A little bit of both but it's probably more on B. Yes, I think what we've been able to learn from our medical product is how we need to reposition our investments and how we think about patient flow and whether or not someone should be sitting in observation, what the followups look like. So I think we've learned a great deal from our MA plan and we think it's part of our success going forward. So, we've done a little bit of both, probably more in the Part B, but we're interested in approaching more employers and having those conversations because we believe employers also have to be scratching their head saying when is this going to stop. The increases are just not sustainable for them as well.

Eric Tower: Well that's certainly what Deb Geihsler said. So as you're flipping the switch from traditional medicine to population health, how do you accommodate the fact that if you get a lot fewer patients and you keep patients healthy, you've got a lot of bricks and mortar that are sitting empty and you're paying, and you're at least servicing those bonds. How do you get yourself ready for that transition or are you there yet or are you in the process?

Mike Englehart: What's interesting about Trinity is that every one of the markets will move at their own pace, but directionally I think everyone's moving towards the total cost of care. I think the velocity you can take on some of these opportunities is directly related to what's the market going to allow, both from a payor/employer perspective; and then you're right. Your assets, the hospitals that we were all group that we built our enterprises around, really become a challenge as to what should a dollar go for on a go-forward basis. Should it be more ambulatory, IT, online, type of tools? That is directly proportional, I think, to how much upside you have. That's what was so interesting about our Advocate experience. We had critical mass and we were able to – it didn't feel great at the time, but we were able to work with the hospital presidents about it wasn't heads and beds, it was more efficiency in the way that we can our hospitals, that was going to pay – was the right thing to do for the patient and was a differentiator so we could accelerate or slow down as the market dictated how we would take on total cost of care contracts.

Eric Tower: At Trinity, have you noticed any cultural issues about getting people to adopt this mindset, both within your physician presence, as well as in the management?

Mike Englehart: I think that Trinity has done an excellent job and they've been on this journey for five-plus years. So I probably have come into this old and later but I think it's been so embedded into the way that we talk about health care, but maybe four or five years ago, it was more of a painful conversation but now I think

it's accepted and I think what you're seeing is that the hospital presidents now are far more engaged. The PHO [physician-hospital organization] and alignment with both the employed and the independent physicians about what does good care look like. I think there's a level of knowledge that hospital presidents in the past would really not focus on. Now they really start to intimately understand how contracts are set up and how we truly recompensated and that helps them to think in a more holistic manner about where is the best place for the care to be provided and where do we win and lose and where's the best care going to be provided.

So I think there's been a maturation. It's not to say it's not painful. What's painful, and we experienced this in Chicago, and I experience it personally when I was running Presence. When you're in a marketplace like Chicago where there are too many beds and you can't move into a total cost of care environment, either because you don't have the doctors or the contracts, that becomes really painful because here you've got on paper or a license 225 bed hospital that really is running at 125. You've got fixed costs, deprecation, you've got to keep putting money back into the hospital when the reality is, in certain circumstances like in a market like Chicago, the better solution would be to move towards an ambulatory platform and focus on the two or three illnesses that affect the consumers, the patients in the marketplace. That to me is more painful because there doesn't feel like there's a solution and sometimes we make this such a political process about hospitals when really it's about caring for patients where they need to be cared for.

Eric Tower: It should to me like you're describing the service area model of providing care as compared to the hospital centric –

Mike Englehart: Yeah.

Eric Tower: And then a separate ambulatory.

Mike Englehart: I think that's right. What we're trying to do at Trinity is really use our medical group and our CIN (clinically integrated network) and have our physicians to be front and center. The hospital will always play a role but we are extraordinarily cautious about building new hospitals. We really believe that more and more of our care needs to be ambulatory. We will meet with our physicians and open up more access. I think that's going to be how Trinity will succeed, and any good health care system is going to have to that balanced portfolio.

Eric Tower: You're describing a very judicious building process as far as whether you're willing to build new hospitals. But, do you think patients are willing to travel to centers of excellence? Have you considered those? You know, they could reduce costs in theory or do patients want care in their community? How do you approach that?

Mike Englehart: I'll use – right now I'm serving as the interim CEO in Columbus for Mt. Carmel which is part of the Trinity family. Columbus is an interesting marketplace because it's got three really good health systems. You've got Ohio State, Ohio Health and Mt. Carmel, and I think what we're starting to come to – the

conclusion is – I think we're going to have to get far more judicious about service lines. I don't think it makes sense to have open hearts in all of our hospitals. I think we have to really be thinking about as we think about these programs on a go-forward basis, I think that is not an unreasonable expectation that someone will make that commute, that travel for certain subspecialty expertise. I do believe that primary care and most services needs to get as close as possible to the consumer and hospitals are generally not the best way to access the patients. I do believe patients will travel for some of the subspecialty work but they want the convenience of their primary care and some of the basic care as close as possible to their home and they want access in a way that 15 years ago, we wouldn't have dreamt of but our kids now being in college, I can barely talk my daughter into getting a primary care physician. They think that everything should be done in real-time just like a bank transaction is done right now.

Eric Tower: Well, what do you think about the notion of partnering with non-owned health systems to create geographic coverage in particular markets? Do you think that that would work? Because there are some out there saying, gee all this consolidation, it only drives up costs. But you need to have market coverage in order to offer some of these plans, don't you?

Mike Englehart: I don't think – there are very few health systems that can build and own everything underneath their portfolio. So I think out of necessity you have to figure out who your partners are and fill in the gaps. Sometimes it's a one-off transaction and sometimes they're part of your contract, total cost of care contract, because you believe they're part of the secret sauce. You know, there's some that will use a Medicare Advantage dual-eligible medical home strategy and they'll use third parties and others will build that. Some will use online services for patients that want to be able to call their doctor in the middle of the night and determine whether or not they need to come into the emergency room or not. Some of that will be insourced and some of that will be through strategic partnership. I don't believe most health systems can go it alone. I think we're always going to have to be open to partnering, learning from others, and let's be clear: private equity has moved in a more aggressive fashion than I would have imagined three years ago.

Eric Tower: Let's assume I'm the CEO of St. Elsewhere health system –

Mike Englehart: Okay.

Eric Tower: And I want to partner with St. Nowhere.

Mike Englehart: Yes.

Eric Tower: We're taking full cap and then splitting it, probably based on unit-based services, correct? Do you think that will work? Because it kind of seems like – how would you structure that?

Mike Englehart: Here's – I think there's a step before that. What I've seen in this market, in the Chicagoland market and other markets is, the payors are inclined to try and orchestrate a network but allow the pods to live on their own. So, if you

were in a metropolitan area and you wanted to have coverage and we're missing some pieces of the puzzle, what the payors have always done is allowed, and the piece together, a market. I think what's happening now is the providers are going to them and saying right now I'm not sure we can commingle our risk because I'm more mature than they are but I'd like a three-year glide path so that we can eventually then all take the risk but I can't do it day one because I've been taking risks and you haven't but you know you've got to do it. We will afford the payor the opportunity to offer a solution and then meet up in the road in three years. I do believe that is in fact happening in certain markets where people can find that frenemy— I like to use that term frenemy – strategy. I think that that is a very doable thing and it's actually – the payors like it because the payors have always been anti-consolidation. They've always viewed it as they don't want to afford the providers more leverage.

Eric Tower: So let's assume there's a patient in my geography and they're attributed and maybe we'll cover attribution in a couple of seconds because that is a term, right?

Mike Englehart: Yeah.

Eric Tower: But they're attributed to be at St. Elsewhere but then they end up at St. Nowhere.

Mike Englehart: Right.

Eric Tower: What stops St. Nowhere from running all the tests all over again, spending a lot of money and then saying well, this isn't my patient and just discharging them and you know, letting me try to pick up the pieces?

Mike Englehart: So there's two ways you can avoid it: one, if you were on the same platform, you could have rules of the road -- the big player right now is Epic -- if you use the tool to its full extent, there's the option to share that information, that's number one. But the other way to handle it is by using a third party to assist you in the management, care management, the disease management, the attribution. So when that happens, look at it as an impartial third party only interested in doing the right thing for the patient and in the greater interest of the total agreement, they'll be able to say you don't need to run these additional tests. We've already got them, we'll share them with you.

Furthermore, the rules of the road would require that the patient get returned back to their attributed, usually primary care, physicians. The way this is working right now, and I think Blue Cross Blue Shield might be doing this right now, they've got a third party company that is standing up this type of solution where they're essentially doing what we were at Advocate. They are the care management, claims processor, disease management, outsource team that helps to band a group of generally independent hospitals or PHO's together. That's how you would be able to have the rules of the road.

Eric Tower: Well, I think we both agree, though, insurers are notoriously poor at managing care.

Mike Englehart: They have a model and their model services them well. Total cost of care might not be – I can't speak to United Health, maybe they're stronger as a result of everything that's built up alongside them through Optum but, you're right. The traditional payor is a little too bureaucratic and still too inpatient centric. I think the ones that will succeed usually have third party investors and they allow them to work outside of the normal day-to-day of the bureaucracy of a traditional payor. Those are the ones that are more agile. I would agree with you.

Eric Tower: You stood up this health plan -- do you think it's necessary to truly partner with the physicians? Can a system just do this and dictate what happens or how do you see that process working?

Mike Englehart: No. I firmly believe in physicians, all the clinicians need to be at the table. But the physicians most certainly. Advanced practitioners as well. Because ultimately, I believe that all the key decisions are made between the patient and the physician. If the physicians are not on board, don't understand what's being measured, what does success look like, have a voice, it falls down. You can "incentivize" people and that does work but if they're not provided constant feedback and additional assistance to call forward their more challenging patients, then the nature of health care is transactional. They end up worrying about who's in the lobby and who else do I need to see before I call it a day, when what we're really talking about is, it's not only those patients, there is this bolus of five to ten percent of your attributed lives that are really risky and we need to do something special and different. If you educate and partner with physicians and align incentives, I think it becomes really powerful and I've seen nothing but good things come of that. But you can't break the trust. They've got to be at the table and it's got to be clear rules of engagement.

Eric Tower: So we've discussed this notion of attribution. Why don't you just introduce the idea?

Mike Englehart: Sure. Attribution, as I define it and as I've been taught, is how payors, providers take an individual, a patient, and determine whether or not they're tied to Dr. A or Dr. B. And usually rule of thumb is they look at how many interactions you've had with the patient over usually an 18 month or two year time period and that's how attribution. You could have shifted from one end of town to another. You could have used an internal medicine physician and then because of cardiac problems you're spending more time with cardiologists. Those events and those frequencies of visits will determine almost an actuarial way of assigning risk from a patient-level to a doctoral level. It's not pristine and there's always patients moving in and out but it's the best tool we have and it's generally been accepted as the way that we can best manage and really own the lives that are attached to us. So that's attribution. How many visits, who has the seniority of the relationship and it's usually viewed over an 18 month period.

Eric Tower: Well, you talk a lot about partnering with physicians and giving them a voice. What are some specific steps or actions you've seen to make sure that you can accomplish that? I mean it's easy to say, oh doctors, we will listen to

you. It maybe a little harder to actually let them feel like they truly have a voice.

Mike Englehart: I think it's how you set up your governance. Most working physicians have time and they're engaged in this portion of their work-life but they cannot spend 40 hours a week like administrators can, looking at data. If I'm a physician, I want to know how I'm getting paid and what are the measures of success? How do I determine if someone goes out of bounds? What are the rules of how we are going to try and work with a physician to bring them back on course? This is a different mentality. It is not "I just go it alone." You actually sink or swim based upon the physicians that are inside your pool, whether it's a PHO or whatever term we're going to use. There's got to be a clear understanding of how information will flow, what does success look like? One of the things that I think we learned was if you leave it up to the payors, they will have no less than 50 different measurements. And that is just too much for a small two or three-person independent physician group to manage. It's just painful. So there needs to be kind of a true north as to how we measure and what does success look like and you don't get that when you try to negotiate on your own but if you come together, you're able to get a consistency in what success looks like and how we measure it and what resources we can bring to bear.

Eric Tower: Are those measurements only for your primaries or do you also include those for your specialists or that progression?

Mike Englehart: It – attribution is, sits heavier with the primaries. The primary, and I lump in their cardiologist because at end of life cardiologists play a critical role. But no, specialists do have measures. They have far less than primary but you need them to be at the table because they play a critical role. If you're in a total cost of care contract, let's talk about this now - in January, CMS is opening up knees and I think hips, to – if you're in a good, if you're physically fit and capable of being cared for, you're going to see may – our estimates are between 10 and 40 percent of the knees are potentially going to move out next calendar year because you know, as these baby boomers are going in for their second knee or their first knee and they're in good health, an ASC offers a wonderful alternative, and so this is really going to be an interesting issue as to where care is going to be provided. And then it's just the overall clinical effectiveness. You need to measure readmissions, any type of cases that go south. There needs to be a profile for the specialists to see who's performing the best care at the lowest costs so it's the triple aim all over again.

Eric Tower: So you've mentioned cardiology, you've mentioned ortho, what other areas do you think are sort of ripe, I might call it low hanging fruit, for someone who's looking to get their arms around total cost of care?

Mike Englehart: I think oncology has a role to play. I think there's a lot more that we can be doing as far as caring for patients as far as infusion and preventing emergency room visits. Endocrinology is a big issue. Pulmonary, respiratory, those are the areas. You almost – the way to look at it is, look at your readmissions, look at your population. We all have data. And every market's

a little bit different but there's usually four or five that are the same and if you look at it from our perspective and say if I was the payor and had to spread the dollar, where would I spend my dollar and where could I impact the patient's care so that they stayed healthier longer at lower cost. I think what you'll find is that primary is the gatekeeper, cardiology is close and then you go into – we could do a hell of lot better when it comes to ortho care, preventative. So there's therapies and all of those. There's oncology and then there's the pulmonary areas that I think – that's traditionally our areas where we could be more proactive and impactful on total cost of care.

Eric Tower: So if you're getting ready for sort of a total cost of care world, what advice would you have to some of these systems that have been buying physician practices and other ambulatory assets and flipping them to provider-based?

Mike Englehart: I would start for – it takes – you can't turn on a dime how you compensate your physicians. So one of the first things you need to do is just start a transition to inserting measures into how you compensate them. So it can't be 100 percent about volume. You need to also be measuring and putting ten, twenty, thirty, you really will have graduated when you're up to forty or fifty percent of their comp is tied to cost and as defined by all of the national benchmarks. And so you've got to start this transition so it's not as painful. When you flip to an ambulatory status and move away from provide-based, unfortunately hospitals tend to over-engineer all of our ambulatory sites and when we have run ASC's, we don't run them as efficiently so the other issue is those have to go to a whole other level of efficiency because people are now shopping.

And you've seen it. I think it was in last week's *Wall Street Journal* and *The New York Times*, United is aggressively going to push – continue to push towards ASC's and so, and all outpatient, they're looking for the lowest cost. So their "incentizing" they're patients to really pause before they go their traditional model. And so I think the way to look at it is are you set for success in your cost structure and your reimbursement to your doctors. Are they seeing information on a monthly basis about how they're performing. I think that's so important because you just can't jump off the couch and run this marathon, you've really got to ramp up. And I think everyone is, but if you're going to go fast over a short period of time, then you really have to paint the picture for your stakeholders which most certainly are the physicians.

Eric Tower: Yeah, the provider-based's, obviously, you know, a cause for concern

Mike Englehart: Yes.

Eric Tower: Maybe the 340B programs.

Mike Englehart: The 340B – our opinion on the 340B. I knew enough when I was in the Chicago market. It was critical. I think it still has a role to play and I think it's going to land in a decent spot. We were nervous six months ago about are they going to completely wipe it out. I just think it – it still serves a purpose for those that are caring for the underserved in some really challenging marketplaces, and it's not something that can be pulled out overnight. So,

340B is going to get some and it really is going through a haircut but I think it's going to land in a reasonable – that's our read right now – that it will land in an acceptable spot and not just go completely away. Because there's no way we would backfill. Most health systems that have Medicaid in a meaningful way north of 12% are dabbling with 340B and there comes a point where it becomes a core component of how you provide care.

Eric Tower: Mike, the patient is important. Is there anything that Trinity is doing that's particularly interesting around patient engagement or coordinating care? You know, the systems even when they were run, there's so many different moving pieces. Keeping all that stuff together is…well, it's a fulltime job for anyone, let alone someone who's maybe sick or having other issues at home to worry about.

Mike Englehart: I think there's two things that Trinity is really trying to move forward on. And that is really viewing the patient more as a member, meaning, just a long term relationship. And at the core of that is how do you meet the patient, the consumer, in the most convenient manner. And so, we're really pressing the envelope hard on virtual visits and really think that primary care a lot can be done with technology today and an area where we've seen some tremendous success is something we call the hospital at home. And we have a virtual care center. This is really focused more on the Medicare patient and we're in…I think it's 19 of our 22 states. We've served over 30,000 patients and any given day we have north of 5,000 patients that we are monitoring. And, what it looks like is…they have a tablet and the tablet allows us to have virtual visits 24 by 7 with either a nurse practitioner or physician and the impact has been profound. We have cut readmission in half with this population and it really feels right and we're getting tremendous feedback from the physicians, the communities, the plans are loving it. And so I think it's the beginning of something that Trinity wants to focus on and really could open itself up and be a catalyst for other opportunities. Again, going back towards that primary care virtual visit makes a lot of sense. The satisfaction that we're seeing, 96% - 98% we recommend. It's great for heart failure patients you think about making sure that they're taking their meds and they're getting weighed. The savings are outstanding and actually, the range of patients has been as young as 25 and as old as 103. So, it speaks to the fact that people are more and more technology savvy and the I-pad or some type of tablet really works so that they can interface and get simple questions to tough questions answered. That married with a home health division…I think that makes a lot of sense. And so, it works well for us. We're proud of it and it's something that we're really trying to scale across all of Trinity.

Eric Tower: So let me drive you back to this iPad. Can you get vitals? I mean how's that work?

Mike Englehart: Yes. You can get all the vitals. It's literally, it looks like an intercom and it has all the capabilities. Every week somebody's turning out something new but we've selected this technology and the iPad is low cost. It's not an iPad, it's something a little bit more generic but it has its own ability to connect so you can see the person on the other side and all of your meds are documented and your vitals are also. And so if they see something that is deviating then

they'll make an outbound reach. What's also been cool is that they're able to do three-ways with other family members. So think of your mom as still living in Texas but you're in Chicago. You could literally do a three-way conversation with a provider and we're excited about those types of things.

Eric Tower: That's interesting. Is that something you've created or you just bought off the shelf, or?

Mike Englehart: I think it was a hybrid, you know, and I'll get back to you on that. I don't know all the details. I was pleasantly surprised as I've come up to speed on – it's kind of a unique differentiator that I think is really powerful.

Eric Tower: So, sounds like a great program. How is that bending the cost curve? Is there any hard data or is this more, you know, in the early phases and we've seen what we hope are good results?

Mike Englehart: No, we've seen some good results. I think the sample size, we'd like to grow it. But we've seen reduction of readmissions by literally in half compared to the static traditional home health visit. It just – the connectivity is so important and the ability to make sure people are taking their meds. It just makes sense. Anybody that's looking at readmissions, the number one culprit is you're not taking your meds. You don't get the order filled and you're not taking your meds. So if you know, A, the order's been filled, and B, now I can track. And usually people, it's not to say people don't veer off course, but if you can get people taking their meds through the first week, it becomes a habit and that is extraordinarily powerful when you're dealing with someone with a chronic illness.

Eric Tower: What are you most proud of in your career?

Mike Englehart: I've had a unique career and I've had an opportunity to, with every promotion or move in my career, take on more responsibility. I think two things really stand out. I'm really, really proud of the work that I did when I was at Advocate working for Dr. Sacks and Advocate Physician Partners. Dr. Sacks is known by many but probably not known by enough people, really, I think was a thought leader and a head of the curve by a significant distance when it came to the way we provide care has got to change and so what he was thinking about was in advance of Obamacare and some of the things that we started here in the Chicago market and I was able to jump in probably in the third or fourth inning and really work with him to take our engagement with our physicians our performance to another level and that was extremely exciting and I think rightfully so. Advocate, Dr. Sacks, Jim Skogsbergh, you know, received a lot of credit for their work.

So that was powerful and I think that was a lesson in creating on the fly. Meaning, we were sitting down and having conversations with payors where not all the rules were defined and we were trying to balance a legacy, heavy bricks and mortar model to where we thought the market was going. And sometimes you get caught in your conversations in the hallway and you don't realize what's your impact you're having on the patient, the community and what impact is it having in the overall market. And I think only until I got away

from that did I appreciate how we had differentiated ourselves and so that was some really interesting time to work with that team, very talented team.

And then the second was, from there I was asked to go over to Presence and you know, a faith-based, at the time the largest Catholic health system, and with 12 hospital. God I think we were north of 25 different skilled nursing and long term housing solutions. And, you know, it was a financial turnaround and it was one that we, we worked extraordinarily hard in a short period of time to stabilize a Catholic health system that really was totally focused on the mission, but had stubbed its toe and I believe we were able to stabilize it and then successfully transition it to a larger Catholic health system that I think will give it a chance to continue to serve their communities herein the Chicago market for years to come. So those are two that I feel good about that I felt I made a difference and frankly while it was stressful and challenging, I look back now with fondness of what we were able to accomplish as a team.

Eric Tower: What do you see happening if the Affordable Care Act is repealed?

Mike Englehart: The Affordable Care Act, that conversation is I think directly tied to the politics that we're living with right now, right? So, I believe if it's repealed, I don't think people will be – I think you're still rewarded for viewing the world through this lens. Meaning, I think you're capital dollars, I think your engagement with your colleagues, your associates, your staff, your physicians, I think that draws you closer. And while you might not be making as much money if it was to completely be repealed, I believe that eventually the commercial, the employer, are going to have to push hard on this issue. And so I think being efficient and responding to the consumer and working closely with physicians and being a good steward wins in almost any model. You just might not move as fast. You might slow down a little bit. You might not be willing to make certain bets that you would have otherwise if you felt like we were continuing to move down this path.

Eric Tower: What do you think the future holds?

Mike Englehart: So as it pertains to the politics, I think this is probably one of the more unique times. I think we will all look back five and ten years from now and say do you remember that time period when the president was in office and what used to be an event that would gobble up months of time are happening on a daily basis. It's a velocity that I've never seen before. So tell me who's going to be in the Whitehouse. Tell me who's going to have control of the Senate and I'll tell you where things are going to move. I am concerned that we have no place in the middle and that middle of the road, Democrat or Republican, has fallen off the map, and I think that that's – I think that's dangerous for society. I think that when the pendulum swings so far from one side to the other, I don't think that's healthy and I think that makes things so adversarial. I would hope that we would find more middle ground and there just isn't right now the temperature for that, unfortunately.

Eric Tower: So Mike, we've talked about attribution and getting data. How do you figure out what to do with all this data. Where do you get it?

Mike Englehart: Yeah, you know, I think that this is really the secret sauce. So, the key elements that anyone would want is one, obviously the demographic information for a patient, you want lab information, you want claims information. If you take those ingredients, claim, lab, patient information, and you weave it together, you start to build profiles for patients and that allows you to really segment the population. So if historically, we look at patients through kind of a transactional model. This is where you start to build basically a map of the actual profile of all of your patients and you're able to identify those that are of the most serious concern. And what – you know, actually kind of going back into our past, we – when I was with Advocate and APP in particular, I worked with Dr. Sikka, Rishi Sikka, excuse me, and Dr. Sacks, and we did something kind of cool with Cerner and that was we build a disease registry because at the time, Chicago was a very – there were just a ton of different EMR's and what we were able to do was extract the key information out and sit this disease registry on top of it and that really helped us to profile and identify patients who had not been seen that had co-morbidities and past visits that really warranted us to apply different resources to engage that patient and so, a disease registry is really the byproduct of aggregating all of the information.

Now, the Cerners and the Epics of the world have that built into it and if you're in an ecosphere where you're sitting primarily on the same platform, that information is quite powerful and flows and both Epic and Cerner have those tools. But at the time, this was gosh this was five years ago, six years ago, it really helped us to move the performance on total cost of care and we were really moving the dial on some of the sickest patients because we leveraged all of this information and gave it to the physicians and the care managers. And this again, goes back to the conversation, well, what does this mean for the physician. When you sit down with a physician and you show them this information about ten of their patients, it's, it really draws them in and they know that they need to do something different and when you feed that information to the physicians, with them you can come up with a care management plan and that's where we really hit the accelerator. And I give a lot of credit to Dr. Sikka and also Dr. Sacks. We had a great relationship with Cerner but I would say that Epic does the same thing now as well.

Eric Tower: So is the solution there, you got the very sickest patients and you kept them well, or was it that you got some patients who were sick and stopped them from being sicker?

Mike Englehart: It's both. And so the way we've historically looked at – like a diabetic patient, is that they're all the same, and they're clearly not. It's the co-morbidities, it's the socioeconomic issues and what we were doing five plus years ago, we were pirating data scientists. This was under Dr. Sikka's oversight. We were – there's the, the platform of how you addressed people with a disease state but then there were extra efforts and extra things that need to be done that would move the dial. And so it was taking the sickest, and you were never going to be perfect, but if you could reduce the amount of readmissions and emergency room visits and be more timely about outreaches to that patient and move the dial. It was also trying to catch someone that was on the cusp of becoming a patient that had multiple co-morbidities. And so it was quite

powerful because you now could see graphically your entire population and where they sat on the continuum and it afforded you an opportunity to take different, specific, unique strategies. And so it really touched everyone in the continuum but it really focused on the sickest two percent and ten percent. There were different strategies. That's where we really made significant progress.

Eric Tower: Well, I suppose you'll be gratified to know that an upcoming guest on this podcast is Rishi Sikka.

Mike Englehart: That's awesome. I think you'll have a great conversation. He's one of the sharpest guys I've had a chance to work alongside of and I think he's out in California on Sutter?

Eric Tower: Yeah, Sutter.

Mike Englehart: I'm sure he's doing some cool stuff out there and I'll be interested to hear what he's doing these days. But he was a thought leader and I'm sure he still is and I'm sure he's doing some pretty cool stuff out there with Sutter.

Eric Tower: Excellent, well Mike, I think that wraps up all the questions I have unless there's something you want to say, we'll call it quits.

Mike Englehart: No. Enjoyed it and thank you for the conversation.

Eric Tower: Thank you.