Roundtable discussion "Risk Management"

By Michael Sparer

This memorandum summarizes the "care-tank" table discussion on "risk management".

At the outset, the participants shifted the focus from classic risk management (i.e., protecting against potential liability in hospitals and other settings) to "population health management".

- Our first task was to define the term: we agreed that PHM is an effort to put in place a business model that re-aligns incentives to encourage "population health". It is an effort to transform the health delivery system, moving from an episodic FFS framework that treats individuals to one that manages the health of populations, and emphasizes value. PHM also is a cultural framework that requires providers to think differently about their job/mission.
- The focus on PHM is driven, in large part, by changes in reimbursement structures, especially the effort to hold health systems at financial risk for the cost and quality of care delivered to defined populations.
- But the movement to PHM is incremental (at best), as there are numerous obstacles
    - Management challenges: changing how organizations work is hard, and not for everybody (or every organization). For example, PHM does not fit simply or easily in an academic medical center culture.
    - Cultural challenges: not only does the effort require changes in the cultures of individual organizations, it often also requires collaborations and partnerships with other organizations with very different cultures. And this all takes place in a health system and a nation that still emphasizes individualism and traditional medical care.
    - Fiscal/Economic challenges: the health system is still largely fee-for-service, and those organizations (such as Mount Sinai) that are pushing for a PHM approach still generate most of their revenue from the traditional fee-for-service world. It is hard to make progress with these cross-cutting incentives.
    - Politics and policy: health care is (in the U.S.) a $3 trillion industry, and thus inevitably a complicated political arena. The politics of redistributing those funds (with the inevitable winners and losers) makes the shift to PHM hard. For one example, we discussed the effort in NYS to transform the health delivery system for the poor (through the so-called DSRIP Program), and heard stories about how the effort was frustrated (at least from the health system perspective) by the political influence of certain large but allegedly inefficient players.
- We then discussed strategies to overcome the obstacles mentioned above.
    - To overcome management challenges, leaders need (a) to pick partners (and providers) who buy into the effort and are willing to make the effort to change; (b) to make the transformation as simple as possible, creating easy to implement changes in workflow; (c) to offer ongoing aid and assistance to providers as they try to change their practice patterns; (d) to increase reliance on non-physician providers; and (e) good data!
    - To overcome cultural challenges requires both strong and effective leadership, and also some short-term immediate "wins" to demonstrate the value of the change.

- To overcome fiscal challenges, leaders need to push hard to quickly change the financial incentives, either by putting doctors (and others) on salary and converting them to paid employees, or to shift as much of the organizations revenue to value-based payment as quickly as possible.
- To overcome the policy obstacles requires changes in key components of state and federal law, including changes to the Stark rules, HIPAA, and reimbursement methodologies more generally.
- To overcome political resistance requires developing coalitions, effective lobbying, and a carefully designed long-term strategy.
- To make it all work we need to acknowledge and focus on the importance of the social determinants.