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New Healthcare Competencies Required for Population Management
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As healthcare becomes increasingly complex, attention to the care given to populations of patients gains importance. While our attention must never forget individuals, populations are made up of groups of individuals and if we are not measuring the performance of our healthcare delivery system by groups, populations or panels, we will never know whether or not we are improving care.

Population Management

Population management is going to require analytics to discover leverage points for improvement of care. SETMA knows our mean (average) hemoglobin A1c for the past fourteen years. We started at a mean of 7.46% which is now 6.65%. If that is all the information we have, we would pat ourselves on the back and move on to another project, but the mean is not the "whole story." In 2000, our HbA1c standard deviation (SD) was 1.98, which is not something I like to publish. In 2000, a significant number of our patients with diabetes were two to three standard deviations from the mean. This means that our patients who were two to three standard deviations form the mean had hbA1c values between 11.42% and 13.40%. These patients were not receiving quality care. Today, our SD is 1.2; still not idea, but dramatically improved. With a mean of 6.5%,, patients two to three standard deviations from the mean have a HbA1c between 8.9% and 10.1%. Dramatically improved from the year 2000, but still with room for improvement, patients who are treated to goal have a have a SD of 0.8 which may be the best possible in a biological system. Designing a quality improvement initiative for improving the "mean" and the SD are deferent.

New Competencies

The new competencies which are going to be required for effective and successful population management are going to involve what IBM calls an "Analytics Quotient". (See the IBM Paper entitled, *Transforming healthcare delivery with analytics*.) In March, 2012, I made a presentation to the Massachusetts Medical Society on *The Importance of Data Analytics in Physician Practice*. In that presentation I said (see http://www.jameslhollymd.com/Presentations/The-Importance-of-Data-Analytics-in-Physician-Practice) I said:

> ""Information" is inherently static while „learning" is dynamic and generative (creative). In *The Fifth Discipline,* Peter Senge, said: „Learning is only distantly related to taking in more information…" Classically, taking in more information has been the foundation of medical education. Traditional CME has perpetuated

the idea that „learning; is simply accomplished by „learning more facts.‟ Analytics transform knowledge into an agent for change. In reality, without analytics, we will neither know where we are, where we are going, or how to sustain the effort to get there.

"For transformation to take place through knowledge, we must be prepared to ask the right questions, courageously accept the answers and to require ourselves to change. Healthcare transformation, which will produce continuous performance improvement, results from internalized ideals, which create vision and passion, both of which produce and sustain „creative tension‟ and „generative thinking.‟ Transformation is not the result of pressure and it is not frustrated by obstacles. In fact, the more difficult a problem is, the more power is created by the process of transformation in order to overcome the problem. The greatest frustration to transformation is the unwillingness or the inability to face current reality.

"Often, the first time healthcare provides see audits of their performance, they say, „That can‟t be right!‟ „Through analytics – tracking data, auditing performance, statistical analysis of results – we learn the truth. For that truth to impact our performance, we must believe it. Through acknowledging truth, privately and publicly, we empower sustainable change, making analytics a critical aspect of \healthcare transformation.

While an Electronic Health Record (EHR) has tremendous capacity to capture data, that is only part of the solution. The ultimate goal must be to improve patient care and patient health, and to decrease cost, not just to capture and store information! Business Intelligence (BI) statistical analytics are like coordinates to the destination of optimal health at manageable cost. Ultimately, the goal will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient and population data."

Healthcare providers generally have an high IQ but most also have a very low AQ. Population management cannot be done without analytics.

Products May Not Produce Performance

Healthcare "products," which are inherent static may not be may not be able to produce the changes we need in healthcare. The nature of the changes which are required in the healthcare system are dynamic and require flexibility. Transformation comes from an internalized passion while reform is dependent upon external pressure created by regulations, rules and restrictions. Products can help but ultimately the changes we want are going to come from organizational culture change. In 2008, the original paper on the Triple Aim, the authors talked about "integrators." The three structural integrators which I see in our current system attempts to change are: Medicare Advantage (MA), Patient-Centered Medical Home (PC-MH) and Accountable Care Organizations (ACO). SETMA is formally involved in each of these. MA

since 1997, (including its predecessors); PC-MH, as an NCQA Tier III since 2010 and as an AAAHC Medical Hoe since 2010 and as a participant in a federally qualified ACO since April, 2012. It is, of course, possible to meet the requirements of each and all of these and not have created a transformative healthcare delivery system. What we all want to produce is not going to be achieved by "plug and play" products, but by ideals which become a part of personal vision and passion.

The Element of Risk in Healthcare Transformation

The issue of risks is central to this process. In his book, *Against the Gods: The Remarkable Story of Risk*, Peter Bernstein said, "The word „risk‟ derives from the early Italian *nisicare*, which means „to dare.‟ In this sense, risk is a choice rather than a fate. The actions we dare to take, which depend on how free we are to make choices, are what the story of risk is all about. And that story helps define what it means to be a human being." The tension between professionalism and entrepreneurism are at the root of healthcare problems today, I think. The quagmire for public policy is how financially to reward professionalism in healthcare administration and activity while meeting public responsibilities. How do you reward "risk-taking" by healthcare professionals while eliminating as much entrepreneurism as possible?

From a person perspective, entrepreneurism chokes out professionalism while from a public policy perspective reward for professional risk taking is often seen as the enemy of the system. Even in the design of the ACO, particularly in the case of savings sharing, the distrust of the rewarding of professional risk taking is at the root of why the ACOs may and, I think, will not fulfill their promise.

Some Healthcare Organizations May do more harm:
The Risks of Entrepreneurism-Professionalism-Entitlement

Realistically, excessive entrepreneurism in healthcare, which was the motivation behind the Stark Legislation (somewhat ham-handedly, I think) has contributed to the coalescence of many primary care providers into employee status with hospitals,, staff model HMOs, etc. The risk in this is that in order to solve one problem, excessive entrepreneurism, you create another and that is the creating of an "entitlement mentality" by physicians who are employees of an organization for which they take no personal responsibility. This results in their demanding as much as they can get, for as little as they can give, for as long as they can, i.e., until the failures of the system cause another iteration of a non-solution to be developed. Unfortunately, again, I think, due to human nature, nationalization of healthcare delivery and the creating of a healthcare "job corps" will create as many, or more, problems than it will solve.

The solution to the entrepreneurism-professionalism-entitlement conflict in healthcare-systems development is, I think, a public/private collaboration, where there is creative, risk-taking with reward (in which system where reward is not seen as a failure but as one of the positive and dynamic parts of the system). Safe guards are needed, of course, because everyone is not motivated by altruism and idealism, even professionals.