THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

EPISODE 8

Analyzing Hospital Data and Population Health Strategy with Adam Lorton

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Lisa Miller (00:00):
All right. Great. Welcome Adam. It's so nice to have you on the Healthcare Leadership Experience. Thank you for being here.

Adam Lorton (00:07):
Great to be part of the show, Lisa. Thanks for having me.

Lisa Miller (00:10):
You're welcome Adam. So can you tell us a little bit about you? This episode is a little bit about population, health strategy, and your work, which is so interesting and I think exciting for our listeners. Can you tell us a little bit about you and your background just so we can get everybody up to speed on what you do?

Adam Lorton (00:30):
Sure thing. So hi everybody. My name is Adam Lorton and today I'm a health care data consultant. So I help primarily POs and PHOs stay profitable in their risk-based contracts or any kind of contracts with complex incentive programs. But I'm actually pretty new to the healthcare industry and I fell into healthcare completely by accident. I was actually a director at a software start-up. I was on my way to the executive team and then I got burned out. I needed a change of pace. Got recruited to this business intelligence team of a mid-sized hospital and they asked me to study these weird new programs called pay for performance. Do you remember when that was a new idea, Lisa?

Lisa Miller (01:10):
Yeah, I do.

Adam Lorton (01:12):
All right. And as you know very well most people, when they enter the business of healthcare, they get very little formal training. And so I was no different, but as I started diving deeper into these pay-for-performance programs, I started to understand that there's this story that's playing out right now. There's this payment model, the volume-based payment model. It only encourages more and more healthcare services, but there's a new wave, the transition to value. And there are champions like Don Berwick, but there's also an old guard. So people who hate change and they want to keep the old way because it's familiar and profitable. So all of this, as a person who's just learning the industry, is really exciting to me. And so I know which side I want to be on. And so my story really started when I built a data model that modeled the CMS HAC penalty.

Adam Lorton (02:02):
The Hospital Acquired Conditions penalty and people listening to this they already know that 25% of hospitals will get a sizable penalty if they're in the worst 25% in their infections and serious safety events. And what I discovered from this data model was our hospital was going to get the penalty and we never had before. And that discovery got me invited to talk to the system senior leadership team. And so this was a pretty intimidating experience for me. So I explained to the system senior leadership team, "We've done a pretty good job of modeling this program and we're very confident we're going to hit the penalty." They didn't panic, to their credit. They did take it seriously. And so they budgeted for the expected lost revenue.

Adam Lorton (02:55):
And then this kicked off a discovery and improvement projects, clinical quality, infection prevention — and it ended up with most likely saving patient lives and certainly saving the hospital money as we started to avoid the penalty. And it wasn't until much later reflecting on that day, I realized that day I had a way bigger impact on healthcare than any doctor did. Especially, and Lisa you can appreciate how much they were paying me compared to a doctor. This is a high ROI experience for the healthcare system.

Lisa Miller (03:33):
I want to say that on the business side of healthcare, there's a lot of heroes there too.

Adam Lorton (03:37):
Sure. And I don't mean to paint myself as a hero because I think they would have found out sooner or later that they were getting the penalty. But I was proud that we were able to get ahead of it early, but ... sorry. So that's the story of how I got into healthcare. And so because I was into pay-for-performance and coincidentally, I also love games like Fantasy Football. Actually my parents, to this day, run a board game store in central Indiana. So I've always loved games. And to me, a healthcare contract feels like a game. It's just like Fantasy Football. Fantasy Football is connected to football, but the person who wins at Fantasy Football is not the person who knows the most about football.

Adam Lorton (04:20):
It's the person who really deeply understands the rules of the game and then can, well I don't want to say exploit, but exploit is the easiest word that comes to mind, can really use the rules to their advantage to make sure that they're scoring the most points. And so to me, hospital contracts feel like a game in the same way.

Lisa Miller (04:39):
Right. Well, I love your story and I think there's a lot of people doing great work in analytics and finance that does support all of the great work on the front lines of healthcare and we need great financial minds to support all their needs. So I'm so thankful for the work you do and a lot of great business operators are doing out there for patients as well. And I think it's super important.

Lisa Miller (05:08):
So I have a couple questions for you, actually lots of questions, but these pay-for-performance contracts are complex and they're ever-changing. Right?

Adam Lorton (05:21):
Yes.

Lisa Miller (05:21):
So you often talk and write about the fact that once you understand one then all of

the sudden they give you another different contract now to deal with. So can you just talk a little bit about that and your experience with maybe a hospital feeling so overwhelmed with, "Oh, wait. Now I have a different model." Maybe a tactic or strategy to help them?

Adam Lorton (05:42):
Definitely. So, as you can imagine, with me all roads lead back to data and data models, but that doesn't mean that somebody who's just getting their heads around an incentive contract needs to build the perfect, the most complex data model possible. Even knowing the simplest things like how many covered lives are we talking about with each of these contracts? Let's say we have 10 contracts. 80% of our covered lives are most likely in two or three of those contracts.

Adam Lorton (06:13):
So that would be a good place to start. Knowing how much money is flowing through each contract — and of the money flowing through each contract, how much of that is variable? Because for the most part, we're talking about fee-for-service contracts that are adjusted up or down based on your quality outcomes. Now we could also be talking about a full risk arrangement and full risk arrangements, in ways, are easier to wrap your head around because if your patients go to the hospital too much, you lose in the full risk arrangement.

Lisa Miller (06:41):
Mm-hmm (affirmative).

Adam Lorton (06:42):
But back to the idea that you would want to start simple with contract modeling. It would be the idea of what are my contracts, how many dollars are flowing through each one — and of the dollars flowing through each one, how many of those dollars are variable? And then a layer of even more advanced would be of those variable dollars, how many are really within our control or how many are we going to succeed at, whether we try harder not? And so then you're starting to really zoom in on the place where you can make a difference. And I think you, Lisa as a cost accountant, will be able to appreciate the creativity that can go into this. I think cost accounting really gets a bad rap around the word “creativity” because the idea of bucketing

things into categories and making sure the right things are going in the right category is an incredibly creative process from where I sit.

Adam Lorton (07:37):
And I think that happens in cost accounting and in revenue modeling, but making sure that you can roll up your diabetes measures into diabetes care, or all of your costs and utilization measures into one theme. Then you can start to see, "Oh, okay. If we just focus on utilization or if we just focus on our diabetic population or our heart disease population, we'll be hitting 60% of our variable incentive dollars." So this is where we start to get smaller and smaller slices of the pie where we can actually make a difference.

Lisa Miller (08:12):
Yeah. Thank you. And I have a different question that just came up since you were talking. Do you find that auditing or ensuring that the payers are paying correctly, I mean, part of you, what you do is modeling and directing, right?

Adam Lorton (08:32):
Yes.

Lisa Miller (08:32):
And putting things together maybe to predict and to help hospitals focus their direction. But what's your experience? I know what I've seen and I could imagine maybe you might see it too that the errors, maybe the effort needed to make sure that the payers are paying the right amounts.

Adam Lorton (08:53):
Well, exactly right. And this is getting closer to your area of expertise than mine, Lisa, but you're exactly right. That just because it was said in the contract and often it's even less about the contract and more about the really beautiful PowerPoint deck that was used to sell the contract. In that PowerPoint deck everything works great. Down to the penny. Every quality outcome is accounted for and every dollar is directed appropriately. And of course you and I both know, the devil's in the details. So you're exactly right that that's a huge area of opportunity and it's way less sexy than predictive modeling and hence gets less attention a lot of times.

Lisa Miller (09:32):
Yeah, that's the truth. But you can learn a lot from history and a lot from digging into that really to help them models going forward. But everybody loves predictive, new and exciting technology. I don't really like auditing always very much, but there's a lot of information, like you said, a lot of details that can be uncovered in that review.

Adam Lorton (09:53):
Well, you're exactly right and it hits on an inherent conflict in data work, which I'm sure you've experienced — which is on the one hand we want the healthcare leaders who are consuming this data, we want them to believe the reports and to take decisive action because to question every single-line item on a report, well that's valuable time that someone could be spending actually improving their organization. On the same side of the coin, it does fall to someone — and I think the data people are an appropriate place for that to fall — to make sure that the inputs going into these reports that are powering decisions that affect thousands of patients, hundreds, thousands of employees, millions of dollars of expenses, that those decisions are based on a solid foundation.

Lisa Miller (10:41):
Absolutely. In some cases, even the strategy and those impact the things that you just spoke about. So absolutely. In reading your work, I found this one line that you said that's so important and I always talk about the operating room a lot. I mean, that's where I started my healthcare career. Share more with that with you later, but-

Adam Lorton (11:09):
Mm-hmm (affirmative).

Lisa Miller (11:10):
You say, "I saw a lot of investment in operating rooms and not a lot of investment in primary care." So you kind of saw that early-on. Can you talk a little bit about that?

Adam Lorton (11:19):
Well, sure. And this is part of my evolution in the healthcare business. There's this idea in psychology that anything you're paying attention to right now consumes your attention and becomes way more important in your mind probably than it actually is. And that was how pay-for-performance programs became for me. As I'm

warning our executive team, "Look. There are hundreds of thousands of dollars at risk in the readmissions reduction program. Over a million dollars at risk in the HAC penalty. You guys have to pay attention to this." And meanwhile, especially on the readmissions reduction program, it would have been easy for a person with broader perspective than I had to look and see, "No, actually readmissions are not just not a problem —they're actively profitable. Profitable to the tune of several million dollars."

Adam Lorton (12:15):
"An order of magnitude greater than the penalty we could possibly get on these. So, sorry, Adam. We appreciate your work, but it would be counterproductive to focus where you suggest we're focusing." So that was initially frustrating. And of course, seeing greater perspective, understanding the profitability angle, I can understand why the executives were making the decisions they were and that made me all the more motivated to push for contracts — when I had the influence to do so — push for contracts that were more aligned to population health because if we get rich by doing more repair care as opposed to getting rich by keeping people healthy, then that's not good for this whole country.

Lisa Miller (13:02):
Yeah, no. That's absolutely true. While we have some still time left, can you just talk about maybe you focus quite a bit on physician offices and that is your sub sub specialty, right?

Adam Lorton (13:18):
More like physician organizations.

Adam Lorton (13:20):
Groups of providers who are banding together to negotiate a contract, often a risk-based contract, with an insurer. By the way, an insurer who is a lot better at math than they are a lot of times.

Lisa Miller (13:31):
Yeah. Right. You know what? I'm going to ask you one question first.

Adam Lorton (13:36):
Yeah. Go ahead.

Lisa Miller (13:36):
How important is negotiation in this process? So you develop these great models and you're looking at the contract that's probably proposed and you're kind of saying, "Well, we need to change these three things. I think this is a big opportunity, but this one might be put you at risk. Here's my strategy," but now you have to go negotiate it.

Adam Lorton (14:04):
Quite right. And it's a tricky thing because, especially on the glitzy PowerPoint deck, it'll look like a take it or leave it kind of offer. And so the experience, and I'll be frank in saying that I would rely on somebody with more experience than myself to really know what are the numbers that we can push on here in this contract and what are the terms that are going to be fixed for everybody who's being presented this offer? But you're exactly right that contract selection and how it plays into an organization's overall risk strategy. It's not enough just to evaluate a single contract on its own — because if you were at risk for 150% of the money you could possibly make in a year, that would seem like, over-leveraged is the term they would use in finance.

Lisa Miller (14:51):
Right. But if they have someone like you on their team, it's a bit like chess, I would imagine. Data's a really important part about negotiation. The more data, the more information you're giving those that's got to sign or review the contract, the ability to get to maybe outsmart or outmaneuver a little bit. And I only mean that in the respect that this does become a negotiation and I think data probably helps quite a bit. I don't know-

Adam Lorton (15:30):
No, you're exactly right, Lisa. And actually I can point to times that we've actually shared our analysis, imperfect as it is, with the insurance company and say, "Look. We ran the numbers according to what you gave us and we see ourselves as profitable in year one, but underwater in years two and three. We can't agree to this." And having that level of transparency builds trust in the negotiation, lets a person maybe negotiate on some of the intangibles or the non-monetary aspects of the contract, and I'm a fan of that style of negotiation-

Adam Lorton (16:07):
High transparency because aren't we supposed to be aligned in this population health thing?

Lisa Miller (16:12):
Absolutely. You are 100% right. But I love what you just said, you just said you're able to look year out two, three, and four. That's an important analysis not to look out one year. I think taking, rolling that out to year two and three is so important. Go ahead.

Adam Lorton (16:32):
Well, exactly right. Especially because when we're talking about a full risk contract. The reason we're entering into this contract is because we're trying to bend the cost curve, we're trying to provide higher quality care at a lower cost, and so that means the cost targets are probably going to ratchet down every year. Are they ratcheting down a reasonable amount, an achievable amount? Those are the questions that a good analysis would seek to answer — and it's a tricky question to answer, but forgetting to answer it at all, I think would be a mistake.

Lisa Miller (17:05):
Yeah. So before we end, I want to talk about how important it is for healthcare organizations to have really great data analytical skills within their organization. And we're going to get to your brand new handbook, it's called the *Healthcare Data Hiring Handbook* and we'll get to where people can go in and to get that handbook and I'm sure you're offering some advisory services also in that capacity as well because of your experience. But can you talk about why you wrote the book and why it's so important for a hospital, a physician organization, to have these skills internally?

Adam Lorton (17:48):
Sure.

Lisa Miller (17:49):
And the reason, the gap maybe.

Adam Lorton (17:51):
Well sure. I really appreciate the question, Lisa. And so let me bring you back to my

story about discovering this big HAC penalty looming. Millions of dollars at risk and the analyst's ability to influence the direction of the organization. And as you know, organizations, some faster than others, are getting more and more data-driven. Well as organizations get more and more data-driven those executive decisions that again are affecting thousands of patients, thousands of employees, and millions of dollars of expenses, those are being based on data. That data comes from somewhere, right? So when you think about the ROI of an analyst, I would encourage you to think about it through that lens if you're listening to this podcast, And Lisa, as a person who appreciates the cost side of the ledger, I would like to offer a comparison with physician recruiting.

Adam Lorton (18:50):
So like I said, that day I was more influential than any physician was on the organization. And that's not to diminish, in general, the ability of a physician or the impact of a physician — but let's compare recruiting analysts to recruiting providers. And by the way, I'm not talking about a recruiting an established, productive surgeon. If we're talking about somebody who is guaranteed to bring in millions of dollars in year one, by all means, spend away, buy them a steak dinner or whatever you have to do, get their spouse a job, no problem whatsoever. But I'm talking about recruiting physicians fresh out of school versus analysts and data scientists. You'll see a lot of hospitals or healthcare organizations visiting the medical schools, buying lunches, you're offering weekly professional development seminars. And this physician recruiting program, basically a multi-year onboarding where you're teaching them the business of healthcare.

Adam Lorton (19:47):
Now a lot of your healthcare analysts, it's much less expensive to recruit, much less expensive to pay them — and when you think about the value a good analyst or a good data scientist can bring to the organization, it seems to me like this is a real opportunity. Now if you're a person like us, you're probably like, "Yeah, yeah Adam. I get it. Of course data people are valuable, but it's not like I can just go steal some of the physician recruiting budget or start offering the things that physician recruiting is offering." So I have some ideas about what you could do if you wanted to recruit better data talent. And so thinking first, what does the Hippocratic oath start with? First do no harm.

Lisa Miller (20:31):
Mm-hmm (affirmative).

Adam Lorton (20:33):
So the first way to do no harm in your recruiting of data people would be don't hire somebody who won't add value. So this would be playing defense a little bit. And the way I would encourage people to think about this is making the screening process more rigorous. So for example, a lot of people, once a candidate passes an initial screen, will just jump them straight to an in-person interview. An in-person interview, as you know Lisa, is really expensive — and, for an analyst, not always actually the best indicator of how they'll perform on the job.

Adam Lorton (21:06):
So one of my recommendations is to start with a work sample screen. Say, "Hey, candidate. We want somebody who produces analytical work that stands on its own, that you don't have to explain. So can you just email us something you've already done and we'll review it. And if your work product looks like the work product of an analyst, then we'll bring you in for an interview." So that's something that can save you money and would you believe half of people who apply for jobs, don't send in a work sample?

Lisa Miller (21:34):
Yeah.

Lisa Miller (21:37):
I agree with that. And I want you to continue because this is so awesome, but I will say for us when we hire data analysts, we want a work sample and then we give them a project-

Adam Lorton (21:48):
Great.

Lisa Miller (21:51):
And then we tell them what the project is, we give them a laptop, and we want to see how they perform. But I don't want to jump, but I want you to keep on going.

Adam Lorton (21:59):
No. I love it. And that's directly in line with what all the smartest organizations out there are doing and I'm not just talking about healthcare, I'm talking about in high technology, that's what you you'll see. So yeah. Definitely recommend a work sample. If you can give them a sample project, especially a sample project. I'm guessing Lisa that you're giving them something that maybe one of your senior people has already attempted. So you know what a great work product would look like for this project.

Lisa Miller (22:25):
Exactly. We know what it should look like. Absolutely. And it's not brand new. It's something that everyone in the organization — particularly a more advanced analyst — would know how that needs to be thought through, put together, and even in a timeframe. Now I know it's stressful in an interview, but we kind of also have an idea of that. And of course, any mistakes, accuracy.

Adam Lorton (22:50):
Yep. Exactly right. I mean, if you took nothing else away from this and you wanted to improve your recruiting process, asking for a work sample, that would be my very top recommendation. But after that, if a person passes a work sample, my next recommendation would be to use behavioral interviewing. So this is not going to be new to a lot of hiring managers, but asking them specifically what they did in their past experience as opposed to how would you hypothetically handle a situation? People love to tell you how they would hypothetically handle a situation. And a lot of times, hypothetically, they handled it a lot better than they did in their past.

Lisa Miller (23:25):
Right.

Adam Lorton (23:28):
That would be a second recommendation, behavioral interviewing.

Lisa Miller (23:31):
Mm-hmm (affirmative).

Adam Lorton (23:33):
So those are all what I would call defense tactics, avoiding a bad hire, but there are

also steps a person can take to have a better chance of a good hire. And so that be well, number one, to work your network. So that is to say, don't just post a job description and pray — actually reach out to trusted colleagues and say, "Hey. There's an opening. Do you know anyone who would be interested?"

Lisa Miller (23:57):
Mm-hmm (affirmative).

Adam Lorton (23:58):
And then you would have to forward something, that thing would be a job description. And actually the job description I see as a huge opportunity for a lot of organizations. Let's think about some of the offending job descriptions that I've read. Candidate supports the mission, vision, and values of our local healthcare. Candidate reports to the director of clinical operations. Compare that to something that actually sells the opportunity. If you're hiring a great talent, let's hope you believe that you're actually a great place to work. Surely you must have something to offer that candidate. And the first sentence of your job description should be more like, "Are you looking for X?" Where X is an actual development opportunity or an actual something that a top candidate would be excited about.

Lisa Miller (24:53):
Right. It's something like innovative environment or creative where we want you to think differently. I mean, you want to get them excited, right?

Adam Lorton (25:00):
Right. Or even, "Are you interested in applying your data analysis skills to population health?"

Lisa Miller (25:05):
Right.

Adam Lorton (25:05):
I mean, even that is a better question than, "Supports the mission, vision, and values of our local healthcare."

Lisa Miller (25:11):
Right. That's a great point.

Adam Lorton (25:13):
Sure. So actually for anyone listening to this, I made a free handout called Healthcare Data Job Description templates and that would be a great place to get started. And that's at analyticaliq.com/jdt, J-D-T for job description templates.

Lisa Miller (25:30):
Mm-hmm (affirmative).

Adam Lorton (25:31):
And so all the ideas that I've been talking about just now, those are in the healthcare data hiring handbook, which is also available on my website. That'd be a paid product and the idea is that it gives you email scripts, processes, and entire start-to-finish process that you can use and is completely ready to go for you. So that instead of doing the, I don't want to say backbreaking work, but doing the emotional labor of creating the documents and training your team that a lot of that work, you can just hit the ground running on. So that's the promise of the handbook. And if anybody's interested, it's easy to find.

Lisa Miller (26:07):
Thank you so much, Adam. And I would go and just talk about that for a minute because when we do our work, I am often trying to tell a lot of the healthcare leaders about bringing on analysts and adding that and I know that adding...is not always...it just depends, right? They have so much to balance, but I've always shared the value of having a data analyst in different areas and give them insights into how we would utilize them. And a lot of hospitals have taken that advice and have come back and just said, "Well that ROI was 20, 30, 40 times."

Lisa Miller (26:48):
And I just think we have to look at places where we can plug in really great data scientists or data analysts into the organization. They will pay extraordinarily dividend. And I love the fact that you wrote a handbook. It's really needed. And I just want to let everybody know again, it's analyticaliq.com. And Adam Lorton. He is an expert on those population and pay-to-performance agreements. You can reach out

to him as well as with the handbook and thank you today for being so generous with your information and time. We appreciate it.

Adam Lorton (27:30):
Well thank you, Lisa. It was a fun conversation.

Lisa Miller (27:33):
Yeah. Let's talk soon.

Adam Lorton (27:35):
Yes.

THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

MEET LISA MILLER

It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999.

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through front line insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.

She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book The Entrepreneurial Hospital is being published by Taylor Francis.

THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

MEET ADAM LORTON

Healthcare Data Consultant, Analytical IQ and the author of The Healthcare Data Handbook: All the tools you need to add new analytical talent to your team.

I started my healthcare career as a hospital pay-for-performance analyst. I was teaching providers about the CMS readmissions program. I warned that if our patients came back to the hospital after hip and knee replacements, we'd be in trouble. We could lose tens of thousands of dollars!

Trying to understand the bigger picture, I became a hospital profitability analyst. The picture started to come into focus. Reducing readmissions was the right thing to do for patients, but not for hospital finances! We got paid for every readmission. The CMS readmissions penalty was a drop in the bucket compared to our profit margin on readmissions.

Even though I heard a lot about 'population health', actions spoke louder than words. I saw a lot of investment in operating rooms and not a lot of investment in primary care.

It seemed like everyone was talking about Population Health, but they were perfectly content with the status quo.

Eventually, I found myself doing contract work at a PO. To my surprise and delight, I was suddenly among people who were actually transforming healthcare. They had a network of primary care providers working to keep their patients out of the hospital. They were using data to target the highest-priority patients. They wanted me to tighten up their data strategy, so they'd be ready for the risk-based contracts they knew were inevitable — and I was excited to dive in.

I decided POs are my kind of people!

If the transition to value is the most important thing happening in healthcare, and if POs are the ones driving that change the hardest, then POs are who I'm going to serve.

Transforming healthcare is hard work. From what I've seen, there's no easy fix. But I think it's worth fixing the hard way.