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Q&A: Christopher Stanley, M.D., M.B.A., of Henry Ford Subsidiary Populance

Nonprofit population health services company starts with internal customers but plans to expand

David Raths

In 2024, Detroit-based Henry Ford Health launched a nonprofit subsidiary dedicated to advancing population health. The health system said the new company, called Populance, will support doctors, hospitals and health plans by providing value-based care services designed to improve outcomes and enhance the patient experience while lowering the total cost of care. Its initial internal customers are the health system's clinically integrated network and its insurance company subsidiary. Populance President Christopher Stanley, M.D., M.B.A., the former chief population health officer at Sutter Health, recently spoke with *Healthcare Innovation* about the plans to expand within Michigan and eventually beyond its borders.

Healthcare Innovation: Was the impetus for the creation of the company things the health system itself was hearing from providers about things that they need more help with, like managing chronic conditions or transitions of care?

Stanley: Yes, absolutely. I'd say that the transitions of care, complex case management, and end-of-life care were all things that we as a system had been doing in little pockets or in certain practices for many years. We had just never really scaled it up across the entire enterprise or across the entire community. So a big part of the impetus was to be able to scale it up, build upon our capabilities that we had already made investments in and directly in line with what physicians asked us to provide, as well as patients and our own health plan as well.

HCI: Are there some things, such as the analytics, that might differentiate Populance from other population health platforms or services?

Stanley: Yes. I'll highlight two or three pieces that I think are key differentiators for us. One is that we are not developing our capabilities from scratch and imposing it inside of a health system. We actually are more sort of organic. We have been founded and birthed out of a nonprofit care delivery system with an integrated health plan. So rather than being told what to do on the physician side, we actually have been building these capabilities and now enabling it based upon how they work, using things like Epic.

A second differentiator involves the analytics piece. Many external, especially venture capital-backed organizations, will pull publicly available information or claims information from just a segment of available information. We actually have a much more holistic view. We combine both the clinical information we get through Epic and other electronic medical record information with claims information we either get from external payers or our own health plan, combining it with social driver of health data and patient-provided information. That allows us to do things like risk stratification, risk identification, and understand who would really benefit from our services.

Another piece that I think is a real key differentiator for us compared to a lot of organizations is that we are not just built to provide a service, get paid for the service and then grow it and sell it off. We actually are looking to drive results, drive a difference in experience, quality and total cost of care. Are the programs actually delivering the results that we need? Are they reducing readmissions? Are they reducing avoidable ED visits? Are we improving diabetes care?

HCI: Are you using a homegrown tech platform or is it developed in partnership with a company like Innovaccer or Arcadia?

Stanley: To date, we've largely built our capabilities upon Epic with some internal, homegrown analytic capabilities. We actually are in the final stages of adding

analytics capabilities with one of those companies that you just mentioned around things that we don't have the time or the speed or the knowledge to do.

HCI: When it comes to something like care management, is the Populance team actually talking directly to patients? Or is it making recommendations to the providers they're already connected to?

Stanley: Our primary role really is directly talking with patients. We have care managers who are embedded in the majority of our larger primary care offices. They are part of the care team along with the physician and the office staff and are directly working side by side with them. For patients who don't have a direct connection to primary care, we also have a telephonic group that will outreach to patients via phone or some other electronic messaging.

We make sure to have a feedback loop to the physician. Many times an individual who has a chronic disease or transitions out of the hospital has transportation, financial issues, food insecurity — typical SDoH type of issues.We may provide either linkage back to community benefit providers or to the physician. I, as a pediatrician, would like to know if my patients can't afford their medication. I may prescribe something less expensive, or I may ask for them to be included in a community assistance program. There is that ongoing feedback loop, but we are not just making recommendations that someone else then needs to execute.

HCI: Henry Ford has a clinically integrated network. Can you offer the same care management services to both employed and affiliated physicians in that group?

Stanley: The quick answer is yes. Without going into the clinically integrated network's mechanics too much, they are a really important customer for Populance, one of our two primary customers right now, and we do want to offer the same services and capabilities for independent but aligned physicians who are part of that integrated network, as we do for the employed. Just as each employee practice looks a little bit different, whether they're more rural, whether they're more urban, whether they're a big practice or small practice, we also try to tailor our services based upon

what that independent physician's needs are like as well. But yes, Populance spans the entire breadth of our clinically integrated network.

HCI: When I talk to people working with clinically integrated networks, I often hear that one of the challenges to overcome is that they're on a dozen different EHRs, which makes data sharing difficult. Is that an issue you have to address?

Stanley: This was a pleasant surprise to me that almost all of our independent physicians are on the Henry Ford Health instance of Epic through Epic Community Connect, which is a different experience than I've had with other organizations. To have the majority within the Epic ecosystem doesn't necessarily mean that it's always simple and easy. There are still nuances associated with that. And there is no guarantee that as Populance grows and starts to provide support for other provider organizations in the state and hopefully even in the region and nationwide, the same Epic-based ecosystem will exist. That's why we have other alternative solutions for care management capabilities that will integrate with other EMRs or with data exchange processes. For instance, in Michigan, we can share through MiHIN, the health information network.

HCI: You mentioned the possibilities of scaling this up quite a bit larger. What kind of expectations do you have for how rapidly you might be able to grow this, both within Michigan and then beyond?

Stanley: We are approaching this as an internally funded business that has a certain level of independence. We are definitely looking to grow externally with other provider organizations, maybe smaller health plans, potentially even direct to employer. I do want to emphasize, though, that we are not growing just for growth's sake. Rather, we are looking at this really for two main drivers. One is we believe that done correctly, especially as provider organizations and care delivery systems are moving more and more into risk-based payment models, that the services that we offer and the results that we are delivering and enabling are what other communities need to have available and accessible for them.

Being a nonprofit, and therefore not having a big margin associated with it, we're really looking to improve health, not necessarily to make a lot of money. We believe that will resonate with physicians as well. So it'll be a nice competitive edge for us. And we certainly want to make sure that we are being very successful with our core partners, our anchor partners, if you will.

We've already started talking with some other Michigan-based provider organizations that are very interested in the model, with the results and with the economies of scale that come along with analytics tools. We're hoping that we will have our first external customer, even if it's reasonably small, in 2025 and then continue to grow in 2026.

HCI: Henry Ford has had experience with value-based care. Is Michigan fairly advanced or sophisticated in terms of adoption of these alternative payment models? And are a lot of physician groups in Michigan already participating in in value-based care contracts?

Stanley: They really are. The largest payer in the state, Blue Cross Blue Shield of Michigan, and our own Health Alliance Plan (HAP) have been pioneers in alternative payment models that make sense for physicians and provider organizations. That started well before many other locations in the U.S. did.

Our state is relatively very evolved, commercial payers in particular, and Medicare Advantage and Medicaid too have started on that journey. We want to accelerate that journey.

HCI: What's the relationship between HAP and Populance?

Stanley: I mentioned before that the clinically integrated network is one of our customers. The other customer that we have is HAP, our health plan. The care management, transition-of-care support, and a little bit of utilization activities are now essentially in-sourced to Populance. We were actually formed in the beginning of 2024 by combining three different teams of care management and other support staff that existed broadly within the company. Some of those were nurses and social

workers out of HAP. They became Populance employees. The same was true for our medical group, which was where a lot of care managers were housed. And then we have a market in the Jackson, Michigan, area called Jackson Health Network, and there was a collection of care managers there, too. We brought together all of these care managers and other related staff, roughly a total of about 140 FTEs who were working in isolation, and unfortunately, at times, they were even competing with each other for resources. They were contacting the very same patients, sometimes with different messages.

HCI: It sounds like that consolidation provides opportunities for alignment and training and a consistent message…

Stanley: That's exactly it. To give you one example. In transition-of-care programs, there are very standard things that have been proven to improve quality experience but also reduce readmissions, which is a cost driver. Our baseline, before Populance, was that x number of patient contacts were happening every day, week or month in helping patients transition. When we moved everybody into Populance and standardized the process, where we have a common platform and tool, we've actually gone to 2x for the number of contacts that we're making on a daily and weekly basis with the same number of staff that we had before.
Similarly, on the complex case management side, we're reaching about 25% more people in complex case management on a monthly basis than we were before. So we firmly believe that because we're touching patients more, we're standardizing the processes and tracking our results, we will see the results coming out of that. So it's not just about efficiency, but also driving the results.

HCI: Anything else you want to mention?

Stanley: Another aspect, which is critically valuable and housed within Populance, is managing the post-acute space. We have a very dedicated team around working directly with the best SNFs in our region, with very clear expectations about quality experience and readmission rates. We are managing a highly curated SNF network and then helping patients transition into, through and out of those locations. That’s a more advanced capability than what many organizations will have.