Governance Best Practices for Managing Risk around Population Health

By Brian Silverstein, M.D., The Chartis Group

The emergence of population health management over the past several years has introduced new economic dynamics and governance considerations within the healthcare market. Increasingly, healthcare providers are attempting to advance the health of the populations they serve through coordinated programs and activities that address both clinical and social determinants of health, incentivized by value-based payment models that reward high-value care delivery and improvements to specific populations' health.

Multiple factors are driving the adoption of new payment models. Insurers are opting to move toward population health management to reduce the total cost of care and associated economics. State regulations can also push payers and providers in this direction. Healthcare organizations and physician groups that excel at proactive patient care may opt for this sort of value-based contracting to align incentives to reward the high-value care they seek to provide and, in turn, improve their financial performance. Employers seeking direct health system contracts and consumers demanding increased value and convenience are also forcing moves in this direction.

While fee-for-service reimbursement is still highly prevalent, several different value-based payment models have emerged that in many cases complement fee-for-service models. The pay-for-performance model typically lays atop a fee-for-service scheme, with some portion of provider reimbursement tied to specific metrics. Bundled payments group specific services for which providers agree to take responsibility for service costs. Several accountable care organization (ACO) models are also employed. ACO shared savings plans, which are often combined with some degree of fee-for-service, analyze actual spending compared to a specified target for a defined population over a set period; providers and payers then share in the savings realized. Under a capitation model, a provider group receives prospective fixed payments and takes responsibility for managing all associated costs.

Key Board Takeaways

Managing risk around population health requires:

- The active involvement of clinicians in tandem with hospital/health system owners
- Contracts and financial models that balance risk and reward
- Well-thought-out network configuration and management
- Close attention to care management and clinical collaboration to create a seamless patient care process
- Business intelligence, analytics, and connectivity to drive and support the effort
- Awareness of the need to manage a range of populations
- Coordination between system-level and practice-level operations

Guidance for Governance

Clearly, hospitals and health systems making the move toward population health management-based payment models need to have strong governance and a robust strategy to succeed. As has proven to be the case with ACOs, clinicians are critical to the governance of population health efforts. The governing board should be clinician-led, with physicians and other practitioners actively involved in designing and implementing clinical programs. The governance structure should balance clinician leadership and involvement in decision making with owners' own reserve powers, providing the entity with the appropriate protections and governance rights for owners. Beyond the board, targeted committees and *ad hoc* workgroups featuring additional clinicians may address specific aspects like performance management, contracting, information technology (IT), and network development.

Providers seek to proactively develop a contracting strategy and product portfolio approach with an incentive model that is closely aligned with the overall clinical strategy. Metrics need to be carefully chosen to reflect and reinforce the goals of the organization's population health management endeavors. Steps should be taken to monitor the financial performance of value-based contracts in real time to surface any issues as they arise.

Network configuration and management also require careful consideration. Advanced approaches are needed to attract clinicians and build a high-value network positioned to manage the targeted population. The network of owned and contracted services must be optimized in order to provide full access across the continuum to high-value services. The primary care network, which in many ACO models is the basis for population attribution and management, is particularly critical to be aligned and integrated to best attract and serve target populations.

Creating a seamless patient care process over the full continuum of care necessitates close attention to care management and clinical collaboration. Evidence-based systems of care based on specific target populations need to be developed. Performance improvement must be embedded in operations, supported by performance management processes and systems. Care management for at-risk individuals should also be proactively implemented to help keep them healthy.

As in most aspects of healthcare, data and technology—specifically around business intelligence, analytics, and connectivity—play critical roles in population health management. The electronic health record system and other systems must be able to support the value-based model, with ties to a single comprehensive data warehouse accompanied by robust policies and procedures for governance. All of the human and electronic infrastructure and operations needs to support value-based

care delivery are different than what is needed for fee-for-service. Data analytics can be used to stratify risk by population and other data types integrated to refine risk adjustment. Predictive modeling is essential for anticipating community needs and prioritizing intervention.

The Risk Management Approach

Compounding the challenges posed by population health management is the simple fact that hospitals and health systems do not manage a single population, but rather multiple populations with different levels of risk under myriad reimbursement models; providers must manage the business paradox posed by engaging in both fee-for-service and value-based care contracts and care delivery. Adding new services to improve patient health, such as care management, without a clear value-based reimbursement mechanism to support these services can lead to increases in operating costs. Meanwhile, resulting improvements to patient health can ultimately lower utilization of some services. Both dynamics may be good for patient health but can create challenging economics for the organization.

While there is no single prescriptive methodology for managing risk around population health, there are some key activities that healthcare organizations need to perform well. Effective population segmentation and stratification must be performed to determine how best to engage or intervene with each cluster of patients. Clinical management and care models have to advance in order to develop a proactive patient-centric care system. Strategically engaging provider and community partners while also promoting consumer engagement and access combine to guide high-risk individuals toward better health before chronic conditions advance. Economics need to be aligned through a strategic payer portfolio strategy, with contracting that provides incentives to all parties and proper resource management. Providers need a strong foundation in IT, workflow applications, data, and the analytic capabilities to utilize and manage data to drive outcomes. It is critical that boards have a competent management team in place to take these actions or a focus on hiring staff that can execute on these strategies. Another opportunity is to hire advisors as a stopgap or to supplement the team.

The Governance Institute thanks Brian Silverstein, M.D., Director, Value-Based Care Practice, The Chartis Group, and Governance Institute Advisor, for contributing this article. He can be reached at bsilverstein@chartis.com.