Six Business Imperatives Expand Board Oversight

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Healthcare's transition to a population health model presents hospitals and health systems with significant business opportunities and challenges. Increasingly, organizations will be responsible for providing defined care to a specific population while managing the population's total cost of care.

The value-driven approach to care delivery and financing focused on population health management (PHM) alters the established business fundamentals. To succeed, healthcare directors and executives must rethink the scope of their enterprise, including where, to whom, and how their organizations provide services, and which services are most appropriate given the unique needs of the populations they serve.

Significant additional board knowledge and oversight will be needed to arrive at a sustainable "solution set" for managing population health. Some organizations are changing board composition to include physicians and members with expertise in quality improvement, risk management, cost reduction, and other key PHM areas; other organizations need to move more rapidly to gain needed experience.[1]

Addressed here are six business imperatives that should be front and center on all board radar screens in developing and implementing their PHM strategy. These imperatives are interrelated and interdisciplinary, crossing strategic, financial, clinical, operational, and capital management domains.

Key Board Takeaways

Below are six business imperatives boards should focus on as they develop and implement their population health management strategy, as well as questions to consider related to each:

1. Physician and clinical alignment:
   - » How do we ensure alignment with employed and independent physicians?
   - » What incentives are available for physicians? Do contractual arrangements clearly delineate the criteria for incentives? How do we address physicians not performing up to defined standards?
   - » How is leakage of patients to non-network physicians prevented? Do physicians clearly understand how attribution works?
2. Contracting strategy:
   - » What's our plan for gaining experience in managing risk through contracting arrangements?
   - » What's our strategy to ensure inclusion in key networks forming in our community?
3. Network optimization:
   - » What role will our organization play in a care delivery network? How are we determining the best combination and location of services and programs?
   - » How are we learning about consumer preferences and purchasing behavior?
4. Operational efficiency:
   - » How are we working with physician practices, post-acute, home care, and other providers to ensure efficiency and deliver value?
   - » What can we do to transform our cost structure to a much lower level?
5. Enabling infrastructure:
   - » Which means are we considering—building, buying, partnering—to gain needed infrastructure quickly?
   - » What process are we using to make capital investment decisions that support the organization's role in PHM? What return do we expect from these investments?
6. Clinical management:
   - » How do/will we prioritize PHM efforts across patient health-risk categories?
   - » What interventions will we develop and implement? How do/will we evaluate the success of these interventions and ensure improvement on an ongoing basis?

Physician and Clinical Alignment

Improved economic and clinical alignment between hospitals and physicians will be essential to:

- Change the way patient care is delivered.
- Enhance patient, family, and provider satisfaction and engagement.
- Improve each element of the value equation (i.e., quality, access, patient experience, and operating/capital efficiency).
- Succeed under value- and/or risk-based arrangements.

Developing a solid hospital–physician alignment plan involves recognizing that one strategy will not be appropriate for all physicians, and that hospitals should offer physicians multiple options.

Finding the right incentives to motivate physicians is vital. Incentives should cover dimensions including financial, access, competition and recognition (e.g., quality ranking scores), and patient care (e.g., improved health outcomes). The most important principle is to develop uniform, readily quantifiable, consensus-driven incentive standards and metrics that have a consistent application across clinicians, locations, and specialties.

As health systems start building their physician networks, they typically have more relaxed (or lower threshold) performance criteria. As their experience grows, they tighten the criteria and are able to be more selective with physician participation. Physicians not performing up to defined standards often opt out or are *not* allowed to continue to participate in the network's value-based contracts.

For success with PHM contracting arrangements, a hospital or health system must have an integrated network of primary care physicians and must ensure accurate attribution of the targeted population segment(s) to this network. *Attribution* in PHM programs is the assignment of an individual to a specific primary care provider, typically based on past medical claims.

Contracting Strategy

Contracting is fundamental to PHM programs as it is the vehicle to delineate what payers or other purchasers and providers will be accountable for. Organizational and market nuances dictate the types of contracting arrangements pursued for targeted population segments, and how far and quickly an organization moves toward full risk models.

1 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition,* 2013 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Hospitals and health systems can participate in a variety of value-based or risk contracts, ranging from fee-for-service with incentives (e.g., gain sharing and pay-for-performance) to partial or full risk models (e.g., global payment, partial capitation, or full capitation). Fully integrated health systems will be able to use all types of contracting arrangements that tie payment to performance and outcomes, while small providers will be more limited in the types of arrangements they can secure.

Contracting for PHM will require consideration of the risks and opportunities related to the health/risk characteristics of the populations served by specific insurance products, design of HMO, PPO, and employer-directed plans, contract terms and conditions, narrow and tiered networks requirements, and partnership opportunities related to specific networks, products, and plans.

Hospitals that do not pursue PHM contracting with purchasers soon may find themselves excluded from key networks in their region or may be relegated to the role of a discounted vendor of acute care services.

Network Optimization

Effective and sustainable PHM requires the design and continuance of a high-performance delivery network. This network must cover the care continuum under an optimized contracting strategy, and apply effective approaches to engaging stakeholders, including patients, families, employers, and others. Sophisticated organizations will be developing an optimized network; other organizations will look to participate in an optimized network provided by another entity. To optimize networks, leaders consider:

- **Essentiality and adequacy:** The breadth and depth of care desired by the purchaser, and the ability to handle the projected volume of patients across the defined care settings
- **Service distribution right-sizing:** The elimination of duplication by reconfiguring the network to be highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care
- **Network growth strategy:** The ability to grow the attributed or accessible managed populations to support organizational infrastructure and associated costs

Consumer engagement ensures both the clinical and business success of managing a population's health within a network. Effective consumer engagement enables an organization to help shape healthy behaviors, achieve the right level of utilization, and steer individuals to the best site of care.

Operational Efficiency

As an organization's sphere of influence widens in a value-based environment, its cost/efficiency focus shifts from the traditional view, involving inpatient and physician-centric entities, to a population health view, involving a broader scope of the care continuum.

Broad strategic thinking about the care patients receive after they leave the hospital's four walls is required of leadership to ensure the right care in the right place, at lower costs and better quality.

Enabling Infrastructure

Managing population health involves major clinical and organizational transformation made possible by investment in areas including:

- Management and governance structures that include a high level of physician involvement and cover contracting, risk assessment, clinical, and operational decision making
- A delivery network of sufficient size and scope
- IT systems that are able to support clinical care management processes, common electronic health record systems, clinical and predictive analytics, and business functions
- Care management and coordination tools and protocols tied to an enterprise-wide decision support and reporting function
- Contracting and risk assessment and management capabilities
- Patient engagement programs to build loyalty and "stickiness"

PHM will require leaders to rethink their infrastructure needs and invest and organize in a way that supports the organization's role and key initiatives in PHM going forward.

Clinical Management

Three clinical imperatives apply to all hospitals and health systems, however large or small a role they play in PHM:

- **Identify, stratify, and prioritize the patient population along the health-risk continuum:** Organizations identify the geography they serve and the contracting arrangements for the patient populations within this geography. They then prioritize their PHM efforts for efficiency and effectiveness across patient health-risk categories.
- **Develop and implement interventions to improve health, access, and outcomes, and to reduce costs:** Hospitals understand the impact of technology and care settings, and recognize the importance of consumer engagement, new provider types, collaborative practice, and evidence-based medicine. They then design and implement prevention initiatives based on population health risk categories, spanning wellness, care transitions, disease management, care coordination, care navigation, and end of life, as appropriate.
- **Evaluate and refine the approaches and interventions:** Hospitals and health systems understand the big-picture objectives of performance improvement and the on-the-ground challenges of selecting and implementing appropriate measures of PHM progress. They select their targets and start moving toward the end goals of effective and efficient PHM.

The degree and pace at which organizations pursue the six business imperatives described here will depend on a variety of internal and external forces. These include organizational readiness with new competencies required for value-based care, overall stage of market evolution, vertical collaboration across health plans and provider organizations, and existing risk contracts and relationships. But population health management is the way U.S. care delivery is going, so all healthcare boards and management teams must work to develop the knowledge and skills to move their organizations in the right direction.

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