Getting Ready for Population Health

BY RITA E. NUMEROF, PH.D., AND MICHAEL N. ABRAMS, M.A., NUMEROF & ASSOCIATES, INC.

Healthcare delivery in the U.S. is entering a period of business change that is likely the most profound in its history. Driven by unsustainable levels of cost inflation, providers are being challenged by payers to adopt a new business model in which they accept greater accountability for the total cost and quality of care.

In a population health model, delivery organizations commit to providing comprehensive care to a designated segment of patients at an agreed-upon price with specific quality guarantees. Success will require dramatic changes in the management of clinical cost and quality, and in where, when, and how care is delivered.

The Centers for Medicare and Medicaid Services (CMS) is the country's largest payer and, by default, in the best position to lead this change. Under pressure to curtail cost inflation that threatens to overwhelm the national budget, CMS is becoming more aggressive in its efforts to force change on a system that nearly all agree is seriously flawed.

The CMS Bundled Payments for Care Improvement Initiative (BPCI) was one of many pilot programs implemented as an outgrowth of the Affordable Care Act (ACA) in 2010, intended to test new models and encourage hospitals and health systems to assume greater risk for care episodes. While participation in BPCI and numerous pilot programs that followed has been voluntary, Medicare is now introducing new bundled payment models where participation is mandatory. The recently implemented Comprehensive Care for Joint Replacement (CJR) program mandates that 800 hospitals in 67 selected metropolitan statistical areas across the country accept bundled payments that cover knee and hip replacement surgery from initial hospitalization through rehabilitation to 90 days post-surgery. CJR is indicative of where CMS is going, and we expect to see similar bundled payments in other high-cost, high-utilization therapeutic areas.

The ACA also introduced measures intended to hold delivery organizations accountable for quality shortfalls like medication errors, hospital-acquired infections, and excessive 30-day readmissions. The net effect has been to pressure delivery organization finances and spotlight quality and safety systems. CMS remains focused on the "Triple Aim" of improved patient experience, improved health of populations, and lower per capita cost. Through its efforts to test other payment models, CMS is also making it clear that the fee-for-service (FFS) payment model that has characterized the current care delivery landscape is going to be replaced by one in which providers accept risk for the quality and cost of the treatment they provide.

In light of the growing pressure to rein in costs and improve quality, delivery organizations are increasingly looking at population health management as a way to transition to what has been labeled a value-based payment model. The goal of population health management is to keep patients out of acute care settings, lowering overall costs and redefining "healthcare" as more than just "sick care." Unlike the current model, providers must coordinate treatments delivered across the entire care continuum—from preventative care programs to post-acute care settings. However, operating in this model will require many delivery organizations to make significant changes that run counter to established cultural norms. To complicate matters further, many of the pilot programs initiated by CMS incorporated improvement from historical baseline efficiency into payment, raising concerns for some that initiating change too early might actually penalize them.

Given that today's payment model is still predominantly FFS, many hospital boards and executives are scratching their heads and asking themselves two key questions:

1. When should we make the move to population health?
2. And where do we start?

Key Board Takeaways

Population health management represents a new business model in care delivery that forces providers to take accountability for cost and quality. However, it requires dramatic changes that run counter to established cultural norms. Successful transition must be accomplished with active guidance from the board. Now is the time to assess where your organization is in its ability to successfully handle value-based payment initiatives, and where you want to be in the future. Based on the results from Numerof's national survey on the state of population health, below are five steps for the board:

- Develop a clear vision for population health and plan to operationalize it.
- Communicate the vision broadly.
- Allocate resources to develop necessary capabilities.
- Identify where partnerships are needed.
- Hold staff accountable for implementing the organization's plan and achieving results.

When and Where to Get Started

Now is an opportune time for organizations to determine the direction they want to take, recognizing that the scale of operational and cultural change necessary in transitioning to a new business model requires time, and the clock is running. There are potential costs to being a leader, but there are also potential competitive advantages. And there are definitely potential costs in being a follower or a laggard. In any case, taking action now to prepare for population health is the only responsible choice for those with fiduciary accountability. In addition, the ability to manage variation in cost and quality that is central to population health can actually enhance margins in the current model while positioning the organization for competitive advantage going forward.

Developing bundled pricing for an acute procedure like hips and knees in the CJR bundle can be a reasonable starting point for transitioning to population health. Such an acute procedure has a clearly defined beginning, middle, and end. Once an organization develops the necessary infrastructure and builds the capabilities to manage variation in cost and quality, it can leverage that experience to tackle more challenging areas like the many chronic conditions that account for major care expenditures.

Those that learn how to do this quickly can create competitive advantage in the marketplace and can leverage that position with payers, employers, and consumers. In order to provide hospital executives with appropriate guidance and support as they work to transition their organizations, boards of directors need to understand not only what population health is, but also what it will take to transition to a new model. Boards that understand the challenges and obstacles their organizations face will be better prepared to ensure success.

Indications are that CMS is determined to drive business model change in the industry, and that value-based approaches are increasingly on executives' minds. Yet there has been little data available to characterize the status of implementation. To address this, Numerof & Associates partnered with David Nash, M.D., Dean of the Jefferson College of Population Health on a multi-phase assessment of healthcare delivery organizations across the U.S. The first phase consisted of in-depth interviews with healthcare executives nationwide. A survey was deployed for the second phase to quantify the progress organizations have made in population health efforts. (For additional information about the methodology, see the sidebar "Numerof State of Population Health Survey: Methodology.")

Numerof State of Population Health Survey: Methodology

During the qualitative phase of the survey between January and June 2015, Numerof conducted 104 in-depth interviews with executives and key decision makers across healthcare delivery organizations nationwide. Special efforts were made to include a variety of viewpoints based on such factors as region, organization type, organization size, and individual role. Interviews were conducted via telephone using a structured interview protocol that explored areas including the definition of population health, state of progress, roadblocks toward implementation, and rationale for pursuing it.

In the quantitative phase between June and July 2015, Numerof developed an online survey to validate and further explore key insights gathered during the qualitative phase. Approximately 8,750 individuals were invited to participate. The target audience for the survey was defined as individuals working in U.S. provider organizations, including healthcare systems, hospitals, and academic medical centers at the executive or vice president level.

Numerof received 315 completed surveys, corresponding to a response rate of 3.6 percent of individuals and 11 percent of institutions. Respondents included C-suite executives across the entire U.S. in urban, suburban, and rural areas. They represented standalone facilities, small systems, and IDNs; for-profit and not-for-profit institutions; and academic and community facilities.

There were 305 responses that passed the inclusion criteria, which required that respondents work for a healthcare delivery organization or physician practice as well as have at least partial knowledge of their organization's current population health management efforts.

Going forward, Numerof and Dr. Nash have committed to conducting the quantitative survey on an annual basis in order to track the evolution of population health management over time.

Key Research Findings

Based on the results of both the qualitative interviews and quantitative survey, a series of key themes emerged that characterize the provider market with respect to population health management at this time.[1]

1. Definitions of Population Health Vary Greatly, with Implications for Pace and Prioritization of Initiatives

During the qualitative interviews, organizations provided various definitions of "population health." Some defined it more narrowly (e.g., primarily focusing on wellness), while others saw it as a much broader initiative that includes full accountability for patient populations in a given community. Several even reported multiple definitions being used internally, resulting in heightened confusion across the organization.

Talking about her recent struggles with achieving alignment, the senior vice president of a large health system said, "There are many different definitions of population health in the organization, and this is part of the challenge."

Overall, how population health is internally defined has real implications for the pace at which the organization can move forward on its value-based initiatives as well as what specific initiatives are prioritized over others. Not surprisingly, organizations with a clear and focused approach to population health management were generally much further along than those without clarity and focus.

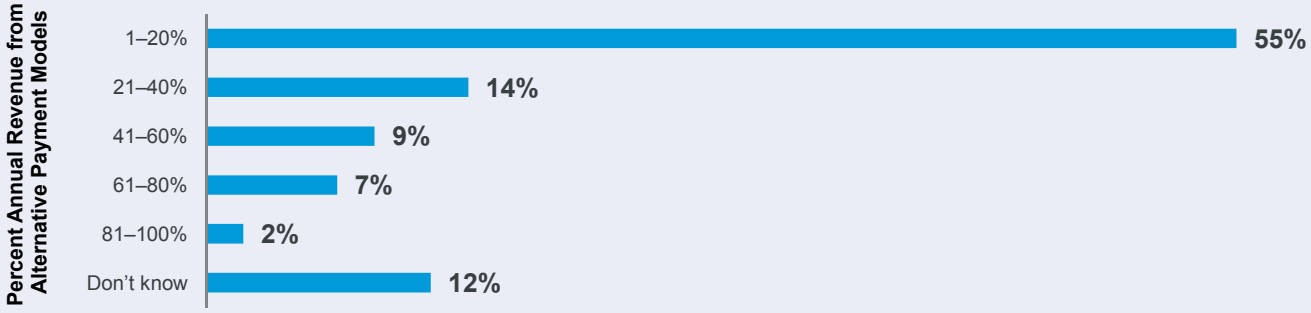
2. Many Are Exploring Alternative Payment Models, but Most Are Still Waiting to Take Bold Action

Although a significant majority of organizations are actively exploring alternative payment models, overall progress thus far appears limited.

Nearly four in five respondents (79 percent) reported that their organization is in at least one agreement with a payer that includes either upside gain or both upside and downside gain/risk. For organizations engaged in these types of arrangements, approximately half were in upside-only programs, while the

1 Portions of this section are from *The State of Population Health: Numerof Survey Report* conducted by Numerof & Associates in collaboration with Dr. David Nash, Dean of the Jefferson College of Population Health, released in January 2016.

Exhibit 1: Percent Annual Revenue from Agreements with Risk Potential*



*For respondents reporting participation in at least one agreement with upside gain and/or downside risk

other half were participating in at least one agreement with both upside gain and downside risk.

However, regardless of the exact structure of these agreements, most organizations have limited exposure to them (see **Exhibit 1**).

Over half of respondents (55 percent) reported that 20 percent or less of their organization's revenues currently flow through these agreements. This suggests that many organizations are still focused on small experiments and/or pilot programs (e.g., CMMI pilots), a hypothesis that's strongly supported by the findings from the qualitative interviews.

Most interviewees described these programs as important business model experimentation. For instance, the Senior Vice President of Population Health at an academic medical center clearly laid out the impetus behind the move to risk. "With respect to bundles, we've done work in different areas to standardize care. This is a good opportunity—we haven't done an episode to include post-acute care, where the opportunity really is. CMS doesn't care too much from a cost perspective on how the DRG is managed—they just pay the DRG. So the real issue is the 90 days after that. We've done a lot of good work, but not outside our institution. Now we have an 'opportunity'—we *have* to do this and focus on our relationships with SNFs, home health, etc."

When we looked at the data in Exhibit 1 in terms of which organizations are farthest along in readiness for population health, we found that those organizations most confident of readiness, (i.e., Leaders; see sidebar "Defining Leaders, Followers, and Laggards" for definitions) are moving more of their revenue potential into at-risk models (see Exhibit 3 on the following page).

Defining Leaders, Followers, and Laggards

Through our in-depth qualitative interviews, we identified systems and processes that were consistently in place at hospitals engaged in population health management. We present the results here in three categories: Leaders, Followers, and Laggards.

Survey respondents were categorized into one of three groups based on their self-reported readiness for at-risk payment models on a seven-point scale, now and in two years, with one representing "Not At All Prepared" and seven representing "Completely Prepared." Leaders were defined as those reporting their current readiness as a six or seven (n=61); Followers were defined as those who reported their current readiness as a five or below and their readiness in two years as a six or seven (n=121); and Laggards were defined as those who reported their readiness in two years as a five or below (n=123).

In summary, Leaders reported that their organizations were ready to take on financial risk now, and felt that they had key components in place. Followers described their organizations as not ready for financial risk today, but expected they would be in two years. Followers are committed to working to make the transition and are in the middle of putting supporting structures in place throughout the organization. Laggards described their organizations as not ready for financial risk today, and also not ready to assume financial risk within the next two years. Although many Laggards have started the transition, they describe their organizations as being in the early phases of that work.

3. Culture Is Critical for Success

In the survey, respondents reported numerous reasons for engaging in population health, including better control of cost, quality, and outcomes; concerns about the viability of the current FFS model; and mission/cultural alignment. They were also asked to select the primary factor for pursuing population health from a list of reasons that were frequently cited in the interviews. Leaders most frequently cited mission/culture as a primary rationale (see **Exhibit 2** on the following page).

> Boards of directors need to understand not only what population health is, but also what it will take to transition to a new model. Boards that understand the challenges and obstacles their organizations face will be better prepared to ensure success.

In many ways, Leaders have made the most progress toward alternative payment models and population health management. Compared to others, these organizations are more likely to move significant portions of revenue to at-risk models (see **Exhibit 3**). Leaders also rate their ability to manage variation in clinical cost and quality significantly higher than others (see **Exhibits 4** and **5**).

These findings are consistent with the qualitative interviews. Discussing his organization's culture, the CEO of a leading medical institution said, "Historically, we've been a leader in addressing the challenges facing healthcare—it's part of our culture and mission statement." These organizations also reported facing fewer challenges in achieving clinician "buy-in" on population health management, since it's widely viewed as "the right thing to do." In some cases, organizations are even able to make significant strides toward value in markets still dominated by FFS. In the words of the CEO of one such system, "Currently, only a small percentage of revenue is driven by at-risk agreements—most of the market is still FFS…[but it's] part of our mission to provide the best care for patients."

Not surprisingly, culture can be a significant roadblock for organizations pursuing population health. Among survey respondents, two of the leading challenges/barriers to pursuing population health management are related to cultural issues (difficulty in changing the organization's culture and resistance/lack of buy-in from physicians) (see Exhibit 8 on page 10).

The importance of culture came up repeatedly in our interviews with executives. Those interviewed noted that without a strong existing culture focused on achieving quality outcomes in a team-based approach, modifying behavior can be very challenging, especially when the organization is still profitable under FFS. Talking about culture, the CEO of a large academic system said, "People will say 'We don't have time for a culture change!' Well, sorry, you can't just flip the switch!" On this same topic, another CEO stated, "Internally, people have to change their way of thinking, especially those who have been focused on filling beds for many years. The waste in the system is someone else's revenue."

Exhibit 2: Primary Driver for Pursuing Population Health Differs in Leaders and Laggards

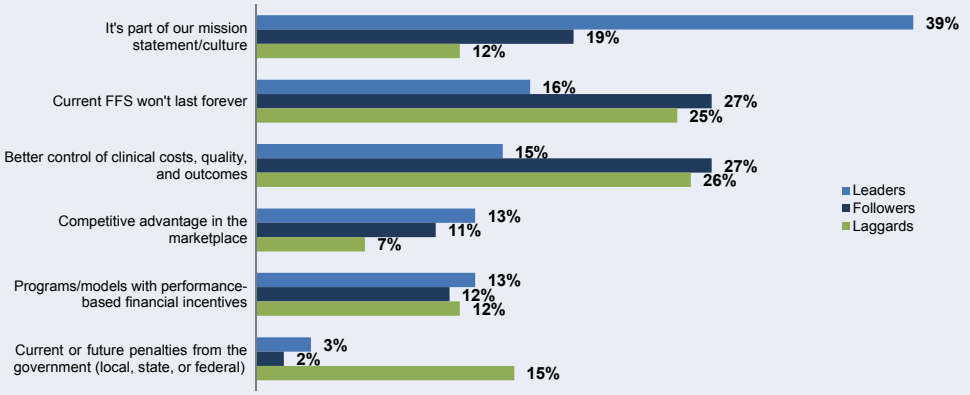


Exhibit 3: Leaders Are Moving Significant Portions of Their Revenue to At-Risk Models

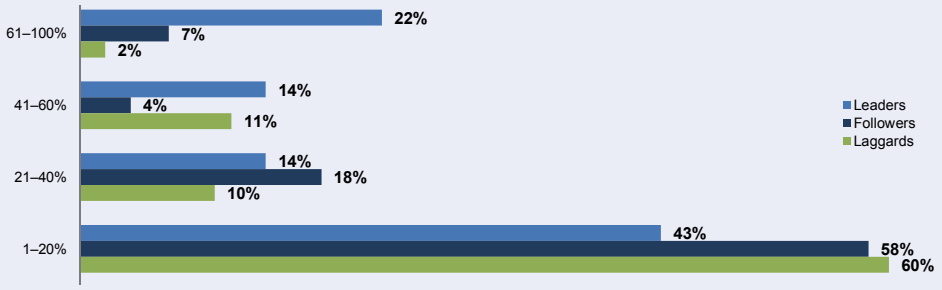


Exhibit 4: Ability to Manage Physician Variation in Cost

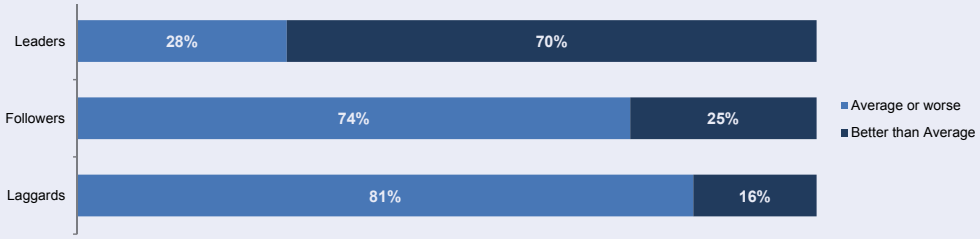
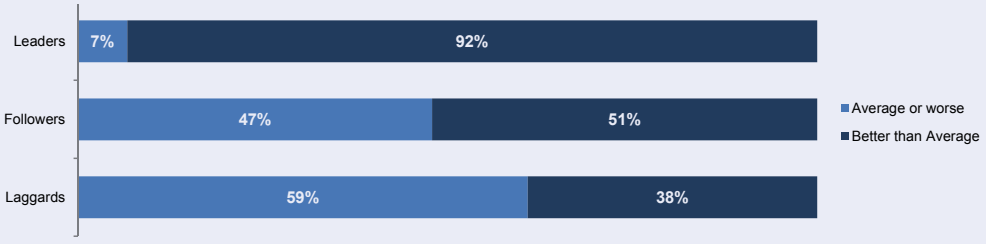


Exhibit 5: Ability to Manage Physician Variation in Quality



4. Collaborations Are Key

Although some larger healthcare networks "own" the entire continuum of care, many of the organizations that participated in the interviews noted that they've opted for partnerships and collaborations instead. According to the CEO of a large healthcare network, "We can't be all things to all people!" A common theme among organizations making progress toward population health has been the ability to forge deep relationships with entities across the care continuum. These relationships have enabled the development of an infrastructure for monitoring and measuring the performance of these partnering facilities.

There were several notable success stories from the interviews, including that of a provider organization primarily made up of a network of physician groups. Given

Exhibit 6: The Extent of Coverage across the Continuum: Ownership and Partnerships/Alliances

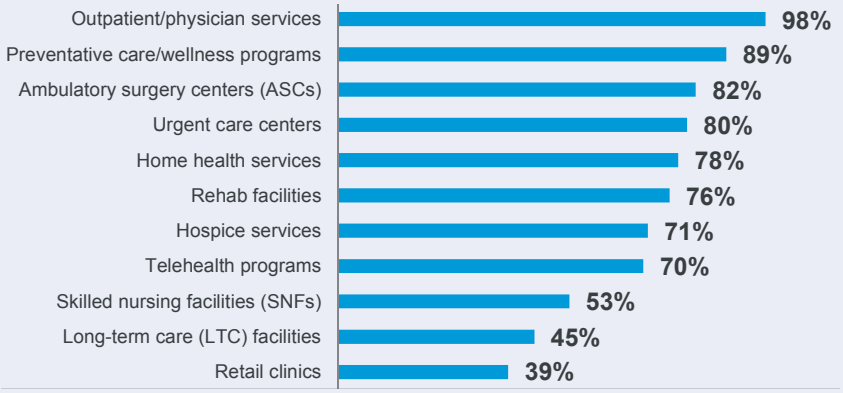
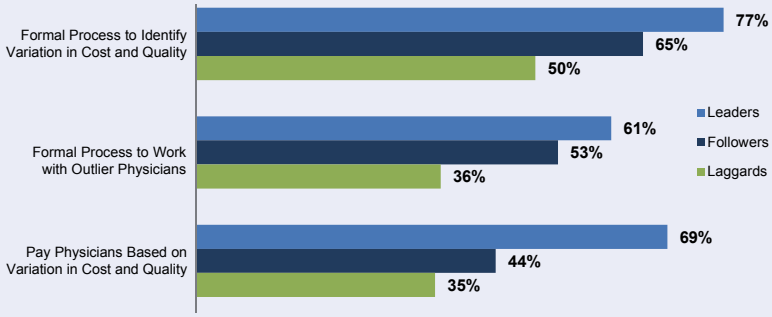


Exhibit 7: Leaders Recognize Importance of Formalized Process for Managing Variation



the organization's unique business model as well as its involvement in a very competitive market—where payers have moved aggressively to at-risk payment models—it has had to develop strong partnerships across the entire care continuum. This includes a joint governing structure with partner facilities in which key metrics are mutually developed and continuously tracked through comprehensive reporting. When partners don't meet their goals, the organization works directly with them to improve performance.

Another example further illustrates the importance of partnerships—especially with at-risk vulnerable populations. Coordination and alignment with internal and external partners are critical components of success for a Midwestern system. Externally the organization has formalized partnerships with food banks, homeless shelters, and faith-based nursing homes. These partnerships enable it to ensure that when patients leave its system, they have a place to go to continue their healing. Ensuring a successful transition is also part of its internal focus. A group of RNs, social workers, and care coordinators work collaboratively to ensure care transitions occur with minimal disruption to care. Finally, the organization trains its physician partners to recognize the "doorknob moment"—that point when he or she is about to exit the room and asks the patient if there is anything else they should discuss. It's at this point that patients often share additional factors (like something happening at work or within the family unit) that might be contributing to the symptoms they had been discussing.

No matter the approach, most organizations, regardless of if they are Leaders, Followers, or Laggards, have extensive coverage across the entire care continuum (see **Exhibit 6**). In addition to traditional areas of focus like outpatient/physician services, a significant majority of respondents reported that their organization either owns or has partnerships with urgent care centers (80 percent), home health services (78 percent), rehab facilities (76 percent), hospice services (71 percent), and telehealth programs (70 percent). Nearly four in 10 (39 percent) respondents cited retail clinics as part of the mix, which we expect will be more prevalent over time.

5. Managing Variation in Cost and Quality Remains a Significant Hurdle

Respondents generally feel that their organization has room for improvement in managing variation. About two in three respondents (68 percent) rated their organization's ability to manage variation in cost at the physician level as "average" or worse, while more than two in five (44 percent) consider their organization's ability to manage variation in quality similarly in need of improvement.

Although it appears that many organizations are taking steps to manage variation in cost and quality, Leaders recognize the importance of managing variation and are more likely to have established a formalized process for doing so (see **Exhibit 7**). In addition, they are more likely to have a formalized process for addressing outliers and structure physician pay based on variation in cost and quality.

Although interviewees didn't typically identify the challenge of managing variation in cost and quality spontaneously, further exploration identified it as a critical roadblock for most. When prompted to discuss how well they were performing in this area, many organizations stated that progress had thus far been slow.

In discussing this topic, a senior vice president of a well-known health system said, "[Managing variation] is at a stage of infancy, and we're just starting to do some of this work within treatment areas.... Traditionally, we've been inpatient focused. Yet even here, we've struggled to understand variation in cost and quality." In addition, some interviewees specifically indicated that their organizations hadn't yet expected physicians to control cost and quality, even when they might have the data to do so. According to the CMO of a regional health system, "The biggest challenge [in managing variation in cost and quality] is getting actionable data to folks and getting people to understand the value [of this data]."

6. Having the Appropriate Systems, Platforms, and Benchmarks Represents a Significant Roadblock

In the survey, respondents identified issues with internal systems (e.g., IT, tracking, management) as the leading challenge/barrier to pursuing population health management (see **Exhibit 8** on the following page).

These findings are consistent with the results from the qualitative interviews, which found that many organizations struggle with acquiring the data necessary

for supporting their population health management initiatives. Of particular note are problems with accessing data outside of the "four walls" of the provider organization. According to a senior vice president at a regional academic medical institution, "We have good data to show what happens within our walls, but we have a hard time accessing data in the post-acute setting. Seventy percent of the utilization is occurring in places we don't have much data about."

However, even when data is available, it can be difficult for providers to create actionable insights. In discussing this topic, a senior vice president at a leading academic medical center said, "There are registries going back 20 years with quality data, risk scores, etc. However, it's been difficult to create actionable information."

7. Organizations Are Struggling with When to Make the Transition from the Current Model

From both the interviews and survey, it's clear that executives and decision makers increasingly believe that the current FFS model won't last forever, but there's also significant hesitancy in how—and when—to move forward. Among survey respondents, two of the leading challenges/barriers to pursuing population health management were concerns over potential financial losses and the timing of the transition (see Exhibit 8).

During the interviews, some talked about "bad memories" from previous healthcare reform efforts, and how these are influencing organizational receptivity to change. According to a vice president at a nationally recognized academic medical center, "We're in the early stages of our population health efforts…however, we're hesitant given previous experiences with capitation. In the 1990s, we aggressively pursued capitated payments, resulting in about $200 million in losses."

This reluctance was especially common in markets where there hasn't been the regulatory "push" to transition to value-based models of care or where organizations are still financially successful under the current FFS environment. There was also the feeling among several interviewees that some long-serving executives—especially those nearing retirement—aren't interested in enacting comprehensive change.

In the words of the CMO of a large health network, "Some executives are saying, 'I just hope that the changes don't happen until I retire!' The fee-for-service model has been profitable for a long time, and population health goes against this." However, given the rate at which the market is currently evolving, a "wait-and-see" approach is a potentially dangerous strategy for providers.

We heard one anecdote that illustrates an important source of the underlying ambivalence that delivery organizations have regarding the adoption of a population health model of care, and the values that drive early adopters to move to action. In our interview about their progress toward population health, the CEO of a regional health system shared her successes in targeting a specific chronic disease subpopulation—diabetic expectant mothers—and taking steps that cut the cost of care. By working with community support organizations, families, patients, and primary care physicians, she had saved the community over $2.5 million compared to the expected cost of caring for these patients. Unfortunately, in doing so, she had cost her own institution over $600,000 in foregone acute care revenue. She had done so knowing that she would incur a cost because, as an institution driven by religious values, it made sense to take steps to mitigate the pain and suffering that accompanies diabetes when it's not adequately managed.

Exhibit 8: The Primary Challenge/Barrier in the Pursuit of Population Health

Exhibit 9: Designated Leadership Plays a Role in Population Health

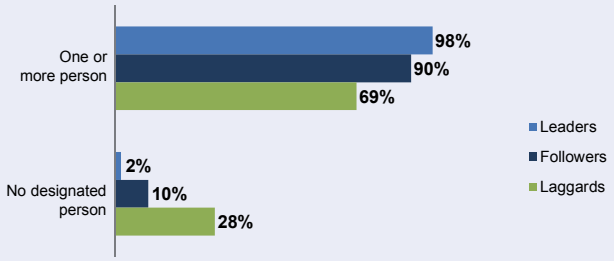
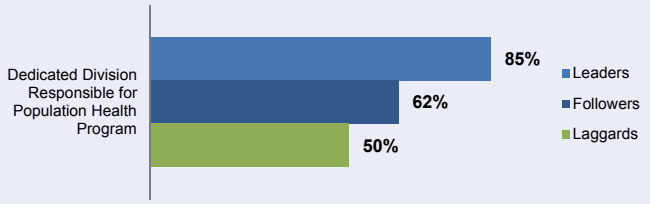


Exhibit 10: Creating a Division for Population Health Helps Organization Focus



She also saw the project as a learning exercise, and reaped important lessons. But, she cautioned, her freedom to make societal contributions at the expense of her own organization was limited. She had not yet found ways to recoup the acute care revenue she had foregone, and would need to do so if she was going to apply what she had learned more broadly.

8. Clear Accountability for Population Health Initiatives Is Associated with Progress

Although most organizations have established at least some form of leadership structure around their population health management initiatives, individual approaches appear to vary greatly. Almost all of the Leaders and 90 percent of the Followers have at least one person responsible for population health management (see **Exhibit 9**).

Similarly, Leaders recognize the importance of giving visibility to population health initiatives and frequently create a division focused on population health initiatives (see **Exhibit 10**).

Although it's difficult to directly attribute leadership structure as a key determinant of achieving progress, findings from the qualitative interviews do provide support for this idea. In discussing the leadership for their population health management initiatives, interviewees with multiple individuals leading these efforts tended to describe it as a loose arrangement between executives, rather than a formal structure with defined responsibilities. Given this observation, it's not unreasonable to expect that organizations with someone who is formally in charge of population health management generally will be further ahead than those in which accountabilities are dispersed across multiple individuals and potentially not clearly defined at all. As in other areas of business, clear accountability for results tends to yield better results.

Implications for Boards of Directors

The survey results reinforce the conclusion that building a model for population health is a significant undertaking. Organizations need to think now about what it will take to be successful in this environment. Boards and executive teams need to work closely together to ensure their organization is prepared and able to succeed in current models while also planning for the future environment.

For organizations that have not yet started the transition, Medicare's CJR presents a great opportunity to begin to operate in a population health environment. Since rates will be established on a regional level, if current costs are higher than average, time and effort need to be spent on reducing costs—and the sooner, the better. This will have implications across the board for operations. However, if an organization's costs are lower than average, there might be a competitive advantage that can be leveraged in today's environment while working to gain favor with key stakeholders like payers and employers.

For organizations with pilot programs in place already, it's time to evaluate those programs, make necessary improvements, and consider expanding into new areas, like chronic care management.

Based on our own experience and the results of the survey, we've identified five key ways in which boards of directors can help position their organizations for success in population health.

1. Ensure Development of a Clear Vision for Population Health and Plan to Operationalize It

Organizations need to develop a clear and consistent definition of value-based care and population health as these become critical organizing principles for priority setting, communications, and operationalizing the vision. Population health is more than a set of competencies; it represents a different delivery model in which ensuring that the right services are delivered by the right people at the right site of care is a core consideration. It is this transformation of the care delivery model that is at the heart of value-based care and population health. A clear vision that is established, agreed upon, and understood by the board, leadership, and executive staff will help focus and accelerate the journey.

2. Communicate the Vision Broadly

Once the vision has been defined, organizations need to develop an umbrella communications and deployment approach so that internal stakeholders understand the new direction. Population health requires more than tweaking current models; it will require functions and individuals to develop new competencies and processes to support the delivery of care and health services across the care continuum. A coordinated communication plan can help to reduce complexity for the organization and decrease the likelihood that people will be overwhelmed during the transition.

The communication plan should also address what this means for external stakeholders like payers, employers, and consumers. Defining what's different about the new model and "connecting the dots" to what the changes mean for these stakeholders will help to create differentiation in their eyes. The more they understand how the new model will enable them to achieve their objectives of better health outcomes and lower costs, the more value they will

see in a particular system. This could have long-term implications for the prices organizations can charge.

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3. Allocate Resources to Develop Necessary Capabilities

The ultimate goal of population health management is to improve the health of a population by engaging patients as consumers in making better choices about their own health, by supporting wellness, and by providing the right care at the earliest practical time at the most cost-effective point in the care continuum. This is a significant departure from current operations at many health systems, and will require developing new clinical, analytic, and coordination capabilities.

At the clinical level, providers will need to develop and implement care protocols based on best practices, clinical guidelines, and peer-reviewed literature. New analytic capabilities will be required to support implementation of new clinical practices and goals, identify opportunities to manage variation in cost and quality, and facilitate alignment of incentives across the organization. In addition, a new approach to financial analytics should tie new cost accounting capabilities to relevant clinical units, putting information about the cost ramifications of different clinical behaviors into the hands of those who will be held accountable. Also, processes for ensuring care coordination across the continuum will be required.

Boards need to take a critical look at resources to ensure that funds are directed toward those activities that will enable them to build effective and sustainable capabilities. In addition, serious consideration should be given to requests to add space for more acute care beds. In light of the move to providing care at the lowest cost possible, a better decision might be to repurpose acute care beds for long-term care, rehab, observation units, and other points of care along the continuum.

4. Identify Where Partnerships Are Needed

One of the key factors for success in a population health model is the ability to manage transitions and variation in cost and quality. This requires working across the entire care continuum—from preventative care programs to post-acute facilities. Boards need to work with staff to identify which partnerships will add the most value across the care continuum to their population health offering. Based on these insights, they can then work to structure appropriate partnerships. Ownership of these partners is one option, but not a requirement for population health. Instead, strong relationships can be built and processes designed to ensure appropriate monitoring and performance measurement. Whether the partner is owned or based on a performance agreement, boards should ensure that specifics of the partnership, including expectations and metrics, are clearly defined in advance and progress is monitored.

5. Hold Staff Accountable for Implementing the Organization's Plan and Achieving Results

Implementation of a plan for population health will not happen on its own; it will require a well-orchestrated effort across a disparate group of stakeholders. The board should work with the executive leadership team to define the desired results and key milestones that need to be accomplished. Information should be made available to the board on a regular and timely basis so it can track progress and determine if results are being achieved. When goals aren't being met, leadership should be accountable for explaining why and for developing countermeasures in order to meet targets.

Population health is a comprehensive solution. When properly implemented, it can reduce overall healthcare costs, improve the quality of care, and create a source of differentiation for a healthcare delivery system. Getting to this new model will require a coordinated effort by board and executive leadership. Given the rapidly evolving market and the acceleration of value-based payments, adopting a wait-and-see approach has become exceedingly risky. In our opinion, the time to act is now.

The Governance Institute thanks Rita E. Numerof, Ph.D., President, and Michael N. Abrams, M.A., Managing Partner, at Numerof & Associates, Inc. for contributing this article. They can be reached at rnumerof@nai-consulting.com and mabrams@nai-consulting.com. The authors would like to thank Kimberly White, Eric Abrams, and Kelsey Tinkum for their contributions to this piece.