The American Hospital Association's

CENTER FOR HEALTHCARE GOVERNANCE™

Empowering Board Members to Improve Population Health through Value-Based Care

Monograph Series

About the Author

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The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information, visit www.americangovernance.com.

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Section I: New Urgency in the Transition to Value-Based Care

The U.S. health care system is quickly moving toward a care delivery model that encompasses entire populations, not just the patients who present themselves for care. This is because many at-risk individuals in the community seldom, if ever, seek treatment or health screenings—and they have a disproportionate impact on total health care spending.

The purpose of population health management is to reach all community members "upstream" before they experience late-stage, preventable illnesses. To accomplish this goal, hospital and health plan boards must reshape governance structures, acquire new competencies and forge new alliances outside the hospital walls. Improving population health requires much more than a vague mission statement. The task demands dynamic, informed board leadership.

In the past, hospital boards have typically drawn on the talents of current/former physicians and local business and faith leaders. As value-based care becomes the prevailing model in U.S. health care, board composition needs to widen to include trustees with a deep understanding of risk management, data analytics and care management. Boards can also benefit from fresh perspectives from members with experience in public health, wellness and organizations that successfully engage people in healthy behaviors, such as Weight Watchers, the YMCA and other local fitness centers.

In any industry, it's seldom the leaders who embrace disruptive innovation. For example, when Tower Records faced a new competitor in music distribution, Apple's iTunes, it was reluctant to move to a new business model before it was too late. Likewise, many successful health care organizations are finding it difficult to detach from the fee-for-service model. But now is the time for action, not delay.

The shift to value-based care is sometimes characterized as a deep dive, but it's actually a transition that can be managed in a thoughtful, step-by-step manner.

This monograph examines how board members can help steadily lead this transition to value-based care—and how those efforts will affect the board's structure and function.

Value-Based Care: Sea Change in Care Delivery

Hospital trustees have every reason to feel overwhelmed by the shift underway from fee-for-service (FFS) reimbursement to value-based care (VBC). FFS has been the prevailing paradigm in U.S. health care for decades. With impetus from the Affordable Care Act (ACA), however, the industry is now moving steadily toward a VBC model, which encourages patient-centered "care systems" that encompass not just the hospital but skilled nursing facilities (SNFs), rehab centers, home health, and much more. In the past, these organizations typically operated independently from one another.

In the new model, the physician's role is becoming that of a care team leader rather than a solo decision-maker. The VBC approach requires greater cooperation and transparency between providers and payers in the community—especially when it comes to sharing data and aligning financial incentives.

Value-based care also places greater emphasis on patient engagement and accountability. For example, one North Carolina health care system recently helped a self-insured area employer design incentives for at-risk employees that can be monitored and tracked. Simply by making progress in categories like weight and cholesterol scores, employees could receive either cash bonuses or reductions in health care premiums.[1]

Another cornerstone of VBC is clinical integration, where health systems and area physicians develop clinical agreements designed to control costs and improve the quality of care. Clinical integration requires extensive data collection and analysis. In 2009, OhioHealth Group, a clinically integrated network with nearly 2,000 providers, implemented a clinical integration platform that improved real-time access to vital reports. Since that time, OhioHealth has seen its Health Effectiveness Data and Information Set (HEDIS) scores improve in each successive year.

Because VBC involves a total transformation of hospital culture and roles, it's not surprising that many health care systems are behind schedule in its adoption. One national survey recently revealed that only 46 percent of health care systems are "fully committed and underway" with population health management, while 27 percent were in the pilot stage and 23 percent have either not yet begun or are still weighing whether to participate.[2]

A "Wait and See" Attitude Can Be Costly

Health care organizations cannot be tentative or complacent about making the transition to value-based care. Quite simply, the train has already left the station. It's a mistake to think that health reform is destined to be a short-lived repeat of the Health Maintenance Organization/capitation debacle of the 1990s.

Leavitt Partners estimates that more than 8 million Americans have already enrolled in health insurance exchanges and that 18 million lives are now covered by Accountable Care Organizations (ACOs). The firm also predicts that one-third of all Americans will have a shared risk health plan by 2020,[3] where provider organizations and the plan share both financial gain and loss to varying degrees.

In addition, Accenture predicts that in just three years the number of people enrolled in private health insurance exchanges may exceed the number enrolled in public ones.[4] In the future, hospital utilization will decrease—and providers that don't move with the times will get hurt financially. By assuming more risk, a health system or hospital can better capitalize on what would otherwise be a revenue loss.

Value-based care is being driven by the popularity and flexibility of the insurance exchanges. Employers are saving money by moving away from national health plans and offering employees a lump sum to select and buy their own insurance. That puts health care consumers in the driver's seat—and many of them are opting for lower priced, high-deductible plans.

This creates an atmosphere of innovation, where providers can take on more risk—sometimes even competing directly with commercial payers. Some health systems are launching regional health plans of their own that are less expensive and more effective than most commercial plans.

For example, a health care system in Mississippi, which has one of the highest rates of stroke in the U.S., can create risk-sharing programs that offer incentives for patients/members to make lifestyle changes that can prevent strokes. Or a health care system that's experiencing a high number of preterm deliveries can craft incentives and outreach programs to help lower that rate. Today's commercial payers can't do that with the same speed and wealth of care delivery resources as providers.

When health systems assume more risk, more money stays in the system, and a much smaller portion walks out the door. It's a trend that will only accelerate in coming years. Providers that remain tied to the fee-for-service model are putting their organizations in financial peril.

The Importance of Data Analytics

At the very heart of population health management and value-based care is the

ability to identify at-risk populations in the community (e.g., those dealing with obesity, diabetes, asthma, at-risk pregnancies, etc.). Then, area providers must align their services to meet these specific needs and to establish preventive and interventional programs.

This requires far more than a shared Electronic Health Record (EHR). Providers need tools that allow them to gather and analyze demographic trends, track clinical/coaching interventions, monitor patients' medication adherence and wellness milestones, and much more.

Geographic Information System (GIS) tools are already proving that some communities are sicker than others—even in adjoining zip codes. A recent study in the journal *Spectrum* (published by the American Hospital Association's Society for Healthcare Strategy and Market Development)[5] shows that the eastern suburbs of Orlando are extremely healthy because they're populated mainly by young couples with children. The downtown areas of Orlando have a far higher percentage of Medicare-age patients, with higher rates of diabetes, heart conditions, etc. In the VBC model, the Orlando community would likely want to focus more pediatric resources in the eastern suburbs—and resources tailored for elderly, at-risk patients in the city center.

Data analysis is also essential for establishing new metrics for success that focus on the total cost of care and measurable improvements in community health. In the value-based model, a hospital's volume can actually decline as the population gets healthier. Clearly, providers and payers need to establish new relationships and contracts in line with these new success metrics.

Before hospital and health plan trustees can make truly informed decisions, they need a broad understanding of the two key components of VBC: new reimbursement models that reward risk-assumption and the community-wide data collection and analytics that make population health management possible. Sections II and III of this monograph delve deeper into these topics from a trustee perspective.

VBC Requires Trustees to be Engaged and Educated

Trustees have always endeavored to be good stewards of the communities they serve—and VBC takes stewardship to new levels by measuring and improving community health as never before.

The box on page 7 includes some ways that trustees can help guide their organizations in the VBC journey.

Early Adopters Will Gain Competitive Advantage

Some health care organizations are delaying the move to value-based care because they're under the sway of two misguided assumptions:

a) assuming that health reform will get derailed or greatly downsized by lawmakers and the judicial system; and

b) assuming that it's all right to procrastinate on value-based care until ACOs and other early adopters can pass along best practices and lessons learned.

A complete reversal of the ACA is highly unlikely because many health care organizations are already experiencing the financial benefits of adding millions of newly insured patients to the system. Indeed, we're starting to see the "first fruits" of health reform, including a significant drop in hospital readmissions and lowering of uninsured individual rates in many states.

Health care organizations cannot afford to sit on the fence while VBC early adopters gain market share and competitive advantage. Trustees of hospitals, aligned physician groups and health plans must accept the new realities and lead their organizations into the vanguard of value-based care.

Governing in a Value-Based Environment

Keep aligning incentives—If your organization doesn't have a clinically integrated network, now's the time to start building one. Start exploring the possibility of provider alliances to help manage risk.

Know your organization's strengths and weaknesses—Does your organization have the capital, clinical integration and market share to move forward with risk-sharing? If not, look for ways to add those capabilities through provider alliances, an ACO, etc.

Don't wait to get started—Hospital utilization is already starting to erode, so now's the time to begin positioning your organization for value-based care. If you move too slowly, your census will drop and you won't have revenue to replace it.

Add payer and data analytics expertise—If your board doesn't have a "deep bench" of trustees well-versed in payer issues or data analytics, add some ASAP.

Find capital for risk-sharing initiatives—Assuming risk requires a lot of reserve capital. If you don't have enough, consider a regional alliance with other providers.

Invest in technology that really delivers—Every electronic health record vendor in the U.S. *claims* to have the necessary data analytics for population health, but most don't. It's important to invest in a data analytics platform supported by seasoned analysts and executives who also have deep clinical, actuarial, IT and insurance experience that actually delivers what this monograph outlines.

Anticipate governance disagreements and be prepared to resolve them—The value-based model can create conflict between hospitals, physician organizations and payers. By understanding the new relationships, you'll be better able to resolve problems that arise.

Arrange a board education briefing—Hospital trustees aren't expected to be experts in risk management or data analytics. If you feel overwhelmed by this historic shift in care delivery, get help from outside experts who have the knowledge you lack.

Make a commitment to ongoing education—Because there's nonstop innovation in both risk management and IT/data analytics, board education is not a "one and done" task.

Develop new criteria for succession planning—As board members retire, it's important to fill their shoes with trustees skilled in risk management, data analytics, and other competencies needed for effective population health management.

Section II: Understanding New Reimbursement Models

There's now a formula that's every bit as important to health care as $E = MC^2$ is to physics:

$$\frac{Access + Quality = Outcomes}{Cost}$$

This is the formula that defines VBC going forward—and it's being applied across the entire value-based delivery spectrum.
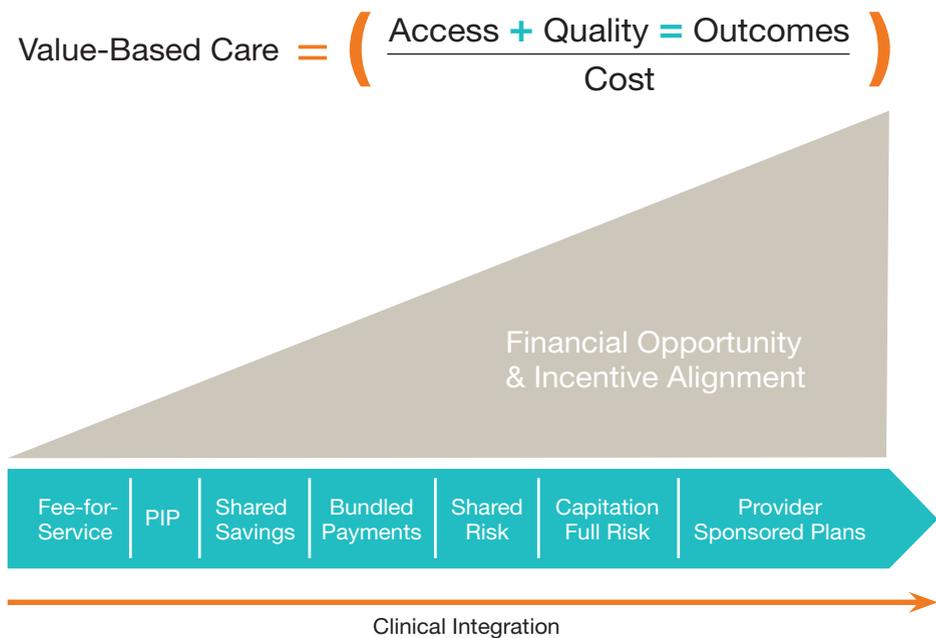
Providers with a high degree of clinical integration can manage more risk. It's important to note that risk for a health system is considerably less "risky" than for a payer. Moreover, early adopters of VBC have some big competitive advantages: the ability to grab more market share and establish a local brand, coupled with greater leverage over payer contracts. That's because both patients and payers want to deepen ties with providers who are taking meaningful steps toward improving outcomes while lowering costs.

All health care organizations can benefit from VBC, but some are extremely well-positioned for making the journey. These include children's hospitals, rural hospitals (which often have an entire network already in place), and hospitals that create regional alliances for VBC and risk-sharing.

Figure 1 provides a roadmap for aligning financial risk with clinical integration. Let's take a closer look at how health care systems are learning to crawl, then walk, then run as they move further along the VBC spectrum.

Figure 1. Formula for Value-Based Care

$$\text{Value-Based Care} = \left(\frac{Access + Quality = Outcomes}{Cost} \right)$$

Financial Opportunity & Incentive Alignment

| Fee-for-Service | PIP | Shared Savings | Bundled Payments | Shared Risk | Capitation Full Risk | Provider Sponsored Plans |

Clinical Integration

The more an organization aligns financial risk with clinical incentives, the more opportunity that organization is likely to realize.

Pay for Performance (P4P)

This model was first popularized about a decade ago. The P4P model offers financial incentives/disincentives that are tied to measured performance. The provider organization receives performance-based adjustments to its FFS rates, usually bonuses for exceeding standards in key metrics.

In the evolution of value-based care, P4P has been an awkward first step. The incentives are often too small to change physician behavior, and the patient population that improves is usually too small to achieve organization-wide change. P4P is basically an FFS model because providers still receive higher payments for rendering more service.

Bundled Payments

The bundled payment/episode of care model provides a single negotiated payment for all services associated with a specific procedure or condition, such as knee and hip replacement surgery, pregnancy and birth and so on. This method uses a comprehensive scorecard to incentivize provider performance.

With an episode-of-care payment system, providers benefit from any savings generated through improved efficiency within an episode—and by preventing unnecessary follow-on episodes of care. The payer saves money by paying the provider less per episode or patient than it did in the past.

Under the Centers for Medicare & Medicaid Services (CMS) bundled payment model, a single discounted payment is made to the hospital and physicians for an episode of care, such as a Diagnosis-Related Group (DRG) procedure.

This model has some financial drawbacks for providers, such as having to cover the cost of services that exceed the negotiated reimbursement amount. Providers are also forced to treat more episodes to increase their income, which essentially makes bundled

care just another version of FFS. There's also the thorny issue of how to divide payments between hospitals and physician groups.

Some providers are already working with private insurers to develop bundled payment programs for various service lines. Take, for example, a program with a very unwieldy name: Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability and Sustainability (PROMETHEUS). The PROMETHEUS Payment® model was developed by the Robert Wood Johnson Foundation, Commonwealth Fund and others. PROMETHEUS issues episode-based payments to providers for heart attacks, diabetes, hip and knee replacement, congestive heart failure and hypertension.

Patient-Centered Medical Home (PCMH)

This is a primary care-driven effort in which a care team—the physician, RN case manager, medical assistant, home health team and often a pharmacist—are responsible for coordinating patient care.

To cover the cost of implementing this model, providers often negotiate a FFS rate increase or per-member-per-month (PMPM) payment to augment FFS payments.

Shared Savings (One-Sided Risk)

Shared savings programs reward providers who reduce total health care spending below an expected level set by the payer. The provider then shares in those savings.

CMS has incorporated the shared savings approach in both its Accountable Care Organization model and Physician Group Practice Demonstration. Providers can earn bonuses for demonstrating slower spending growth than their peers. Any savings greater than 2 percent are shared with CMS, with up to 80 percent for the physician group.

There are several shortcomings in the shared savings model. This approach doesn't pay for any upfront spending needed to implement the technologies necessary for success—and it may take months or years for performance to improve significantly.

Ironically, the shared savings model benefits providers with the highest rates of hospital admissions, highest use of unnecessary procedures, and other wasted resources. In contrast, providers who are already "saving" CMS money by containing costs and keeping quality high receive less reward for doing so.

In the long run, shared savings programs as currently structured may prove unsustainable because they require continuing large invest-ments in care improvement and technologies over a multi-year period.

Shared Risk

Shared risk models offer more advanced risk arrangements where providers receive performance-based incentives to share cost savings, plus disincentives to share the excess costs of care delivery.

In this model, the provider and payer agree to a budget—and require the provider to cover a portion of costs if savings targets are not achieved. This portion could be a percentage of the premium (e.g., 30 percent of overall premium flows) or a set amount (such as a 50/50 sharing of excess costs). With this approach, providers take on more risk, but there's often more opportunity for financial reward.

In this arrangement, it's not uncommon for a payer to pass along more risk than the provider organization is willing to accept. In those situations, a provider can turn to a third party for what's known as "stop-loss" insurance, where (for a fixed fee) the insurer accepts all financial risk beyond a designated level. Providers can also negotiate carve-outs where they don't accept risk for certain types of patients or conditions.

Another way to limit risk is to create risk "corridor" agreements, as shown in Figure 2. These corridors protect a provider from high losses, but also remove the possibility of large financial gains.

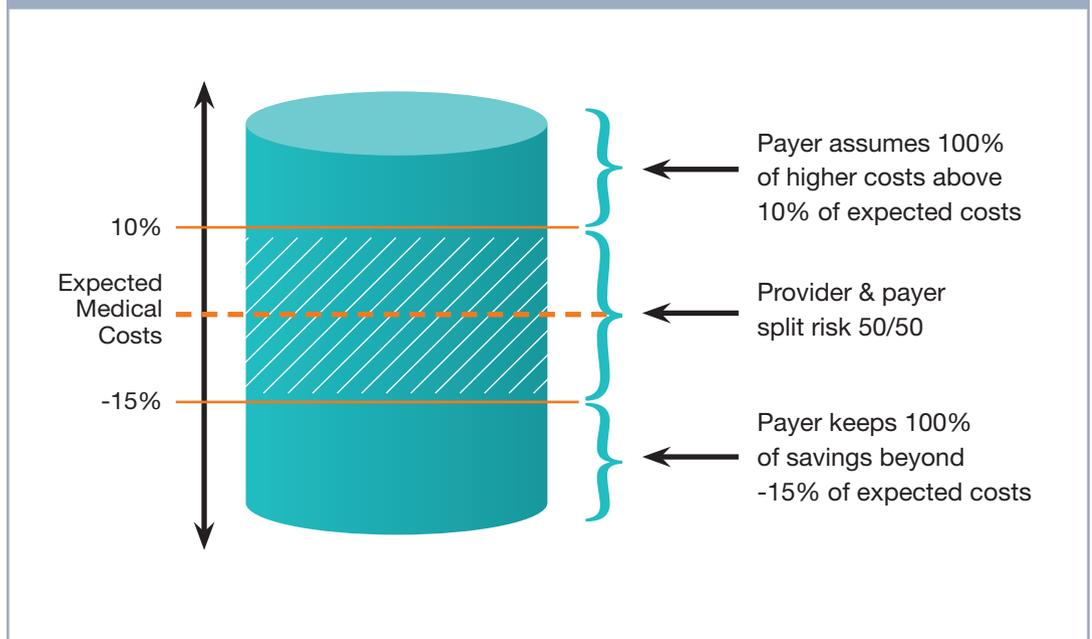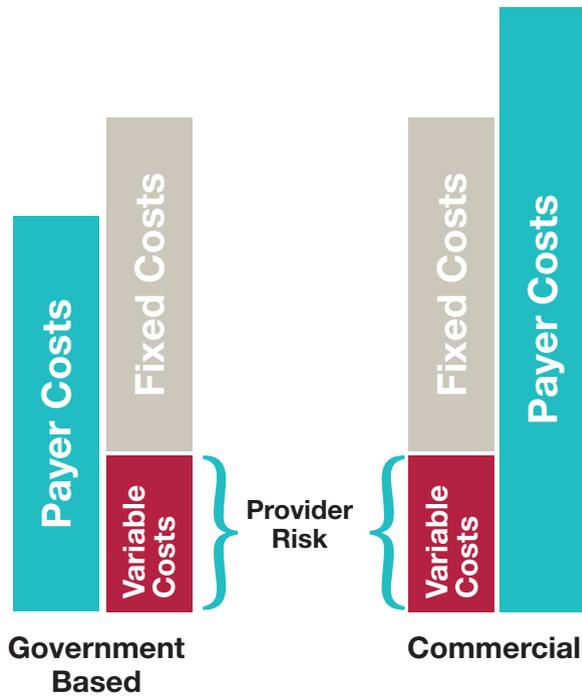Figure 2. Examples of Shared Risk with Corridors Arrangement

- 10% — Payer assumes 100% of higher costs above 10% of expected costs
- Expected Medical Costs — Provider & payer split risk 50/50
- -15% — Payer keeps 100% of savings beyond -15% of expected costs

Figure 3. Payer Risk vs. Provider Risk

Payer Costs · **Fixed Costs** · **Variable Costs** · { **Provider Risk** · **Fixed Costs** · **Variable Costs** · **Payer Costs**

Government Based **Commercial**

Because fixed costs are often greater than 70% for hospitals and health systems, as long as they have excess capacity, their incremental risk can be much lower than that of a payer.

Full Risk (Capitation)

In this model, the provider receives a fixed payment per patient for specified medical services—meaning that the provider takes on 100 percent of the insurance risk for the covered patient and services. These payments are determined by actuarial analysis of historic costs and adjusted for the acuity or level of risk associated with the patient population.

Assuming full risk sounds scary, but hospitals and health systems actually have lower risk exposure than payers. Because a health system's fixed costs are often higher than 70 percent, its incremental risk (assuming excess capacity) can be much lower than that of a payer. (See Figure 3.)

There are two basic capitation models:

Global capitation is an arrangement where the provider organization, or group of organizations, receives a single fixed payment for all the health care services a patient receives. This includes primary care, hospitalizations, specialist care and ancillary services.

Partial capitation is where the single monthly fee paid to the provider covers only a defined set of health care services. Services not covered are then typically paid for on a FFS basis. Some partial capitation models include only physician services (primary care and specialty) and lab services—and exclude hospital-based care, pharmacy and mental health benefits.

With capitation, a provider reaps all the rewards for providing care at a cost below the negotiated rate—but also bears the risk if the cost of care exceeds that amount. As with other forms of risk, providers can carry stop-loss insurance to limit their financial exposure.

Provider-Sponsored Health Plans (PSHPs)

On the risk spectrum, provider-sponsored health plans (PSHPs) are the most comprehensive of the value-based health care models. In this scenario, a provider network (usually led by a hospital system) assumes 100 percent of the financial risk for insuring the patient population. PSHPs collect insurance premiums directly from employers or individuals—and are therefore the furthest "upstream" a provider can get.

PSHPs offer a number of advantages to providers, including:

- **Greater control**—Because providers control both the insurance and care components, they have almost complete control over benefit plan design and the care delivered.
- **Care coordination**—With integrated systems, PSHPs can support more coordinated care across the entire spectrum.
- **Quality**—Research by the Commonwealth Fund and CMS statistics indicate that PSHPs offer higher quality and lower cost than traditional payers.

Because provider-sponsored plans deliver the full potential of value-based care, Appendix 1 on page 17 provides detailed guidance on how to launch and manage a successful PSHP. This appendix also includes case studies of how three health care organizations launched and maintain their own health plans with help from their boards.

Section III:
Data Analytics: Essential for Population Health Management

There's a maxim in both business and medicine that says, "You cannot manage what you don't measure." Without gathering and analyzing all the necessary end-to-end data, it's impossible to implement population health management or value-based care.

Some health care systems create "homegrown" systems for data analytics, but the results fall far short of a comprehensive solution. A typical provider organization has separate software systems for the hospital electronic health record (EHR), revenue cycle processes, case management, and so on. These systems don't share data easily, so the provider organization has to pay a hefty price for redeploying the same data over and over again. In contrast, some population health platforms are designed for easy integration, where data gathered for population health can be shared seamlessly with other hospital clinical/business systems.

Moreover, it's a mistake to assume that a population health management platform is merely an extension of a health care system's EHR. In a typical health care system, there are still many affiliated physician practices that don't even have an electronic medical record (EMR)—and many that do cannot share data with the hospital EHR. Some of today's leading EHR vendors offer population health add-on modules, but most of these only produce clinical continuity reports (essentially clinical snapshots showing outcomes for a specific patient population at a given time) rather than the comprehensive data analysis and reporting capabilities needed for effective population health management (see Figure 4 on page 13). Some of these capabilities are discussed in more detail below.

Figure 4. Transform Data Analytics Into Action

COLLECT

ALL DATA SOURCES | AUTOMATIC/DAILY | DISPARATE SYSTEMS AND ENTITIES | ACUTE AND AMBULATORY | CLINICAL AND FINANCIAL

ANALYZE

COMPARE COMPLIANCE TO EVIDENCE-BASED GUIDELINES | 130+ CUSTOMIZABLE GUIDELINES | PATIENT ATTRIBUTION MODEL

IDENTIFY

PROSPECTIVE AND RETROSPECTIVE CARE GAPS | PRIORITIZE ON CLINICAL SEVERITY FINANCIAL COST, AND IMPACT OF INTERVENTION | HIGHLIGHT PATIENTS WITH RECENT HOSPITALIZATION OR OTHER TRIGGER EVENTS

ENGAGE

SOLUTIONS SUPPORT CARE COORDINATORS TO PROMOTE PATIENT ENGAGEMENT AND IMPROVE QUALITY AT POPULATION AND PATIENT LEVEL | MULTI-MODAL ONE-CLICK PATIENT OUTREACH | DRIVE CLINICAL ADHERENCE TO SPECIFIC ACTIONS | EASY HAND OFF TO CARE COORDINATION PROGRAMS

MEASURE

PATIENT AND POPULATION LEVEL COMPLIANCE | PROVIDER, DEPARTMENT, FACILITY, ENTITY LEVEL | TREND OVER TIME | BENCHMARK AGAINST PEERS

A population health management platform must provide all the capabilities shown here— something that EHR add-ons don't deliver.

Identifying Care Gaps

A robust population health platform can automatically alert clinicians to omissions in a patient's ongoing care. For instance, if a patient with a family history of colon cancer has gone beyond a time threshold for a colonoscopy, physicians are notified immediately and patient outreach begins.

Stratifying Risk

A population health platform uses sophisticated algorithms to provide real-time identification of patients who pose the highest risk. There are hundreds of "trigger" events involved in these calculations: number of days since release from the hospital, family history, previous interventions, etc.

Patient Engagement and Care Coordination

One of the central tenets of population health management is that patients play an active role in their own health and well-being. A population health platform makes it easy to provide the coaching and clinical interactions needed to encourage and empower patients in this effort. The platform helps caregivers across the entire spectrum closely monitor the patient's medication adherence, recommended follow-up visits, lifestyle changes, and so on.

Clinically Relevant Metrics

Many of the current quality metrics (like ones from HEDIS and ACO33) aren't particularly valuable for risk management. A classic example is the metric "Did you give your patient smoking cessation counseling?"

As the health care system shifts to a value-based, risk-owning model, physicians will demand clinically relevant metrics. In the new model, physicians will want to know whether a patient has been readmitted to the hospital within 30 days—or has received imaging that wasn't needed. When physicians are aligned financially with risk management, improving the quality of care is also good for business.

From this new VBC perspective, physicians will seek to know as much as they can about at-risk patients—and even how their peers' performance is affecting quality and financial results. In short, quality metrics become their friend, rather than a source of embarrassment.

Here's an example:

> For a health system managing complex pediatric pulmonology cases, an excellent quality metric would be: "Have you conducted serial surveillance cultures of Child A's sputum?" This could help greatly improve the quality of care for pediatric cystic fibrosis patients because it's so clinically relevant.

The checklist on page 15 can help board members raise questions to better understand the population health management platform their organization may be considering.

Section IV:
How Boards Must Change to Provide Value-Based Care

Since value-based care is a complete departure from the FFS model of the last half-century, board composition and governance will be profoundly changed. The journey toward value-based care will require trustees to re-examine virtually every duty and qualification their role requires.

The initial challenge will be for boards to think outside the walls of the hospital. Boards have a responsibility for actually overseeing implementation of population health management and value-based care, not just making it part of a mission statement. This requires strategic leadership that entails taking a long-term view, identifying care gaps and other critical capabilities, and restructuring organizational relationships and contracts to align with VBC goals.

Many boards find it advantageous to designate one trustee as the "point person" for VBC initiatives—someone who can work closely with a hospital executive who takes the operational lead. This board member can also help other trustees broaden their knowledge of VBC basics and terminology.

New Success Metrics

In the volume-based model, health care organizations have been rewarded for filling hospital beds and increasing patient consultations, diagnostic testing and ancillary services. The value-based model rewards organizations for improving the health of entire populations (e.g., all diabetics in the service area). When a value-based system is working at peak performance, the hospital census often declines—and the sheer number of consultations and allied services may

Trustee Checklist for Evaluating PHM Functionality

Some population health management software platforms are more effective and easy to use than others. This checklist can help board members ask the right questions if called upon to recommend or approve a system-wide platform:

✓ **Data aggregation**—To be truly effective, the software platform must collect and aggregate data from a wide variety of sources: the hospital EHR, the practice management (PM) and EMR systems of affiliated physicians, lab data, payer information, Pharmacy Benefit Manager data, post-acute records, and more. The platform needs to be able to reliably and cost-effectively gather this information—no easy feat in this era of botched implementations and cost overruns.

✓ **Data sharing**—Even the most comprehensive data aggregation is meaningless unless that information can be shared easily. The data need to be easily available, not just to hospital clinicians but to an extended care team that includes affiliated physicians, nurses, care managers, patient scheduling staff, rehabilitation facilities, home health and more.

✓ **Ease of use**—Many population health platforms are designed to be used by IT and business experts. No doctor wants to learn a computer query language like SQL in order to be able to use the platform to make informed, timely clinical decisions.

✓ **System accuracy**—Nothing can torpedo a population health platform faster than jumbling patient records. For example, if there are three patients in the system named Donald Jones—and the records get even slightly jumbled—clinicians can make incorrect, even fatal, decisions based on that data. For that reason, a population health platform needs to incorporate powerful patient-matching algorithms.

✓ **Attribution logic**—Because population health involves shared decision-making, it's important for patient data to get routed to the appropriate care team member. A population health platform needs built-in attribution logic to determine which primary care physician is responsible for each patient—and which team member is responsible for closing care gaps that arise. It's frustrating for primary care doctors to get tagged with responsibility for a patient they've only seen once, perhaps when doing weekend coverage. The system must also alert downstream caregivers promptly and appropriately. For example, when a new diabetic patient visits a primary care physician, the platform should alert a designated ophthalmologist about scheduling an eye exam.

decrease due to better care coordination. Boards need to work with hospital executives and clinical leaders to take a fresh look at the performance metrics the board now reviews and ask, "What should we be measuring and monitoring?"

New Governance Structures

Value-based care often requires a more complex governance structure—typically involving an organization's overarching foundation, the health care system, aligned physician groups, and even the organization's own health plan—each with its own board (with trustees who often have overlapping responsibilities on multiple boards). Together, these boards must share a strategic vision for the entire enterprise, realizing that the ultimate goal for the enterprise is to measurably improve community health and be compensated for achieving better outcomes. There may be times when a hospital census swells, hurting the organization-sponsored health plan. Conversely, there may be instances when the plan does well and the hospital census shrinks. Boards must maintain a holistic perspective and focus on long-range goals.

Some forward-looking organizations are now holding joint retreats where health system and health plan boards learn more about the inter-organizational impact of VBC initiatives. This helps foster a "we're all in this together" approach to making the value-based model successful.

New Competencies

In the FFS era, most boards have included current and former clinicians, local business and faith leaders, and other pillars of the community. The value-based model requires broader representation: trustees with expertise in areas like wellness, public health, data analytics, health plan management and actuarial modeling.

Overseeing New Committees

Under VBC, the committees that report to these boards are becoming less hospital-centric. It's becoming more common to have committees on care coordination, risk management, quality enhancement, contracting and other efforts that have direct bearing on VBC success.

New Trends in Compensation

In the past, being a trustee seldom required major time commitments and ongoing training. That's one of the reasons why only about 13 percent of U.S. hospitals currently compensate board members. But the demands of VBC are forcing some boards to rethink compensation strategy.

Organizations that exploit a value gap can significantly increase revenue and market share. That's why it makes sense to compensate board members for the VBC expertise they bring to the table.

Steady Progress is the Key

The transition underway from fee-based to value-based care is the most fundamental shift in health care delivery since the mid-20th century. Trustees of both hospitals and risk-sharing health plans may balk at the enormity of the task ahead, but it's a transition that has gained virtually unstoppable momentum.

With VBC, it's important for trustees to take a step-by-step approach. Moving across the VBC spectrum isn't achieved overnight. Many boards turn to VBC partners and expert external resources for advice on how to prepare for the new model—and how to transition from one risk option to another.

As health care organizations migrate to new structures to meet new objectives, boards must also get ready for the same transition. Many of the recommendations in this section can be used to expand an existing board work plan so that value-based care becomes the springboard for value-added governance.

Appendix 1
Keys to Implementing a Provider-Sponsored Health Plan

When a provider decides to launch its own health plan, the organization is immediately in the unfamiliar waters of insurance and risk management. The provider must first obtain an insurance license and get approval as a health plan for each state in which it operates commercial, Medicare Advantage or Medicaid plans.

The provider organization must assume all the responsibilities of a payer: eligibility and enrollment, claims payment, customer service, insurance reporting, administrative operations and more.

There are basically four ways to add these new capabilities:

1. **Build**—Working from the ground up, providers can develop these capabilities internally, hiring personnel and implementing the necessary technologies.

2. **Buy**—The provider organization can acquire the assets and personnel of an existing health plan.

3. **Partner**—The provider organization can partner with an existing plan, leveraging that organization's technology, people and infrastructure.

4. **Outsource**—In this model, the provider organization handles some of the payer responsibilities while outsourcing other functions that remain under the provider's brand and guidance.

The chart below shows the pros and cons of each of these options.

MODEL	PROS	CONS
Build	• Control • Specificity of design	• $10-20 million in start-up costs, PLUS risk-based capital • Execution risk due to lack of experience
Buy	• Immediate capability • Experienced operators	• Scarce supply of assets to buy • Very expensive costs between $500-$1000 per covered life
Partner	• Immediate capability • Experienced operators	• Scarce supply of partners • Possible misalignment of incentives • Lack of control
Outsource	• Immediate capability • Experienced operators • Can custom design relationships	• Few experienced vendors • Requires relationship management

Benefits of a PSHP

More revenue stays in the system—
In a PSHP, there are financial incentives for primary care physicians to keep patients within the health care system to foster greater collaboration and care coordination.

Different revenue lines, same P&L—
Let's say that a health system has a risk contract with a private payer and an inpatient has a $30,000 bill (which the insurer pays). In the PSHP scenario, it would still cost $30,000, but the plan writes that check to the hospital (which may only have incurred incremental costs of $5,000). That bed didn't cost any more for the hospital to provide, and the nursing staff was already in place. When the hospital and plan are part of the same organization, money may move from one revenue line to another—but it's still tied to the organizational P&L. The money stays in the system, and a much smaller fraction walks out the door.

Greater financial control—Creating and running a health plan entails new responsibilities (claims processing/payment, insurance reporting, etc.), but the plan has far more control over payment decisions. The PSHP has the power to spend more on care and less on administration. With traditional for-profit insurers, the opposite is often the case.

More effective population health management—A PSHP allows health systems to better understand the unique needs of its patient base and deliver more customized care. PSHPs put health care systems in a better position to improve outcomes and lower costs around specific patient populations.

Tools for managing risk—By harnessing the power of new predictive modeling technologies, a PSHP can do sophisticated actuarial analysis without needing the armies of actuaries that traditional insurance companies employ. These tools give providers unprecedented visibility into financial risk and the ability to manage it.

Risks of Starting a PSHP

Launching a PSHP isn't the right choice for every health system or hospital. Those that lack a clinically integrated network and the cash reserves to fund a plan should probably not create a PSHP.

PSHPs: Where to Begin

The board of a health care system that's weighing the merits of a PSHP should carefully consider these questions:

Network of physicians—What other area providers will be participating, and how strong is our system's primary care base?

Local payer reaction—Will independent payers still be willing to work with our providers—and, if not, can our system function without those contracts?

Market position and local competition—Does our system have a competitive advantage with certain populations and geographic areas?

Community reaction—How will patients and local employers react to a PSHP?

Regulatory environment—Are there state or local laws that would make it difficult for a PSHP to reach its full potential?

Costs and financial readiness—Does our provider organization have a bond rating and enough cash on hand (or the ability to secure that level of capital) to allow us to set aside the necessary reserves?

First Step: A Hospital-Sponsored Employee Health Plan

A health care system can make a gradual transition to the PSHP world by starting its own employee health plan. This provides practical experience in building risk-based payment models—and allows the health care system to learn the finer points of population health management. An added bonus is that value-based care really works—and employees will begin to enjoy greater health and productivity.

A pilot program of this type has its limitations. The health care system is only assuming risk for a population typically numbering in the hundreds, which is obviously much easier than managing risk for all the patients in a large metropolitan area. It's wise to establish success metrics before launching an employee health plan—and those goals should emphasize "progress, not perfection." Employees don't have to achieve Olympic-caliber results; achieving modest health goals will still have a significant financial impact.

Case Studies

Case studies below discuss health plans launched by three different health systems to meet highly targeted objectives. Each case provides a snapshot of board involvement.

Because PSHPs can be easily customized, they're better positioned than most commercial plans to tailor programs that improve outcomes for specific populations, including pregnant women, children and those suffering from conditions like asthma, diabetes and obesity.

Improving the Quality of Children's Care in South Texas

Board Snapshot

The Driscoll system has a foundation with its own board of trustees. Under that governance is the children's hospital, with its own board. The health plan is a wholly owned subsidiary of the hospital and also has its own board. There's quite a bit of overlap between the boards to support the transition to value-based care. In terms of governance, the physician group is also under hospital oversight.

These boards now try to view goals and metrics in a consolidated way. Otherwise, it looks like a zero-sum game: when the hospital census is high, the plan loses money; when the census is low, the plan does well.

The hospital system looks to the health plan to be the primary driver of population health management. Mary Dale Peterson, M.D., Driscoll Health Plan CEO, is on the hospital's Process Improvement Committee and Asthma Committee in an effort to decrease preventable admissions.

The Driscoll Health Plan (DHP) is a provider-sponsored health plan affiliated with Driscoll Children's Hospital in Corpus Christi, Texas. The plan now serves more than 130,000 members and is the dominant Medicaid payer in south Texas. DHP has launched a number of clinical quality initiatives, including:

Cadena de Madres (Chain of Mothers) program that provides prenatal education, lactation consulting, and nutritional counseling to pregnant women enrolled in the State of Texas Access Reform program. Thanks to the program, there's been a 34 percent reduction in the region's preterm births, one of the clinical conditions that carries the highest costs and can lead to lifelong health problems.

Asthma services—DHP offers a free home evaluation for members with asthma. Educators visit the parent/member to identify asthma triggers and assist with care management—and even bring a free protective pillow cover and bed cover. DHP also offers Asthma Camp sponsorships for children with asthma between ages 7 and 14. The camp provides social experiences and asthma-appropriate physical activities.

Health Plan's New Center Offers One-Stop Convenience

Texas Children's Health Plan recently launched The Center for Children and Women in Houston, Texas to provide a key ingredient in population health management: one-stop convenience.

The plan turned a former ExpressJet site into a primary medical home and community resource for its Medicaid members. The vast facility provides pediatric primary care and OB/GYN services—along with behavioral health, radiology and speech therapy services—all under one roof. There's even a "retail" corridor that includes dental and vision services, as well as a pharmacy. This integration is one of the keys to lowering health care costs.

The plan used population health analytics to determine which services to co-locate at The Center. Patient schedules from The Center's EHR data now flow into the plan's electronic data warehouse, which gives the team the ability to review upcoming patient care needs and ensure that nothing gets missed when a member presents. For example, a pregnant mother seeing her obstetrician can get an overdue immunization all in one visit.

This one-stop convenience is especially important in Houston, America's fourth largest city where traffic is often at a standstill. At The Center, plan members can receive prompt attention without having to make separate trips to the dentist or optometrist. And the Center offers extended hours—including Sundays—so that members don't have to visit emergency rooms or urgent care clinics.

The Center has on-site care coordinators to facilitate continuity of care for its pediatric and OB/GYN patients—and pharmacists reach out to patients if a medication hasn't been refilled on schedule. This type of ongoing engagement is an indispensable part of effective population health management.

Giving Members a Voice in Key Health Care Programs

Board Snapshot

The health plan has a 13-member board that includes four physicians and one executive from the oil industry (a field where risk management and data analytics play a central role).

The plan also has a 15-member management staff that provides corporate leadership, with a CEO, COO, CFO, CMO and other C-suite positions.

Scott & White Health Plan serves 200,000 members across 50 counties in central Texas.

The plan's RightCare program for Medicaid patients is taking engagement to a new level by holding frequent focus groups with both members and care managers. This direct feedback then gets turned into innovative programs. Here are some examples:

Smoking cessation program—The plan's "Clearing The Air" program starts with care managers asking members if they want help quitting tobacco products. If members agree to be under physician care for smoking cessation, they can choose from an expanded list of medications and products not on the Medicaid formulary.

Weight management program—The plan will soon replicate its successful "Step Up, Scale Down" commercial program for the Medicaid membership. This innovative lifestyle management program provides both phone and in-person counseling.

Free car seat after four pregnancy visits—Members who have at least four prenatal visits are eligible for a free infant car seat installed by certified technicians—along with instruction on car-seat safety. With enough well-child visits, the member can later receive a free toddler car seat. And by staying current with those visits and immunizations, the member can receive a free child booster seat.

Unlimited health-related calls and texting—RightCare members 18 or older can receive cell phones where all health-related calls and texts are free. It's a great way for members without computers to receive appointment reminders and guidance.

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