Webinar 2 Issue Brief:

**Business Imperatives of Population Health Management**

June 2, 2015
# Table of Contents

**Preface** ..................................................................................................................... 1  
**Introduction** ............................................................................................................... 2  
**Imperative 1. Physician and Clinical Alignment** .......................................................... 3  
  Alignment Strategy ........................................................................................................ 3  
  Primary Care and Patient Attribution ........................................................................... 6  
  Funds Flow Arrangements and Incentives ...................................................................... 6  
**Imperative 2. Contracting Strategy** ............................................................................. 7  
  Contracting for PHM ....................................................................................................... 9  
  Distribution Channels .................................................................................................... 10  
**Imperative 3. Network Optimization** ......................................................................... 12  
  Delivery Network .......................................................................................................... 12  
  Provider Roles in Population Health Management ...................................................... 13  
  Stakeholder Engagement .............................................................................................. 15  
  Critical Consumer-Related Questions for Providers ..................................................... 17  
**Imperative 4: Operational Efficiency** ........................................................................ 18  
  Cost Management versus Cost Transformation ............................................................ 19  
  Leadership Considerations ........................................................................................... 20  
**Imperative 5. Enabling Infrastructure** ....................................................................... 20  
  Management and Governance/Organizational Structures ......................................... 21  
  Risk Management ......................................................................................................... 22  
**Managing the Transition and the Impact on the Business** ....................................... 23  
**Concluding Comments** .............................................................................................. 26  
**Endnotes** ..................................................................................................................... 27
Preface

Governance and leadership teams of California’s hospitals and health systems must have the knowledge and skills needed to succeed under population health management (PHM). To help ensure success, California Hospital Association, in collaboration with Kaufman, Hall & Associates, LLC, is offering this five-part program titled “Population Health Management.” The program provides participants with an understanding of the key components of PHM. Each module features an issue brief and webinar for executives and professionals in a wide range of organizations.

This is the second issue brief and associated webinar in a five-part series. Other modules address a framework for the pursuit of PHM, clinical priorities, technology requirements, and leadership and talent considerations.

For additional information about the program visit: www.calhospital.org/population-health-web or contact the CHA Education Department at (916) 552-7637 or education@calhospital.org.

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“Population health management is the direction health care is moving. Those who commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role. Whether you are already immersed in PHM or just formulating your strategy, this program provides practical, boots-on-the-ground tools. I encourage all hospital leadership teams — from small, rural facilities to large urban hospitals — to consider participating in this program.”

Anne McLeod
Senior Vice President, Health Policy and Innovation
California Hospital Association
Introduction

Health care’s transition to a population health model presents hospitals 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, executives now 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.

Successful PHM participation and execution requires the nation’s hospitals and health systems to address six interrelated imperatives or competencies:

1. Physician and clinical alignment
2. Contracting strategy
3. Network optimization
4. Operational efficiency
5. Enabling infrastructure
6. Clinical management

This issue brief and its associated webinar cover the first five of these business imperatives and their key components. Emphasis is on the first three imperatives due to the challenges organizations are having in these areas, and the comparative scarcity of concise guidance covering these important topics. This publication describes strategies organizations are using to achieve the imperatives, using real-world examples whenever possible.

Due to its breadth and importance, the sixth imperative will be covered in Webinar 3 titled “Clinical Imperatives of Population Health Management.”

These six business imperatives will be essential to hospital and health system success in the future, but it is important to note that the degree and pace at which organizations pursue these imperatives 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, prevalence of managed care products and services, level of vertical collaboration across health plans and provider organizations, and pervasiveness of risk contracts and relationships.

“The degree and pace at which organizations pursue the six business imperatives will depend on a variety of internal and external forces.”
**Imperative 1. Physician and Clinical Alignment**

Under the PHM value-based model, hospital and health system success will be accomplished by offering services with the best possible quality, outcomes, access, and patient experience at the most efficient cost across the continuum of services and sites. Improved economic and clinical alignment between hospitals and clinicians will be essential to:

- Change the way patient care is delivered and reduce clinical variation
- 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)

PHM value-based models are receiving significant focus from the Centers for Medicare & Medicaid Services (CMS), providing health systems with a “menu of payment options” to align physicians, hospitals, and other providers. These payment mechanisms include Bundled Payments for Care Improvement, Comprehensive Primary Care Initiative, Federally Qualified Health Center Advanced Primary Care Practice, Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs), and other ACO initiatives.

Under bundled payment, for example, a single payment is paid to a hospital and a physician group for a defined episode of care, such as a knee replacement, rather than individual payments to individual providers.

CMS now covers 100 million Americans through Medicare, Medicaid, the Children’s Health Insurance Program, and the Health Insurance Marketplace. Physicians and hospitals can expect continued movement of the agency’s care delivery and payment strategy toward models that align providers economically and clinically.

Physician and clinical alignment considerations are addressed here as follows: alignment strategy; primary care and patient attribution; and funds flow arrangements and incentives.

**Alignment Strategy**

Clinical and economic alignment with the organization’s physician/clinician network is critical to success under 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. Physician alignment will require a pluralistic model or hybrid strategy that includes independent physicians, clinically integrated physicians, and employed physicians (as permitted by law).

Historically, on the lower end of the spectrum, U.S. hospitals and health systems can achieve a basic level of alignment with independent physicians by offering practice support in the areas of contracting, technology, insurance, marketing, and other administrative functions.

Contractual arrangements, such as professional services agreements (PSAs), comanagement agreements, joint ventures, management services organizations (MSOs), and others, can offer more advanced levels of alignment through the use of incentives based on productivity, quality, and efficiency metrics, among others.

For organizations seeking to assume lower levels of risk, a targeted approach to physician alignment can be used. For example, with a bundled payment arrangement for orthopedic services, the organization’s alignment efforts can be focused on orthopedic surgeons, anesthesiologists, physiatrists, and select primary care providers (PCPs) required under the arrangement.
A formal Clinical Integration program (distinguished by an upper case “C” and “I” and subject to review by the Federal Trade Commission) is one of many clinical integration models (distinguished by a lower case “c” and “i”) used to pursue tighter alignment between independent provider organizations. A formal Clinical Integration program allows joint contracting between hospitals and physicians to increase care quality and efficiency. Its infrastructure and care delivery requirements are considerable.

Other clinical integration models are being explored in California and nationwide to enhance and coordinate care functions, activities, processes, and sites. Arrangements vary based on the degree of economic and clinical alignment. Different physician-hospital alignment models deliver varying levels of value, based on the degree of provider integration and the cost, effort, and risk involved (Figure 1).

**FIGURE 1: Spectrum of Alignment Arrangements**

Because the direct employment of physicians is prohibited by most hospitals in California, the Foundation Model is used widely in the state. This model involves a health system’s formation of a 501(c)(3) not-for-profit corporation, which serves as the “foundation” and is exempt from clinic licensure. The corporation purchases the assets of physician practices using asset purchase agreements. In turn, the physicians create a professional corporation with which the foundation contracts for medical services.6
The not-for-profit corporation serves community medical, educational, and research needs while offering potential for increased economic and clinical integration of hospital and physician enterprises. It operates as either a controlled hospital system subsidiary or as an affiliated entity under governance of its own board. Professional services agreements are used to contract with physicians and medical groups. The foundation owns the clinic, facilities, supplies and equipment, and management information and billing systems. The physician/medical group continues to provide patient care and is responsible for professional services, peer review, utilization management, quality assurance, and credentialing functions (Figure 2).

**FIGURE 2: Example Foundation Model**

Note: This is a 1206(l) model; structure of models varies widely; MSA is a management services arrangement; PSA is a professional services arrangement

Source: Kaufman, Hall & Associates, LLC

Hospitals and health systems in California historically have integrated with physicians around managed care products and services (i.e., health maintenance organizations — HMOs). Pockets of significant clinical integration exist in some areas of the state. In other areas, health systems face formidable challenges to integrating with independent providers, even those collaborating with organized, sophisticated independent physician associations (IPAs). Despite extensive efforts, fragmentation across the provider landscape contributes to variability in health care cost and quality. This is apparent when looking practice by practice or hospital by hospital, as presented in a scatter diagram in Webinar 1. (See Webinar 1: A Framework for Population Health Management, slide 28.)

A next phase of alignment models is starting to emerge in California and nationwide to enhance current levels of clinical integration and overall quality performance. These ACO-like models align hospitals, physicians, and other key health care delivery entities covering the total cost of care. They
aim to enhance the level of value (price) provided to the community while rewarding providers for superior performance. These models also look to expand coverage to include a broader range of insurance products and services, including preferred provider organization (PPO) and point of service (POS) products, which historically have remained outside of the clinical integration construct.

**Primary Care and Patient Attribution**

For success with PHM-focused value/risk arrangements, a hospital or health system must have an integrated primary care network 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 PCP, typically based on past medical claims. The PCP may be a physician, another clinician (e.g., nurse practitioner or physician assistant), or an entity such as a clinic or hospital, and is responsible for the oversight and/or provision of that patient’s care. The PCP oversees the patients’ use of all health and medical services, including specialist care. In the population health model, therefore, the PCP plays not only a “provider-of-services” role but also a “manager-of-health” role.

Management of attributed patients is one of the biggest challenges nationwide in all types of networks. Without a high-functioning patient attribution and referral management process, patients may directly seek care from an out-of-network provider who is not incentivized or aligned to manage that care. This “leakage” to non-network providers — whose costs are then attributed to the network — can significantly increase the total cost of care while potentially providing lower quality and less coordinated care.

Clinicians need to have a clear understanding of how attribution works so that they recognize the financial impact of PCP assignment and can communicate to their patients the value of choosing and using their PCP network.

Clinicians also will need to evaluate the benefits and drawbacks of a prospective vs. retrospective attribution methodology and the impact this could have on future performance and incentives. Prospective attribution assigns members based on historical claims data, assuming that the patient will use the same provider in the future as they have in the past; retrospective attribution assigns patients based on their actual utilization.

Beyond attribution of patients, an effective care management program that is well understood by clinicians helps to ensure that patients do not seek unnecessary care or care in suboptimal sites.

**Funds Flow Arrangements and Incentives**

Funds flow arrangements between providers clearly delineate the criteria for distribution of earned incentives. The California HealthCare Foundation notes that funds flow risk arrangements “are likely to achieve the most effective overall outcomes because they provide incentives for greater collaboration and care coordination among providers with the primary goal of minimizing unnecessary costs.” Full or partial risk arrangements typically involve one organizing provider entity that receives the payment from an insurer, bears the financial risk, and is responsible for distributing funds or passing funds through to all other providers along the care continuum.

“A next phase of alignment models is starting to emerge in California and nationwide to enhance current levels of clinical integration and overall quality performance.”
Business structure and partnership vehicles can impact how funds flow ultimately will work. In some instances, health systems may create a new company, subsidiary, or legal structure to compensate and implement alignment models with physicians. In others, systems can modify existing contracts, or create new contracts through existing legal structures. The truth is this: “when you’ve seen one model, you’ve seen one model.” Although the specifics of funds flow arrangements vary widely, a standard set of metrics that are tied to incentives represents a typical starting point.

Physicians and other providers engaged in these models will want to understand the specific financial impact of proposed contracts, including performance incentive and penalty structures. They should review structure specifics to ensure that the performance goals are achievable and that the structure will not adversely affect any member of the care network who is meeting those goals. Additionally, clinicians will need to understand how baseline performance is being measured and over what time period.

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 with incentives 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 integrated 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.

The performance of the agreement needs to be continuously monitored and adjusted when possible to ensure that fairness and financial sustainability of incentives are maintained. Performance data should be transparent and regularly reported to physicians, executives, and health system trustees.

**Imperative 2. Contracting Strategy**

Contracting is fundamental to PHM programs as it is the process or vehicle to delineate what payers or other purchasers and providers will be accountable for. The implications of an organization’s contracting strategy span all business imperatives. Organizational and market-specific nuances dictate the types of contracting arrangements pursued for targeted population segments, and how far and how quickly an organization moves toward full risk models. This context defines the degree and the pace at which the organization develops and executes the six big-picture business imperatives.

Hospitals and health systems can participate in a variety of value-based or risk contracts, ranging from fee for service (FFS) 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). Figure 3 shows the variables contributing to care costs and which of these variables the provider could be at risk for under alternative payment systems.

**FIGURE 3: Variables for Which the Provider Is at Risk under Alternative Payment Systems**

While each risk model provides unique benefits and challenges to the provider organization and the purchasers of care, the biggest upside (and downside) potential for parties typically is realized when providers assume the greatest level of risk in population health care management and delivery for the total cost of medical care.

By assuming full risk for a population, providers typically receive a larger piece of the premium dollar for which they can achieve greater improvements in quality, cost, and access. These payments help to ensure sustainable financial and clinical performance.
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 (Figure 4).

**FIGURE 4: Effect of the Level of Organizational Integration on Payment Continuum**


**Contracting for PHM**

A health system will need to define and implement an effective contracting strategy to support its PHM programs and ensure a sufficient population base going forward. This will require consideration and analyses of the following interrelated risks and opportunities related to contracting with purchasers of health care:

- The demographics and health/risk characteristics of the populations served by specific insurance products
- Design of HMO, PPO, and employer-directed plans
- Product benefits, covered services, and pricing
- Contract terms and conditions
- Narrow and tiered network considerations or requirements
- Partnership opportunities related to specific networks, products, and plans

Thorough description of each of these considerations is beyond this publication’s scope, but organizations should evaluate the populations they want to go at-risk for and the types of insurance products that best serve population health goals.

The contracting strategy will vary based on populations served. Populations will be insured by different plans with different benefits. Plan benefits will have a significant effect on an organization’s ability to move the needle on such PHM indicators as admissions per thousand, length of stay, and readmission rates. Care delivery or assumption of risk for particular benefit designs or types of products will be more or less attractive to an organization based on what it can achieve in terms of effectively managing patient care and the associated costs.
Additionally, plans and products are changing with increasing use of high-deductible offerings, driving different care purchasing behaviors by consumers and other purchasers. Narrow and tiered networks are another important contracting consideration that are common with public and private exchanges. Such networks limit patients’ choice of hospitals and physicians to those that the plan administrators define as offering quality services at lower costs.

Narrow networks have been very controversial in California and elsewhere nationwide. Prompted by several lawsuits and consumer pushback about reduced health care access, California’s insurance commissioner increased the access requirements for insurers’ narrow networks in January 2015.\textsuperscript{13} Nationally, CMS tightened its rules for Medicare Advantage in February 2015 to ensure that plans have an adequate network of providers accepting new patients.\textsuperscript{14}

Regulations notwithstanding, hospitals that do not pursue PHM contracting strategies with purchasers now and during the next five to 10 years may find themselves excluded from key PHM networks in their region or may be relegated to the role of a discounted vendor of acute care services. As described later, pursuit of network partnership opportunities may be advisable to help prevent network exclusion, which could have a significant negative impact on hospital and health system performance going forward.

**Distribution Channels**

Distribution channels represent the various avenues through which hospitals can access population segments. Channels include direct contracting with employers, as well as provider and cobranded products across commercial, Medicare, and Medicaid insurance products.

Direct contracting by self-insured employers with health care providers is changing competitive dynamics in many markets and should be considered as health systems look to optimize their networks. A high-profile example is Walmart, which has bundled fee arrangements with six leading hospitals and health systems, to which the company steers employees needing heart, spine, or transplant surgeries.\textsuperscript{15}

Other employers are extending direct contracting efforts to encompass PHM with a narrow set of providers in a defined geographic market. California-based Intel has established a relationship with Presbyterian Healthcare Services in Albuquerque, N.M., for a patient-centered medical home approach with Intel employees in New Mexico called Connected Care. Intel is adapting and scaling the model to other locations where they have a significant number of employees. The model went live in the Portland, Oregon, area in January 2015 with Kaiser Permanente and Providence Health and Services as the collaborating organizations.\textsuperscript{16}

Growth in direct contracting models by large employers will depend on whether the contracts deliver the intended results — lower costs and higher quality. Key qualities that a large employer would find attractive in a potential health system partner include positive outcomes and transparency in sharing cost and quality outcomes, geography and access, and aligned incentives through payment arrangements, such as bundled payment.\textsuperscript{17}

\textit{“Regulations notwithstanding, hospitals that do not pursue PHM contracting strategies with purchasers now and during the next five to 10 years may find themselves excluded from key PHM networks in their region or may be relegated to the role of a discounted vendor of acute care services.”}
On the commercial side, providers will be able to work with employers and employees to further advance the value proposition, potentially though private exchanges. Numerous large employers — such as Sears, Walgreen’s, and Darden Restaurants — pioneered the use of private exchanges as a way to offer active employees a broader choice of plan and coverage options.

Private exchanges predate the public exchanges available under the Affordable Care Act and often are offered on a national level to or by employers who are looking to implement an exchange on a multistate basis. Such exchanges cap the employer’s benefit subsidies through defined-contributions into a limited spending account, and the employee individually selects a carrier and the plan in which to participate.

Surveys suggest increasing interest among employers for private exchanges. Thirty-one percent of large employers (with 500 or more employees) say they already have moved to private exchanges or are likely to do so within the next five years. Accenture forecasted that by 2018 private exchange enrollment will exceed public exchange enrollment by 9 million lives (Figure 5).

![FIGURE 5: Public versus Private Exchange Enrollment](source.png)

In some instances, integrated hospital systems will offer their own “provider-sponsored” insurance products or cobranded products directly to purchasers. For example, in Southern California, MemorialCare is offering Seaside Health Plan, a managed care program for individuals enrolled in Medicare, Medi-Cal, and commercial plans.

Depending on the provider-payer relationships in the market, providers also may seek to partner with health plans to brand their own private label product in the market. A recent example is Scripps Health, which entered into an exclusive cobrading agreement with SCAN Health Plan to develop new products and services for the senior population. The partners are offering three health plan options to Medicare beneficiaries in San Diego County in 2015.
The opportunity to further advance risk contracting in California is considerable. Risk arrangements accounted for only 21.8 percent of total health expenditures of $313.3 billion in California; FFS arrangements accounted for the remaining 78.2 percent. Traditional hospital contracting will evolve as organizations incorporate the care-management elements required for effective PHM and assume related risk.

**Imperative 3. 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 as described earlier, 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.

**Delivery Network**

In moving away from pure FFS care delivery and financing models, organizations must scrutinize their delivery networks in a new light. Although many of the traditional strategic criteria for a viable network still apply (e.g., demand for services, access points and footprint, competitive market positioning), additional criteria will be needed under a PHM construct. Criteria include:

- Network essentiality and PHM care continuum
- Network “adequacy”
- Service distribution right-sizing
- Delivery network growth strategy

These criteria are not mutually exclusive and each has certain nuances that will be important for hospitals and health systems to understand and evaluate.

Additionally, the criteria will need to be looked at on a population-by-population basis, whether Medicare, Medicaid, commercial, insurance exchange, employer, or other insurance products. Each population likely will have unique demand and risk factors driven by demographics, socioeconomics, and a variety of other considerations. These different demands will need to be accounted for in order to meet different service and network requirements.

For example, data show that the Medi-Cal population has higher demand for mental health services and social services, in addition to higher physical health care needs. A PHM network for this population must have, or be aligned with, a network of providers and agencies that are capable of integrating these key functions into the care model. This care model will need to adapt as eligibility criteria and requirements change, and as the needs of the population segments evolve.

“In moving away from pure FFS care delivery and financing models, organizations must scrutinize their delivery networks in a new light.”
Network Essentiality and PHM Care Continuum

“Network essentiality” is determined by health care purchasers based on the scope and scale of the delivery network. To be considered essential, a network must provide the breadth and depth of care desired by the purchaser, and be able to handle the projected volume of patients.

Network essentiality to the purchasers of care is usually tied to an organization’s PCP network and/or geographic presence, and measured based on the population that can be attributed to the provider delivery network. The larger the population captured or covered by an organization, the more essential it likely is in the PHM paradigm.

Hospitals and health systems have critical decisions to make related to network configuration based on the role they assume in population health management. This is particularly true for “population health managers,” who are functioning as the organizers of care delivery or “population health comangers,” as described in Webinar 1 Issue Brief and summarized below.

“Single product participants,” “multiproduct participants,” and “contracted participants” will work within a network managed by a population health manager or comanager. Such participants will not be forming networks themselves, but will want to be essential in their line(s) of business in order to avoid being excluded from future networks.

Most hospitals and health systems cannot afford to own all components of the care continuum, but will partner or affiliate to provide all the necessary pieces, such as post-acute services. Analysis of strengths and weaknesses in delivering care at each point in the continuum is important.

Build, buy, and/or partner options should be considered based on the organization’s objectives, its current capabilities, the required time frame for obtaining the needed capabilities (the “development window”), and resource requirements, including time, cost, and leadership for pursuing the options.

Provider Roles in Population Health Management

1 **Population Health Manager:** Integrated delivery system and/or health plan with the ability to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to develop its own insurance products and/or manage full provider risk

2 **Population Health Comanager:** Regional provider organization, clinically integrated with other organizations, that forms a value-based delivery system; well positioned to participate in PHM and risk-bearing arrangements in a delegated and/or direct fashion

3 **Multiproduct Participant:** Provider organization that works within a network(s) managed by a population health manager/comanager to provide a defined set of services for a broad population base comprised of both government and private-pay patients; critical role in future delivery system

4 **Single Product Participant:** Provider organization working within a network managed by a population health manager/comanager to provide specified and targeted services and/or population; these organizations will be critical components of narrow networks

5 **Contracted Participant:** Smaller niche providers, some of which may serve rural communities, that provide population access points under contractual arrangements; they face significant risk of commoditization

Source: Kaufman, Hall & Associates, LLC
Figure 6 illustrates an example of the care-continuum delivery capabilities of a regional health system. The system had well-developed delivery capabilities with all services except for post-acute and transitional care. Acquisitions or partnerships would be needed to fill these care needs.

**FIGURE 6: Example Health System’s Network Delivery Capabilities**

As organizations determine the right breadth for their network, trade-offs will be apparent. The broader the network, the harder it typically is to manage performance — especially without vested and aligned partner entities. However, the narrower the network, the more difficult it will be to manage a critical mass of patients/populations, thus making it harder to spread the risk for managing these populations.

**Network Adequacy**

“Network adequacy” refers to sufficiency of access to in-network primary care and specialty physicians, hospital services, and other specified continuum of care services in a delineated service area. At the most basic level, the service area is the geographic area in which a risk-bearing provider and/or health plan furnishes access to the continuum of services.

In many instances, service area and network adequacy standards are driven by national and state laws and regulations, which vary depending on the regulator. Adequacy will depend on the population served, so health systems will need to be thoughtful about whether they are able to build, contract for, and deliver an appropriate network, given each population’s variable set of requirements.

Network definitions are dynamic. As care delivery shifts to consumer-driven virtual offerings, providers, purchasers, and regulators alike will be trying to determine how to change historical network definitions from bricks-and-mortar facilities and clinics to virtual delivery mechanisms.
Service Distribution Right-Sizing

To succeed under value-based arrangements, many health systems need to systematically reconfigure their networks 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. Unnecessary duplication of services must be eliminated.

Proactive providers are working hard to determine the best combination and location of services and programs across inpatient and outpatient sites, and across virtual services, such as telehealth. The potential rewards can be significant for organizations that get the right mix, including: dramatic reduction of fixed costs associated with physical assets; more productive use of clinicians’ time; and provision of a greater level of convenience and lower prices for consumers.

Reconfiguring a delivery network is a multiyear transformational process that should be guided by a clear blueprint of the changes to be made, the key interdependencies, the sequence of changes, and the potential challenges. Physician partnership in the transformation process is critical.

Network Growth Strategy

As PHM-based value arrangements reshape utilization, most hospitals and health systems will need to grow their attributed or accessible managed populations to support organizational infrastructure and associated costs. Growth typically requires geographic expansion through strategic partnerships or affiliations with employers, providers, or health plans.

Partnering activity between and amongst providers and health plans is bourgeoning nationwide. Affiliations among systems in non-adjacent geographic markets also are increasing, aiming to increase efficiencies through the streamlining of back-office or administrative functions, and to grow market footprint.

In California, significant new partnership explorations are reported at least weekly. For example, UCSF Medical Center and John Muir Health recently announced creation of a jointly owned network and a new health insurance arrangement to build capacity and covered lives in the Bay Area. Both health systems will remain independent. Sutter Health is expanding its new health plan to include an HMO offering in Sonoma County like it offers in the Greater Sacramento area and parts of the Central Valley.

Absent growth in the number of attributed lives, organizations need to aggressively realign their operations to ensure financial stability. Efficiency is required of providers in all value-based contracting arrangements, as described later.

Stakeholder Engagement

Hospitals and health systems will need to educate and engage physicians, employers, and consumers within their network to maximize the health status and retention of the population under their management. This is true of all organizations participating in PHM.

Consumer engagement is required to ensure both the clinical and business success of managing a population’s health. Effective consumer engagement enables an organization to help shape healthy behaviors, ensure the right level of utilization, and steer individuals to the best site of care.

“Proactive providers are working hard to determine the best combination and location of services and programs across inpatient and outpatient sites, and across virtual services, such as telehealth. The potential rewards can be significant for organizations that get the right mix.”
Understanding how the consumer moves along the path to “purchase” is important. Figure 7 illustrates the four key elements of consumer decision making. Each has essential questions that hospitals and health systems must answer related to decision criteria, information access, consumer activation, and behavioral change.

**Figure 7: Key Steps of Consumer Decision Making in a Value-Based Retail Environment**

- Decision Criteria
  - What does the patient value most about each service?
  - Does the patient have a financial incentive to shop and compare providers?
- Accessing Information
  - How does the patient prefer to research/receive information?
  - Does the patient have access to a high-quality transparency tool?
- Consumer Activation
  - Does the patient actually shop for care?
- Behavioral Change
  - What is the price elasticity of demand?
  - Does the patient who shops for care make a different decision than he/she would have otherwise?

As the ambulatory and virtual care delivery markets have grown, providers’ information about consumer behavior has not kept pace. Many health systems lack fundamental business information, such as code and qualifier data for outpatient and physician encounters, about services that often constitute half or more of an organization’s revenue.

Additional questions that providers need to answer to shape a network in a value-based, retail-oriented environment are listed on the following page. Answering these questions requires a sophisticated mix of demographic, socioeconomic, behavioral, attitudinal, and psychographic information. That information then needs to be used to engage specific populations in particular business functions or goals (for example, engaging consumers in virtual care delivery arrangements). Hospital strategy must be focused around the relationship with the ultimate consumer, independently and/or related to the consumer’s physician or employer.

Provider organizations also will need to understand how pricing affects care decisions by consumers and employers who are increasingly approaching health care choices as they would retail purchases. Consumers with high-deductible health plans or plans with reference pricing are moving the health care marketplace toward elevated price awareness with lightning speed.

For example, in a recent study, cataract surgery patients covered by California Public Employees’ Retirement System (CalPERS) were offered reference-based pricing, which encouraged them to select lower-price ambulatory surgery centers (ASCs) instead of more expensive hospital outpatient departments. Under reference-based pricing, CalPERS offered a fixed contribution toward payment of a procedure. The patient was responsible for any charges exceeding that fixed contribution. Under this arrangement, use of ASCs increased by 8.6 percentage points more than ASC use by enrollees in a non-reference-based insurance plan.
Essential elements of price information for insured patients, as defined by the Healthcare Financial Management Association,\(^3\) include:

- Total estimated price of the services: the amount for which the patient is responsible plus the amount that will be paid by the health plan or, for self-funded plans, the employer
- Network status: indication of whether a particular provider is in network and information on where the patient can try to locate an in-network provider
- Out-of-pocket responsibility: the patient’s estimated resulting out-of-pocket responsibility, tied to the specifics of the patient’s health plan benefit design, including coinsurance and the amount of deductible remaining to be met (as close to real time as possible)

Other information related to the provider or the service sought, such as clinical outcomes and patient safety or satisfaction scores, should be included as possible and applicable.

Clinician engagement and education, as legally permissible, will increase the ability of organizations to provide value under risk arrangements. Health care leaders should ensure that affiliated physicians and other clinicians are educated about appropriate PHM-focused programs for patient referrals. For example, if a health system has a program offering caregiver support for managing chronic diseases at home, do the affiliated physicians and their nursing staffs know about the program?

Clinician focus on the total customer experience with each element of the value equation is important. Are providers improving the patient/caregiver experience? For example, among other variables, providers participating in the MSSP ACOs are evaluated based on the following patient-experience variables:\(^3\)

- Ability to receive timely care, appointments, and information
- Effectiveness of provider communications

### Critical Consumer-Related Questions for Providers

#### About Consumers:

- Which consumers prefer retail clinics, urgent care clinics, or physician office visits for which kinds of conditions?
- Which consumers are willing to communicate with their physicians through telehealth mechanisms, such as email, telephone calls, and video conferencing?
- How do consumers choose a physician?
- How important are convenience factors such as location and parking?
- What types of insurance plans do consumers have?
- How many consumers want to compare prices and how sensitive are they to prices for various services?

#### About Services for Consumers:

- Which members of a population are most likely to require which kinds of health care?
- Which members are most likely to require focused outreach to avoid unnecessary emergency department visits or hospitalizations?
- What demographic factors, environmental conditions, behaviors, and beliefs are associated with patients requiring more intensive levels of care?
- What techniques would be most effective to engage high-risk patients in their own care?

Source: Kaufman, Hall & Associates, LLC
• Access to specialists
• Health promotion and education
• Shared provider/patient decision making

Strategies to educate and engage all types of stakeholders about the organization deserves depth of coverage that isn’t possible here, but industry organizations offer a number of helpful reference titles.32

**Imperative 4: Operational Efficiency**

The need for operational efficiency and rigorous cost management—while improving access, health outcomes, and the patient experience—applies to all organizations, whatever population health role they assume.

California hospitals and health systems working under managed care contracting arrangements have gained considerable experience in restraining costs. Continued operational efficiency improvement will strengthen an organization’s ability to succeed under risk-based models and ensure sufficient financial returns necessary to support the sizable investments required for transformation.

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 (Figure 8).

**Figure 8: The Widening Cost Focus**

“Continued operational efficiency improvement will strengthen an organization’s ability to succeed under risk-based models and ensure sufficient financial returns necessary to support the sizable investments required for transformation.”
Broad strategic thinking about the care patients receive after they leave the hospital’s four walls is required of health system leadership to ensure the right care in the right place, at lower costs and better quality. Hospitals and health systems that are participating in Medicare Advantage, traditional Medicare, bundled payment, ACOs, and other models, will need to work closely with post-acute, home care, and other providers to deliver value. Efficiency will be vital for health systems that want to be included in value-based delivery networks forming nationwide. Network arrangements will “tier-out” or otherwise exclude higher-cost providers by steering patients to competitors that can offer quality services at a lower cost.

Access to traditionally higher-cost tertiary and quaternary care will be required for network adequacy as defined by regulations, but specialty hospitals including academic medical centers and children’s hospitals also will need to focus on cost management in order to remain competitive in their communities.

**Cost Management versus Cost Transformation**

Cost management in hospitals and health systems historically has addressed marginal improvements in areas including labor, non-labor, supply chain, revenue cycle, and overhead costs. This focus, while important for the fee-for-service business model, is insufficient for the value-based business model and for realizing significant total cost improvement nationwide.

Figure 9 highlights the expanded scope required to realize total cost transformation. Entire publications can be devoted to each box in this figure. Suffice it to say here that business reconfiguration and clinical effectiveness initiatives represent “harder” and “hardest” activities respectively.

**FIGURE 9: Total Cost Transformation**

<table>
<thead>
<tr>
<th>Margin Improvement</th>
<th>Business (Re)Configuration</th>
<th>Clinical Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical labor productivity</td>
<td>Corporate/Market scale</td>
<td>Care processes</td>
</tr>
<tr>
<td>Nonclinical labor productivity</td>
<td>Geographic footprint(s)</td>
<td>Clinical variation</td>
</tr>
<tr>
<td>Overhead</td>
<td>Service offerings</td>
<td>Care utilization</td>
</tr>
<tr>
<td>Supply chain</td>
<td>Service line distribution</td>
<td>Care management</td>
</tr>
<tr>
<td>Revenue cycle</td>
<td>Physician alignment and optimization strategy</td>
<td>Clinical integration</td>
</tr>
<tr>
<td>Facility planning/maintenance</td>
<td>New contracting/pricing models</td>
<td>Care transitions</td>
</tr>
<tr>
<td>Capital allocation</td>
<td>Consumer and retail strategy</td>
<td>End-of-life care</td>
</tr>
<tr>
<td>Nonoperating assets/liabilities</td>
<td>Innovation strategy</td>
<td>Patient education</td>
</tr>
<tr>
<td>Corporate risk management</td>
<td>Community investment strategy</td>
<td>Public health and wellness</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC
Leadership Considerations

Few organizations have the time and human and economic resources to pursue all initiatives concurrently. The order of priority for cost transformation for any organization will vary based on its market, clinical resources and environment, and financial position. Political will within the organization, the strength of its management and clinical teams, its culture of measurement and accountability, and other factors also play a significant role in how strategic cost transformation proceeds. An objective evaluation of these characteristics is strongly recommended. At the most fundamental and pervasive level, total cost transformation will require cultural change. Supported by the board of trustees, executive leaders must create a culture of results and accountability. Executive communication of the strategic cost transformation plan to all stakeholder groups is essential. Visionary leaders recognize and enable active participation organization-wide. This will be key to sustaining the required changes. Major initiatives need to be led in a way that is cognizant of the larger framework and the power of participation to drive meaningful change. Webinar 5, Leadership and Talent for Population Health Management, will provide in-depth coverage of leadership considerations, including new perspectives on scale and volume, changing metrics of leadership performance and accountability, new leadership roles, and the leadership implications of partnership arrangements.

Imperative 5. Enabling Infrastructure

PHM infrastructure requirements are extensive and can be daunting for hospitals and health systems. Organizations should understand that the transition to managing population health involves major clinical and organizational transformation made possible by investment in six areas:

- 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, as described earlier
- IT systems that are able to support clinical care management processes, common electronic health record systems, and clinical and predictive analytics, as well as the business functions involved in receiving and distributing payments for the provision of care
- Care management and coordination tools and protocols tied to an enterprise-wide decision support and reporting function that enables the access, collection, analysis, and interpretation of claims, costs, quality, and utilization information
- Contracting and risk assessment and management capabilities, including actuarial skills if the organization is assuming full risk for a population
- And, finally, patient engagement programs to build loyalty and “stickiness” to the organization

PHM will require hospital 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. These investments may be large and most take multiple years to put in place. A high-level look at two key infrastructure needs follows.

“PHM will require hospital 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.”
Management and Governance/Organizational Structures

Most organizations today lack a high proportion of physicians and other clinicians in executive leadership roles and in key positions on board committees. To be described in depth in Webinar 5, this reality will have to change. Physician and nurse leaders who have autonomy and authority must drive the design, implementation, and monitoring of performance of the delivery network within the PHM model. Enabling clinicians to assume management of the clinical enterprise will likely involve assisting them in developing new skill sets. The ability to attract, nurture/build, and keep such leaders is critical.

Organizations will need to establish governance structures for physicians (including those in a Foundation Model and those choosing to remain in private practice) that ensure the appropriate allocation of resources, the monitoring and optimization of performance, and buy-in across the network. This can be achieved through a joint operating committee structure, which enables meaningful representation of physicians in shared governance to drive improvement in care delivery.

Most health care organizations currently maintain hospital/site-centric management and governance structures. These structures typically tie executive and board accountability and performance to individual facilities or geographic areas, rather than to the system as a whole across a region.

Management and operational structures will need to evolve to service- and system-centric models that maximize the functioning of the system across a region.

A sample, simplified organizational chart for a service-centric health system appears as Figure 10. This structure is consistent with a PHM model, reducing the barriers to the integration of services and cost-structure management across the organization.

**FIGURE 10: Service-Centric Model**

Source: Kaufman, Hall & Associates, LLC
Risk Management

The sources of risk that must be managed in value-based contracting under a PHM construct through an appropriate infrastructure, including strategic and operating risk, actuarial or insurance risk, financial/asset and liability risk, and comprehensive risk. A brief description of each follows: 

**Strategic and operational risk** involves an organization's ability to build the competencies for the new business model, such as a robust risk-management infrastructure and a high-performing delivery network for patients. The ability to generate sufficient capital and effectively manage risk allocation is required. Sources of risk include, for example:

- Unexpected competition from new market entrants
- Performance of care-continuum partners
- Known and unknown impacts of health care reform

**Actuarial or insurance risk** is the ability to properly estimate use rates and costs for serving a defined population under a value-based contract, and mitigating risk of inaccurate projections. Examples:

- Fluctuations in risk-adjusted patient utilization
- Changes in payer mix and/or shift in composition of patient population (i.e., the impact of public and private health insurance exchanges)

Health care organizations should be able to meet capital reserve requirements for assuming risk. Only a limited number of organizations currently have the scale and resources to absorb this level of risk, so any organization considering taking on actuarial or insurance risk should seek expert advice.

**Financial/asset and liability risk** is incurred due to the significant capital required to build the infrastructure for value-based care, including technology, physician networks, and care-management resources. Examples:

- Cost of building capital structure
- Credit-enhancement initiatives

As health systems invest in such areas, their ability to invest in other traditional business is restricted.

**Comprehensive risk** refers to the combination of all the component risks listed here, and their aggregate effect on the organization. Examples:

- Declining or flat market share
- Failure to make appropriate investments in needed competencies/resources

Such risk can undermine a hospital's or health system's strategies, market position, financial performance and, ultimately, its ability to serve its community. Health care leaders must understand how their organization's single and comprehensive risk profiles stack up to its ability to handle that risk, and make necessary adjustments to balance these components.
Managing the Transition and the Impact on the Business

As a value-based business model for managing population health replaces the volume-based model, the financial implications confronting hospitals and health systems are rapidly evolving, making it difficult for health care leaders to plan with any level of certainty. Significant challenges during the transition, including increasing price sensitivity from consumers and other health care purchasers, decreasing demand for inpatient services, and shifting in focus to care provided in ambulatory and home settings and through virtual offerings, are increasing operating pressures.

The speed of change will vary from market to market, but hospitals and health systems that wish to serve their communities over the long term must develop realistic plans for making the transition, and navigating the gap in between. Addressing the evolution requires disciplined integration of strategic financial planning and operational execution. This is a continuous process, which involves frequent updating of models and their link to execution.

Leaders should regularly quantify the impact of current market trends with positive and negative financial implications. For example, Figure 11 shows a sample analysis of an organization with a $50 million annual deficit resulting from declining inpatient utilization, narrow networks, “steerage” of patients to other providers, and other trends.

**FIGURE 11:** Annual Estimated Impact of Selected Market Trends Sample Report

Source: Kaufman, Hall & Associates, LLC
Figure 12 compares the revenue and expense targets of a regional PHM company to the estimated performance of a health system in the area. It indicates that Organization X will need to reduce its care delivery costs by $20 per member per month (pmpm) to be competitive and yield the desired 2 percent margin.

**FIGURE 12: Estimated PHM Performance of a Health System**

<table>
<thead>
<tr>
<th>A Population Management Illustration</th>
<th>Population Health Company Target ($ B)</th>
<th>Population Health Company Target PMPM</th>
<th>Estimated Org X PMPM To Deliver Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Revenue: 1,000,000 managed lives @ $486 pmpm premium</td>
<td>$5.83</td>
<td>$486</td>
<td>$486</td>
</tr>
<tr>
<td>60% for network hospital and physician care, less:</td>
<td>$3.50</td>
<td>$292</td>
<td>$312</td>
</tr>
<tr>
<td>30% for other health care costs</td>
<td>$1.75</td>
<td>$146</td>
<td>$146</td>
</tr>
<tr>
<td>8% for administration and care management</td>
<td>$0.47</td>
<td>$39</td>
<td>$39</td>
</tr>
<tr>
<td>Target 2% Margin</td>
<td>$0.12</td>
<td>$10</td>
<td>($11)</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC

Organizations should be incrementally testing the impact of major strategies. These may include traditional cost initiatives in areas such as labor and non-labor savings, as well as PHM-focused initiatives such as facilities reconfiguration and business/service line redistribution.
For example, Figure 13 indicates the potential risks over a three-year period under different scenarios assuming that the sample health care organization achieved only 50 percent of the desired benefits of its strategies related to cost management, facility reconfiguration, and service line redistribution.

**FIGURE 13: Testing the Strategies Through Risk Sample Analysis**

<table>
<thead>
<tr>
<th>Sensitivity/Risk Analysis</th>
<th>Target Goal</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Variance from Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>5.0%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Operating EBIDA Margin</td>
<td>12.0%</td>
<td>8.9%</td>
<td>9.2%</td>
<td>9.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Debt to Capitalization</td>
<td>35.0%</td>
<td>21.6%</td>
<td>20.0%</td>
<td>18.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>200.0</td>
<td>159.7</td>
<td>159.9</td>
<td>147.1</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cost Management at 50%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>5.0%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.9%</td>
<td>(-0.3%)</td>
</tr>
<tr>
<td>Operating EBIDA Margin</td>
<td>12.0%</td>
<td>8.5%</td>
<td>8.7%</td>
<td>8.9%</td>
<td>(-0.7%)</td>
</tr>
<tr>
<td>Debt to Capitalization</td>
<td>35.0%</td>
<td>21.7%</td>
<td>20.1%</td>
<td>18.5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>200.0</td>
<td>155.7</td>
<td>155.9</td>
<td>143.1</td>
<td>(4.0)</td>
</tr>
<tr>
<td><strong>Facility Reconfiguration at 50%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>5.0%</td>
<td>(-1.1%)</td>
<td>(-0.1%)</td>
<td>(-0.8%)</td>
<td>(-2.0%)</td>
</tr>
<tr>
<td>Operating EBIDA Margin</td>
<td>12.0%</td>
<td>64.0%</td>
<td>6.7%</td>
<td>7.1%</td>
<td>(-2.5%)</td>
</tr>
<tr>
<td>Debt to Capitalization</td>
<td>35.0%</td>
<td>24.6%</td>
<td>23.0%</td>
<td>21.4%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>200.0</td>
<td>139.7</td>
<td>139.9</td>
<td>127.1</td>
<td>(20.0)</td>
</tr>
<tr>
<td><strong>Service Line Strategy at 50%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>5.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>(-0.7%)</td>
</tr>
<tr>
<td>Operating EBIDA Margin</td>
<td>12.0%</td>
<td>7.4%</td>
<td>7.7%</td>
<td>8.1%</td>
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<td>35.0%</td>
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<td>20.5%</td>
<td>18.9%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>200.0</td>
<td>149.7</td>
<td>149.9</td>
<td>137.1</td>
<td>(6.0)</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC

Clearly, this represents broad-brush analyses, but it is indicative of the range, specificity, and intensity of risk analyses that can be performed. By quantifying the implications of each initiative independently and in various groupings, leaders can define an optimal portfolio of strategies for sustainable financial performance that will enable the organization to improve patient experience and care outcomes, progressing with PHM goals.
Concluding Comments

Health care in the U.S. is experiencing more structural changes than perhaps at any point in the past century. The ability of hospitals and health systems in California and nationwide to participate in population health management by providing high-quality care with improved outcomes and patient-care experience is a requirement for being able to succeed/thrive in this new environment. An organization with high readmission rates, low process of care outcomes, and low patient satisfaction ratings will not be able to pursue or maintain value-based contracts.

Effective and efficient population health management requires a thoughtfully developed contracting strategy, strong physician and clinical alignment, optimization of delivery networks, and strengthening of stakeholder engagement—particularly patient and family involvement. Operational efficiency and enabling infrastructure also are critical. These business imperatives are complex and interrelated. The sharing of lessons learned will help speed progress going forward.

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Kaufman, Hall & Associates, LLC

“By quantifying the implications of each initiative independently and in various groupings, leaders can define an optimal portfolio of strategies for sustainable financial performance that will enable the organization to improve patient experience and care outcomes, progressing with PHM goals.”
Endnotes

1. Patient-centered (or “primary care”) medical homes (PCMH), a concept first introduced by the American Academy of Pediatrics in the late 1960s, are the entities coordinating care and receiving CMS payment for the two primary care initiatives mentioned here.


4. California is one of several states that prohibits the corporate practice of medicine. The corporate practice ban disallows most hospitals from providing medical services through the employment of physicians.


9. With the exception only of Kaiser Permanente’s closed model


12. Individual contracting models defined in Webinar 1 Issue Brief, page 7.


28 See Kaufman, K.: “New Ways to Know Your Consumers.” Blog from the Chair, March 31, 2015 (kaufmanhall.com) for more information on this topic.
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